

S ummary
P lan
D escription

for:

Health Care Plan

- Medical Program
- Dental Program
- Vision Program

FOREWORD

The following document is the Summary Plan Description for the BB&T Corporation Health Care Plan. Summary Plan Descriptions or "SPDs" are intended to summarize and explain a plan's principal provisions. The material contained in each SPD is taken from the actual legal plan document that governs the principles and provisions under which a plan operates.

Therefore, if any conflict exists between the SPD and the actual plan provisions, the terms of the legal plan document will govern.

The Health Care Plan is designed to provide you and your covered dependents coverage for medical, dental and vision care expenses.

If you are employed in California, you are covered under additional provisions. Please see the California supplement to this SPD for more information.

We encourage Plan participants to read the SPDs carefully. If you have any questions regarding the information in the SPDs, contact the Plan Administrator whose name and address are listed under "Facts About the Plan" for each Plan.

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FACTS ABOUT THE PLAN

Plan Name:	BB&T Corporation Health Care Plan	
Employer Name, Address and Telephone Number:	BB&T Corporation 200 W Second Street P.O. Box 1215 Winston-Salem, NC 27102 (800) 716-2455, option 1 benefits@bbandt.com	
Effective Date:	This summary is a description of the Plan benefits effective January 1, 2018.	
Name and Address of Agent for Legal Services:	Chairman, Employee Benefits Plan Committee Plan Administrator and BB&T Corporation Winston-Salem, NC 27102 P.O. Box 1215	
Plan Number:	56-0939887 / 508	
Type of Plan:	Self-Funded Welfare Plan providing medical, dental and vision benefits	
Plan Year / Benefit Period:	January 1 through December 31	
Benefit Services Manager:	<u>Medical*</u> Blue Cross NC PO Box 2291 Durham NC 27702 (800) 621-8876 BlueConnectNC.com	<u>Dental</u> Ameritas PO Box 82520 Lincoln NE 68501-2520 800-487-5553 Ameritas.com/group/olbc/bbt
	<u>Pharmacy*</u> Prime Therapeutics Mail Route: BLUE CROSS NC PO Box 14501 Lexington KY 40512-4501 www.primetherapeutics.com	<u>Vision</u> Vision Service Plan 3333 Quality Drive Rancho Cordova, CA 95670 (800) 877-7195 www.vsp.com

*Employees in California may be eligible for Medical coverage through another Benefit Services Manager. Please see the California supplement to this SPD for details.

The information contained in "Facts About The Plan," together with the information set forth on the following pages, comprises the Summary Plan Description for the "BB&T Corporation Health Care Plan" as required by the Employee Retirement Income Security Act of 1974 (ERISA).

FUNDING

The cost of the BB&T Corporation Health Care Plan (hereafter referred to as “the Plan”) is shared by you and BB&T (and its affiliates). By sharing the cost of the Plan, we can provide the best possible coverage for you and your dependents at a reasonable cost. The Plan is self- funded, which means no insurance policy has been purchased to pay health care claims. Employees in California may participate in a fully-insured contract which is described in the California supplement to this SPD.

GRANDFATHERED STATUS

Under the Patient Protection and Affordable Care Act, the Plan is required to provide the following notice:

This group health plan believes this plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at 800-716-2455, Option 1. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444- 3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

MEDICAID AND THE CHILDREN’S HEALTH INSURANCE PROGRAM (CHIP)

Under the requirements of the federal CHIP program, the Plan is required to provide the following notice:

If you or your children are eligible for Medicaid or CHIP and you’re eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren’t eligible for Medicaid or CHIP, you won’t be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit <http://www.healthcare.gov>.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these program contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or <http://www.insurekidsnow.gov> to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren’t already

enrolled. This is called a “special enrollment” opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at <http://www.askebsa.dol.gov> or call **1-866- 444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2016. Contact your State for more information on eligibility –

ALABAMA - Medicaid	FLORIDA - Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtprecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA - Medicaid	GEORGIA - Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS - Medicaid	INDIANA - Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.hip.in.gov Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO - Medicaid	IOWA - Medicaid
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	Website: http://www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562
KANSAS- Medicaid	NEVADA- Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900
KENTUCKY- Medicaid	NEW HAMPSHIRE- Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA- Medicaid	NEW JERSEY- Medicaid and CHIP
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710

MAINE- Medicaid	NEW YORK- Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS- Medicaid and CHIP	NORTH CAROLINA- Medicaid
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MINNESOTA- Medicaid	NORTH DAKOTA- Medicaid
Website: http://mn.gov/dhs/ma/ Phone: 1-800-657-3739	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MISSOURI – Medicaid	OKLAHOMA - Medicaid and CHIP
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
NEBRASKA- Medicaid	PENNSYLVANIA- Medicaid
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633	Website: http://www.dhs.pa.gov/hipp Phone: 1-800-692-7462
RHODE ISLAND- Medicaid	VIRGINIA- Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
SOUTH CAROLINA- Medicaid	WASHINGTON- Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
SOUTH DAKOTA- Medicaid	WEST VIRGINIA- Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
TEXAS- Medicaid	WISCONSIN- Medicaid and CHIP
Website: http://gethipptexas.com/	Website:

Phone: 1-800-440-0493	https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
UTAH- Medicaid and CHIP	WYOMING- Medicaid
Medicaid Website: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VERMONT- Medicaid	
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	

To see if any other states have added a premium assistance program since July 31, 2016, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

US. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61465

ELIGIBILITY

An eligible employee is any regular (not temporary or contingent) employee scheduled to work at least 20 hours per week. An eligible employee may become a participant on his or her first day of employment. A participant and his or her eligible covered dependent(s) who incur covered expenses will be eligible for the benefits provided by this Plan. Benefits will be provided only if coverage is in effect for a participant or dependent at the time the charges are incurred.

Becoming a Participant

Eligible employees become participants on the first day of employment, provided they elect to be covered under the Plan. An eligible employee may choose to be covered under the medical portion, the dental portion, the vision portion or any combination.

If an eligible employee does not elect to participate in the Plan, he or she may choose to become a participant by making an appropriate election during the Plan’s annual enrollment period. Other entry dates may be available under certain specific circumstances. Please see “Changes in Coverage” for more information.

An employee who is not currently an eligible employee may become a participant on any such future date that he or she meets the eligibility requirements.

Dependents

As a participant in this Plan, you may cover your "dependents" defined as follows:

- Your legal spouse;
- Your Children under age 26;

For purposes of this Plan, "Child" or "Children" includes natural child, stepchild, adopted child, foster child, or any child who meets the definition of Qualifying Child in section 152(c) of the Internal Revenue Code

You may continue to cover any disabled children who are dependent on you even though they are no longer under age 26. If you want to continue to cover your disabled child, it will be necessary to submit proof of incapacity within 31 days after the date the child would have otherwise ceased to be an eligible dependent. An eligible employee can add a disabled child to the Plan. Proof of incapacity may be required from time to time.

If a child is eligible for coverage by more than one employee, only one employee may cover the child. In addition, an employee cannot cover another employee as a dependent. If you have questions regarding your dependents' coverage, contact Benefits Administration.

Dependent Eligibility

Your dependents become eligible for coverage on the latest of the date you become eligible for coverage and:

1. The date a person becomes your legal dependent (for example, you get married or have a child); or
2. The date an adopted child is placed in your home for adoption, even though the adoption may not yet be final. If the adopted child is a newborn, the child will be covered from the moment of birth if the adoption petition has been filed, subject to coverage rules as defined below.

Coverage for a dependent will begin on the date the dependent becomes an eligible dependent, provided you make an election in Workday within 31 days of the eligibility date. **If you wait more than 31 days to apply for coverage for your dependent(s), you may not add the dependent(s) to your coverage until the Plan's next annual enrollment period.**

LIFEFORCE

The BB&T LifeForce Program encourages healthy lifestyles by evaluating an employee's current health and fitness level, and setting goals for achieving a desired level of fitness for each employee. A significant reduction in premiums for medical plans may be realized by successfully participating in the LifeForce Program. The LifeForce program is a voluntary, outcomes-based wellness program that is subject to federal guidelines. Specific information regarding the program's requirements and the data collected by the program can be found at BBTBenefits.com. Please contact the Human Systems Service Center at 800-716-2455 or visit BBTBenefits.com for more information regarding this program.

CHANGES IN COVERAGE

Prior to January 1 of each year, there will be an enrollment period for employees who wish to add or drop coverage for themselves or their dependents, or change Plan options. Benefit changes made during the enrollment period will be binding for the Plan year unless a status change is experienced. Status changes include:

- Birth, Adoption, Placement for Foster Care, Legal Guardianship
- Marriage, Divorce, Legal Separation
- Gain or Loss of Spouse's coverage due to change in employment
- Gain or Loss of coverage under Medicare or Medicaid
- Loss of coverage due to loss of eligibility for Medicaid or CHIP*
- Eligibility for premium assistance under Medicaid or CHIP*
- Death of Spouse or Child
- COBRA coverage expires or COBRA subsidy expires
- Start or End of Unpaid Leave of Absence
- Start or End of Military Leave
- Change in Daycare (Dependent Care FSA only)
- Spouse moves into or out of the USA
- Significant change in health care cost of spouse's coverage
- Loss of Eligibility under a parent's coverage

Voluntarily dropping coverage is not a status change that will allow you to change your coverage under the BB&T Corporation Health Care Plan. In addition, a child changing student status is not a status change that will allow you to change your coverage under the Plan

It is the employee's responsibility to request changes in coverage after a status change within 31 days of the status change date. Employees can request changes by logging on to Workday through InSite or through BBTBenefits.com.

*For these change reasons only, you are allowed a 60-day period to initiate the change.

TERMINATION OF COVERAGE

Employees

Your health care coverage will terminate on the earliest of the following dates:

1. The 15th of the month in which you terminate if your last day worked is on or before the 15th. If you terminate after the 15th of the month, your coverage will end on the last day of the month in which you terminate employment;
2. The date the Plan is amended to terminate the coverage of a class of employees of which you are a member;
3. The date any required premium contribution is not made;
4. The date the Plan is terminated; or

5. The 15th of the month in which your scheduled hours drop below 20 hours per week if that change occurs on or before the 15th. If your scheduled hours drop below 20 hours per week after the 15th of the month, your coverage will end on the last day of the month.

If you are absent due to an authorized leave of absence, participation may continue during your leave period. Continued coverage under the above conditions shall terminate upon failure to make any required premium contribution. Contact Benefits Administration for details regarding these important benefits.

Dependents

Coverage for dependents ends on the earliest of the following dates:

1. The date your coverage ends;
2. The date you stop participating in the Plan;
3. The end of the month a dependent child ceases to be a dependent child (e.g., reaching the age limit);
4. The date the Plan is amended to terminate dependent coverage;
5. The date you fail to provide required information on your disabled dependent children or qualifying child; or
6. The date you and your spouse become divorced.

LEAVE OF ABSENCE

While on leave of absence (with or without pay), your coverage will be continued. However, during that time, you will be required to make any necessary premium contributions for coverage. Once leave has ended, if you have not returned to active employment with the Company (or been granted additional leave), coverage will terminate. Continuation of Benefits will be offered as described under the "Continuation of Benefits (COBRA)" section, beginning on the earlier of the date on which (i) your approved leave ends, or (ii) you inform the Company that you do not intend to return to work.

CONTINUATION OF BENEFITS (COBRA)

The 1986 Consolidated Omnibus Budget Reconciliation Act (COBRA) requires BB&T to offer continuation of medical care coverage to employees and their eligible dependents when certain events occur. As an employee of BB&T covered by the Plan, you and your eligible dependents have the right to choose this continuation coverage if you lose your medical coverage because of a qualifying event. Refer to the "Summary of Qualifying Events" chart.

Continuation periods are available for the following events: 18 months – employee, spouse, eligible dependent:

- Termination (other than for gross misconduct) (continuation of coverage may be extended for an additional 11 months if disabled at any time during the first 60 days of continuation coverage)
- Reduction in scheduled hours to less than 20 per week

36 months – spouse of an employee:

- Death of employee
- Divorce or legal separation
- Employee becomes eligible for Medicare

36 months – employee's eligible dependent child:

- Death of employee
- Parent's divorce
- Parent becomes eligible for Medicare
- Dependent child ceases to qualify as a "dependent child" under the Plan's definition

You will be notified by BB&T if you become eligible for this continuation coverage because of termination or reduction in hours. **It is your responsibility to contact Benefits Administration within 31 days of the date of the qualifying event if you are divorced.** BB&T's notification will include an election form, more information about the cost of coverage, payment methods and the period of coverage.

If, during the 18-month continuation period, the former employee dies or divorces, or if a child ceases to qualify for dependent coverage as defined by the Plan, the period for the affected dependent may be extended beyond the 18 months, but in no event beyond a total continuation period of 36 months.

If an employee or covered dependent becomes eligible for Medicare after the date of the COBRA election, coverage will cease.

If you had Medicare coverage prior to COBRA coverage, Medicare will be the primary payer. If you enroll in COBRA coverage and later enroll in Medicare, your COBRA eligibility will end. If you are eligible for Medicare but choose not to enroll, you may elect COBRA coverage.

If an employee or covered dependent first becomes covered under another group health plan after the date of the COBRA election, coverage will end.

If you elect this coverage, it will be the same program provided to active employees. You will have to pay the total cost (i.e., with no Company subsidy) of the continuation coverage plus a 2% administration fee.

Continuation of coverage also may be provided to the extent specified by law in the unlikely event the Company files for bankruptcy.

Continuation of COBRA coverage will stop before the end of the time period indicated if:

- You or your dependent first becomes covered under another group health plan after the date of the COBRA election;
- You or your dependent becomes eligible for Medicare after the date of the COBRA election;
- You do not pay the required premium within the grace period;
- BB&T ceases to provide group coverage to any employee; or
- The continuing participant ceases to be disabled according to Social Security Administration after the 11 month disability extension has begun.

Summary of Qualifying Events

Qualifying Event	Who Is Eligible	Maximum Extension	Who Must Notify Plan Administrator	Time Period for Notification ²
Termination of employment (other than for gross misconduct)	Employee/Spouse/Eligible Dependents	18 months ¹	Employer	30 days
Reduction in hours which renders Employee ineligible	Employee/Spouse/Eligible Dependents	18 months	Employer	30 days
Death of Employee	Spouse/Eligible Dependents	36 months	Employer	30 days
Employee becomes eligible for and selects Medicare	Spouse/Eligible Dependents	36 months	Employer	30 days
Divorce or legal separation	Spouse/Eligible Dependents	36 months	Spouse /Dependents	60 days
Dependent no longer meets eligibility requirements	Dependent	36 months	Dependent	60 days

¹If the insured is disabled at the time or within the first 60 days of termination, coverage may be extended an additional 11 months at 150% of the full premium.

²Maximum period which runs from the date of the qualifying event.

AVAILABILITY OF COVERAGE UNDER PPACA (HEALTH CARE EXCHANGES)

Under the Patient Protection and Affordable Care Act, insurance exchanges are available which allow individuals to purchase health insurance coverage. For additional information about exchanges (also known as the Health Insurance Marketplace) please refer to BBTBenefits.com. Because BB&T's plans meet the coverage and affordability requirements under PPACA, associates who are eligible for coverage at BB&T are not eligible for subsidies through the exchanges.

HIPAA PRIVACY RULES

The Health Insurance Portability and Accountability Act (HIPAA) requires that health plans protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Plan's privacy notice which is published at BBTBenefits.com.

This Plan and BB&T will not use or further disclose information that is protected by HIPAA ("protected health information") except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. By law, the Plan has required all of its business associates to also observe

HIPAA's privacy rules. In particular, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of BB&T.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

This Plan maintains a privacy notice, which provides a complete description of your rights under HIPAA's privacy rules. For a copy of the notice, please contact the Human Systems Service Center or visit BBTBenefits.com. If you have questions about the privacy of your health information, please contact the BB&T Benefits Manager in the Human Systems Division.

NEWBORN MOTHERS HEALTH PROTECTION ACT (NMHPA)

Group health plans and health insurance issuers may not, under Federal law, restrict benefits for any hospital length of stay in connections with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

WOMEN'S HEALTH AND CANCER RIGHTS ACT

The Women's Health and Cancer Rights Act of 1998 requires medical plans that offer mastectomy benefits to also provide coverage for reconstructive surgery. Coverage extends to: Reconstructive surgery of the breast on which the mastectomy is performed; treatment to produce a symmetrical appearance following a mastectomy; Prostheses; and Physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

The manner of coverage will be determined by the medical plan in consultation with the patient and the attending physician. This coverage will be paid according to the normal provisions of the medical plan. These provisions apply to mastectomies received while either you or your dependent is covered under the Plan.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO)

If a qualified medical child support court order (QMCSO) issued that requires you to provide health coverage to a child who is not in your custody, you may do so under the Plan. To be considered qualified, a medical child support order must include:

- Name and last known address of the parent who is covered by the Plan;

- Name and last known address of each child to be covered under the Plan;
- Type of coverage to be provided each child; and
- Period of time the coverage is to be provided.

Medical child support orders should be sent to Benefits Administration. If the order is determined to be qualified, you may cover the children under the Plan.

STATEMENT OF YOUR ERISA RIGHTS

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

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

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of this Plan. The people who operate your plan — called "fiduciaries" of the Plan — have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining benefits under the Plan or exercising your rights under ERISA.

If your claim for a benefit under this Plan is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$147 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits that is denied, or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified

status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that the Plan's fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a

federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees (for example, if it finds your claim is frivolous).

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

EFFECTS OF MEDICARE ON BENEFITS

Under the Medicare Secondary Payer (MSP) rules, employer-provided health plans are generally primary to Medicare. Although Medicare is designed to provide health coverage for individuals over age 65, it will pay on a secondary basis if a retiree or spouse is covered under an employment-related plan and either the retiree or the retiree's spouse works.

Under the MSP rules, Medicare is generally the secondary payer of medical bills with respect to the following three types of Medicare beneficiaries:

1. Medicare beneficiaries age 65 and older (and their spouses age 65 and older) who are covered under an employer group health plan by virtue of their current employment status (these individuals are sometimes referred to as the 'working aged');
2. As described more fully below, disabled individuals who have current employment status and are covered under an employer group health plan; and
3. Individuals with end-stage renal disease (ESRD), or permanent kidney failure (the employer group health plan must provide coverage for the first 30 months, and then Medicare becomes primary).

If you are entitled to Medicare benefits on the basis of disability (Medicare generally requires that you be disabled for 29 months), Medicare is primary unless you have "current employment status" with the Company, in which case Medicare is the secondary payer. You have "current employment status" only if you are actively working with the Company. If you reach age 65, and become eligible for normal retirement Medicare benefits, Medicare will be primary even if you have not been disabled for 29 months.

LEGAL INFORMATION

No action at law or equity can be brought against the Plan until 60 days after a claim (proof of loss) has been received. No such action can be brought against the Plan more than three years after the service was incurred.

Interpretation Of Plan Provisions

The Committee and the Plan Administrator shall have the duty and discretionary authority to interpret and construe the provisions of the Plan and decide any dispute which may arise regarding the rights of participants, including the discretionary authority to interpret the Plan and to make determinations as to any employee's eligibility to enter the Plan and a participant's benefits under the Plan. However, BLUE CROSS NC has been given the authority to make final determinations regarding benefit payments under the Plan. Interpretations and determinations made by the Committee and the Plan Administrator shall apply uniformly to all persons similarly situated and shall be binding and conclusive upon all interested persons. Such interpretations and determinations shall only be set aside if the Committee and the Plan Administrator are found to have acted arbitrarily and capriciously in interpreting and construing the provisions of the Plan.

Plan Amendment/Termination

The Company has reserved the right, by written action of its Board of Directors or its authorized officer, to modify, amend or terminate the Plan as applied to each employer-party. Except as otherwise provided in the Plan, the right to modify, amend or terminate the Plan will not in any way affect your right to claim benefits, or diminish or eliminate any claims for benefits under the Plan to which you may have become entitled to claim prior to such termination or amendment. The Plan is not a contract, and the Company does not guarantee and makes no promise to offer a specific level of benefits in the future. The right to future benefits under the Plan will never vest.

Fiduciaries Under The Plan

The Chairman of the Employee Benefits Plan Committee (the "Committee") is the Plan Administrator and is the agent for service of legal process on the Plan. The Board of Directors of the Company, the Committee and the Plan Administrator are the named fiduciaries for purposes of the Employee Retirement Income Security Act of 1974 (ERISA). The members of the Committee are appointed by the Board to serve at the pleasure of the Board. Any member of the Committee may resign at any time. The Company reserves the right to engage a third party administrator to (i) act as agent for the Company, the Plan Administrator and the Committee in receiving and processing claims for benefits under the Plan; and (ii) to perform such additional duties as the Company and the third party administrator may agree upon.

BLUE CROSS NC MEDICAL INFORMATION

The BLUE CROSS NC website, BlueConnectNC.com, has important information for you regarding the Plan including:

- Access to a **Provider Directory**
- Medical claim forms
- Explanation of Benefits
- A link to contact BLUE CROSS NC Customer Service

Please note that not all information on the BLUE CROSS NC website is specific to the BB&T plan. Always check this Summary Plan Description to verify benefits.

THE BLUECARD PROGRAM (Services received outside of North Carolina)

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

All claim types are eligible to be processed through Inter-Plan Arrangements, as described above, except for dental services (unless provided under your medical benefits), prescription drug or vision care benefits that may be administered by a third party contracted by Blue Cross NC to provide the specific service or services.

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

This "negotiated price" can be:

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

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

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

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

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

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

Value-Based Programs: BlueCard® Program

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

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

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

Blue Cross Blue Shield Global Core

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

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

Inpatient Services

In most cases, if you contact the Service Center for assistance, hospitals will not require you to pay for

covered inpatient services, except for any applicable copay, deductible or coinsurance amounts. In such cases, the hospital will submit your claims to the Service Center to begin claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for Covered Services. You must contact BLUE CROSS NC to obtain precertification for non-emergency inpatient services.

Outpatient Services

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

Submitting a Blue Cross Blue Shield Global Core Claim

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

For information on the BlueCard participation status of Providers, call 800-621-8876 or visit BlueConnectNC.com.

IMPORTANT CLAIM INFORMATION

The benefits you receive will depend on whether the provider of medical services is an In-Network or Out-Of-Network Provider. You will receive the maximum benefits that can be paid if you use In-Network Providers and get approval, when required, before obtaining medical care. The amount you have to pay for services and supplies will increase when you do not use In-Network Providers.

It is also important to remember that claims for services not covered by the Plan, (for example, excluded services or services obtained that exceed Plan maximums) will be charged to you by the Provider as an out-of-network benefit even if the Provider is an In-Network Provider.

BlueCross BlueShield makes every effort to contract with physicians that practice at In-Network Provider Hospitals. For various reasons, some physicians may elect not to contract as In- Network Providers, and therefore, services performed by these physicians will be paid at the Out-of-Network Provider level of benefits.

If you receive covered services from an Out-Of-Network Provider, you may be liable for the difference between the Out-Of-Network Provider's billed amount and any payment the Plan would make for the covered services.

The "Definitions and Coverage Requirements" section tells you what an In-Network Provider is and how you get approval for benefits to be paid for medically necessary services or supplies.

How to Get Help on Claims

Customer Service and health claims inquiries: 800-621-8876

Pre-Certification:

800-672-7897 (Pre-Certification for Inpatient and Outpatient procedures)

800-359-2422 (Pre-Certification for mental health and substance abuse care)

866-455-8414 (Pre-Certification for advanced diagnostic imaging)

Please note that Pre-Certification is required for:

- All Inpatient procedures
- Certain Outpatient procedures
- Mental health and substance abuse care (not required for Office Visits)
- Advanced diagnostic imaging (MRI, MRA, MRS, CT, CTA, Nuclear Cardiology Scans, Echocardiography and PET)
- Sleep Studies

Failure to Pre-certify these procedures will result in a \$200 penalty for inpatient, a \$100 penalty for outpatient procedures and denial of claims for imaging services and sleep studies.

HOW TO FILE CLAIMS

In-Network Providers have agreed to file with BlueCross BlueShield claims for Health Care Services they rendered to you. In the event a Provider who rendered services to you does not file a claim for such services, it is your responsibility to file the claim with the BlueCross BlueShield plan in the state where services are rendered. If you choose to use an Out-Of- Network Provider, you may be responsible for filing your own claim.

If you need a medical or pharmacy claim form, you may print a copy from BlueConnectNC.com or BBTBenefits.com, or you may call BlueCross BlueShield Customer Service at 800-621-8876. After filling out the claim form, send it to your Claims Representative at the address below:

Blue Cross NC Claims Department
P.O. Box 35
Durham, NC 27702-0035

Claims for prescription drugs should be mailed to:

Prime Therapeutics
Mail Route: Commercial PO Box 25136
Lehigh Valley, PA 18002-5136

Please refer to the claim form for instructions on how to complete the form. Remember to attach a copy of an itemized statement.

Time Limits for Claims

Except in the absence of legal capacity to file a claim, claims must be filed no later than 18 months from the time you or your dependents received medical services or supplies.

MEDICAL PLAN OPTIONS

Coverage is available under two medical plan options: the Select Option and the Consumer Option. A participant or his/her covered dependent(s) who incurs covered expenses shall be eligible for the medical care benefits provided by these programs. Medical care benefits shall be provided only if coverage is in effect for

the participant or dependent at the time the charges are incurred, or during a period in which coverage has been extended.

The benefits provided will be determined in accordance with the following schedule of medical care benefits subject to all Plan conditions, exclusions and limitations.

SCHEDULE OF MEDICAL BENEFITS: SELECT OPTION

This table is a schedule of benefits and is subject to all other terms and conditions of the Plan:

To maximize your benefits, seek medical services from an In-Network Provider. Please call 800-621-8876 or access BlueConnectNC.com to find out if your provider is an In-Network Provider.

GENERAL PROVISIONS		
	In-Network	Out-of-Network
Calendar Year Deductible	\$1,150 per person per calendar year; \$2,875 per family per calendar year	\$1,150 per person per calendar year; \$2,875 per family per calendar year
Annual Out-of-Pocket Maximum	\$1,650 per person, \$3,375 per family including the calendar year deductible; covered expenses are paid at 100% of the Allowed Amount after the Out-of-Pocket is met for the remainder of the calendar year. See below for exceptions.	\$2,150 per person, \$3,875 per family including the calendar year deductible; covered expenses are paid at 100% of the Allowed Amount after the Out-of-Pocket is met for the remainder of the calendar year. See below for exceptions.
Lifetime Maximum	None	None

By receiving care at an *in-network provider*, you will receive the highest level of benefit coverage. *In-network providers* will file claims for you and obtain any necessary certifications. If you use an *out-of-network provider*, it is your responsibility to obtain any necessary certifications. In addition, your cost for *covered services* may exceed the stated *co-insurance* percentage or *co-payment* amount because actual *provider charges* may not be used to determine the *Plan's* and *member's* payment obligations. For *out-of-network* benefits, you may be required to pay for charges over the *allowed amount*, in addition to any *co-payment* or *co-insurance* amount.

Physician Office Services**Office Services**

Primary Care Provider	\$30 co-payment	80% after deductible
Specialist	\$40 co-payment	80% after deductible
Advanced Diagnostic Imaging	90% after deductible	80% after deductible

Office Services include office surgery, diagnostic X-rays and diagnostic lab tests charged as an office visit. Services outside of the office visit will be applied toward the deductible. Services provided through Doctor on Demand will be charged as a \$30 co-payment.

Preventive Care

Primary Care Provider	90%, no deductible	80%, no deductible
Well Child Care (through age 5)	\$30 co-payment	No coverage

Preventive Care covered under the Plan includes those services rated A or B by the United States Preventive Services Task Force, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention and guidelines supported by the Health Resources and Services Administration. A complete listing of services and their frequency can be found at BlueConnectNC.com. Please note that prescriptions for birth control are not covered under the preventive care coverage. Covered prescriptions are paid under the prescription benefit (see *Prescription Drugs* below).

Flu shots are covered at 90% with no deductible.

Annual OB/GYN visits, screening mammograms and PAP Smears are covered at 90% with no deductible for non-LifeForce participants or 100% with no deductible for LifeForce participants. Screenings are limited to one service per Plan year.

See "Outpatient Services" for outpatient clinic or hospital-based services. Office visits for the evaluation and treatment of obesity are limited to a combined in- and out-of-network maximum of four visits per benefit period.

Allergy Shots

At Primary Care Provider

-if billed as an office visit	\$30 co-payment	80% after deductible
-if billed without an office visit	90% after deductible	80% after deductible

At Specialist Provider

-if billed as an office visit	\$40 co-payment	80% after deductible
-if billed without an office visit	90% after deductible	80% after deductible

Allergy Serum	\$30 co-payment	80% after deductible
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Short-Term Rehabilitative Therapies

Physical Therapy, Speech Therapy,
Occupational Therapy, Respiratory Therapy

Chiropractic services, dialysis, cardiac rehabilitation	90% after deductible	80% after deductible
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Combined *benefit period* maximum applies to home, office and *outpatient* settings. 60 visits per *benefit period* for Physical and Occupational Therapy
 30 visits per *benefit period* for Speech Therapy 12 visits per *benefit period* for chiropractic
 No visit limits on Respiratory Therapy, dialysis or cardiac rehabilitation

Chemotherapy/Radiation (no visit limits)		
Office Visits	\$40 co-payment	80% after deductible
Outpatient Facility	90% after deductible	80% after deductible
Home Setting	90% after deductible	80% after deductible

	In-Network	Out-of-Network
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Urgent Care Centers and Emergency Room

Urgent Care Centers	\$40 co-payment	80% after deductible
Ambulance	90% after deductible	90% after deductible
Emergency Room Visit	\$150 co-payment	\$150 co-payment

If admitted to the *hospital* from the emergency room, *inpatient hospital* benefits apply to all *covered services* provided. If held for observation, *outpatient* benefits apply to all *covered services* provided. If you are sent to the emergency room from an *Urgent Care Center*, you may be responsible for both the emergency room *co-payment* and the *urgent care co-payment*.

Ambulatory Surgical Center	90% after deductible	80% after deductible
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Outpatient Services

Physician Services and Hospital-based Services Clinic Services	90% after deductible	80% after deductible	Hospital
	90% after deductible	80% after deductible	Outpatient
	90% after deductible	80% after deductible	

Outpatient Diagnostic Services:

Outpatient lab tests and mammography	90% after deductible	80% after deductible	Outpatient
X-rays, ultrasounds and other tests, such as EEGs, EKGs and pulmonary function tests	90% after deductible	80% after deductible	diagnostic
Advanced Diagnostic Imaging received in any location, including in a physician's office*	90% after deductible	80% after deductible	

*Failure to pre-certify advanced diagnostic imaging (MRI, MRA, MRS, CT, CTA, Nuclear Cardiology Scans, Echocardiograms and PET) will result in the claim being denied.

Therapy Services

Physical Therapy, Speech Therapy,
Occupational Therapy, Respiratory Therapy,
Chiropractic services, dialysis,
cardiac rehabilitation

90% after deductible 80% after deductible

Combined *benefit period* maximum applies to home, office and *outpatient* settings. 60 visits per *benefit period* for Physical and Occupational Therapy

30 visits per *benefit period* for Speech Therapy 12 visits
per *benefit period* for chiropractic

No visit limits on Respiratory Therapy, dialysis or cardiac rehabilitation

Temporomandibular Joint Dysfunction (TMJ) 90% after deductible 80% after deductible

	In-Network	Out-of-Network
Home Health Care and Private Duty Nursing	90% after deductible	80% after deductible
30 visits combined per <i>benefit period</i>		

Hospice Services 100% after deductible 100% after deductible

Inpatient Hospital Services*

Physician Services 90% after deductible 80% after deductible
Hospital and Hospital-based Services 90% after deductible 80% after deductible

Includes maternity delivery, prenatal and post-delivery care for mother.

Newborn coverage

Nursery charges (well care)	90%, no deductible	80%, no deductible
Care if admitted (sick care)	90% after deductible	80% after deductible
In-hospital pediatrician care (if charged separately)	90% after deductible	80% after deductible

*If *certification* is not obtained for covered *out-of-network inpatient* admissions, allowed charges will be reduced by \$200.

Skilled Nursing Facility 90% after deductible 80% after deductible

Combined *in-* and *out-of-network* maximum of 100 days per *benefit period*. Services applied to the deductible count toward this day maximum.

Durable Medical Equipment 90% after deductible 80% after deductible**Diabetic Nutritional Counseling**

Office Visit at PCP	\$30 co-payment	80% after deductible
Outpatient Facility	90% after deductible	80% after deductible

Prescription Drugs

Retail

	<u>Up to 30-Day Supply</u>	
Tier 1 Drugs	\$15 <i>co-payment</i>	No Coverage
Tier 2 Drugs	\$30 <i>co-payment</i>	No Coverage
Tier 3 Drugs	\$50 <i>co-payment</i>	No Coverage
Tier 4 Drugs*	25% <i>coinsurance</i> (minimum \$50, maximum \$150)	No Coverage

Diabetic Supplies \$30 *co-payment* No Coverage

For retail pharmacy, 31-60 day supply is two *co-payments*, and 61-90 day supply is three *co-payments*. For extended supply (greater than 30 days at retail), please visit the BlueCross NC website for a listing of pharmacies that participate in the Extended Supply Network (ESN).

Mail Order

Up to 90-Day Supply

Tier 1 Drugs	\$30 <i>co-payment</i>	No Coverage
Tier 2 Drugs	\$60 <i>co-payment</i>	No Coverage
Tier 3 Drugs	\$100 <i>co-payment</i>	No Coverage
Tier 4 Drugs*	25% <i>coinsurance</i> (minimum \$50, maximum \$150)	No Coverage

***Prescriptions for Specialty Drugs must generally be filled using the Alliance Rx Walgreens Prime Specialty Pharmacy Program. Please see the section of this document titled "Prescription Drugs" for more information. Specialty Drugs can generally be filled for no more than a 30-day supply. If a Specialty Drug is available for a 90-day supply, the cost to you will be 25% with a minimum of \$100 and a maximum of \$300.**

Mandatory Generic: If a *generic* form of the drug is available, the medical program requires employees and covered dependents to ask their physician if there is a *generic* drug option. The physician should give you the option of receiving the brand name version of the drug or the *generic* equivalent. You have the choice of which drug to receive. If you choose the *generic* drug, you will

pay the lowest *co-payment* for a drug that is chemically identical to the brand name. If you choose to have the brand name drug, you will pay the *co-payment* on the higher tier plus the difference in the cost between the *generic* and brand name drug.

Certain drugs require Prior Approval. Please see the "Certification Requirements" for details.

Mental Health and Substance Abuse Services

Certification is required by Magellan Behavioral Health for *inpatient* and certain *outpatient* services.

	In-Network	Out-of-Network
Mental Health <i>Inpatient/</i> <i>Outpatient</i> Services	90% after <i>deductible</i>	80% after <i>deductible</i>
Mental Health Office Services (no pre-certification required)	\$40 <i>co-payment</i>	80% after <i>deductible</i>
Substance Abuse <i>Inpatient/</i> <i>Outpatient</i> Services	90% after <i>deductible</i>	80% after <i>deductible</i>
Substance Abuse Office Services	\$40 <i>co-payment</i>	80% after <i>deductible</i>

SCHEDULE OF MEDICAL BENEFITS: CONSUMER OPTION

This table is a schedule of benefits and is subject to all other terms and conditions of the Plan:

To maximize your benefits, seek medical services from an In-Network Provider. Please call 800-621-8876 or access BlueConnectNC.com to find out if your provider is an In-Network Provider.

GENERAL PROVISIONS		
	In-Network	Out-of-Network
Calendar Year Deductible	\$2,500 for Employee Only coverage per calendar year; \$5,000 for Employee and Spouse, Employee and Children or Family coverage per calendar year	\$5,000 for Employee Only coverage per calendar year; \$10,000 for Employee and Spouse, Employee and Children or Family coverage per calendar year
Annual Out-of-Pocket Maximum	\$5,000 for Employee Only coverage, \$10,000 for Employee and Spouse, Employee and Children or Family coverage including the calendar year deductible; covered expenses are paid at 100% of the Allowed Amount after the Out-of-Pocket is met for the remainder of the calendar year. See below for exceptions.	\$7,500 for Employee Only coverage, \$15,000 for Employee and Spouse, Employee and Children or Family coverage including the calendar year deductible; covered expenses are paid at 100% of the Allowed Amount after the Out-of-Pocket is met for the remainder of the calendar year. See below for exceptions.
Lifetime Maximum	None	None

By receiving care at an *in-network provider*, you will receive the highest level of benefit coverage. *In-network providers* will file claims for you and obtain any necessary certifications. If you use an *out-of-network provider*, it is your responsibility to obtain any necessary certifications. In addition, your cost for *covered services* may exceed the stated *co-insurance* percentage or *co-payment* amount because actual *provider* charges may not be used to determine the *Plan's* and *member's* payment obligations. For *out-of-network* benefits, you may be required to pay for charges over the *allowed amount*, in addition to any *co-payment* or *co-insurance* amount.

	In-Network	Out-of-Network
Physician Office Services		
Office Services		
<i>Primary Care Provider</i>	80% after <i>deductible</i>	60% after <i>deductible</i>
<i>Specialist</i>	80% after <i>deductible</i>	60% after <i>deductible</i>

Office Services include office *surgery*, diagnostic X-rays and diagnostic lab tests charged as an office visit. Services provided through Doctor on Demand will be paid at 80% after deductible.

	In-Network	Out-of-Network
Preventive Care		
Primary Care Provider	80%, no deductible	60%, no deductible <i>WellChild</i>
Care (through age 5)	100%, no deductible	100%, no deductible

Preventive Care covered under the Plan includes those services rated A or B by the United States Preventive Services Task Force, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention and guidelines supported by the Health Resources and Services Administration. A complete listing of services and their frequency can be found at BlueConnectNC.com. Please note that prescriptions for birth control are not covered under the preventive care coverage. Covered prescriptions are paid under the prescription benefit (see *Prescription Drugs* below).

See "Outpatient Services" for *outpatient clinic* or *hospital*-based services. *Office visits* for the evaluation and treatment of obesity are limited to a combined *in-* and *out-of-network* maximum of four visits per *benefit period*.

Allergy Shots

At Primary Care Provider	80% after deductible	60% after deductible
At Specialist Provider	80% after deductible	60% after deductible

Short-Term Rehabilitative Therapies

<i>Physical Therapy, Speech Therapy, Occupational Therapy, Respiratory Therapy, Chiropractic services, dialysis, cardiac rehabilitation</i>	80% after deductible	60% after deductible
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Combined *benefit period* maximum applies to home, office and *outpatient* settings. 60 visits per *benefit period* for Physical and Occupational Therapy
 30 visits per *benefit period* for Speech Therapy 12 visits per *benefit period* for chiropractic
 No visit limits on Respiratory Therapy, dialysis or cardiac rehabilitation

Chemotherapy/Radiation (no visit limits)	80% after deductible	60% after deductible
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Urgent Care Centers and Emergency Room

Urgent Care Centers	80% after deductible	60% after deductible
Ambulance	80% after deductible	80% after deductible
Emergency Room Visit	80% after deductible	80% after deductible
Ambulatory Surgical Center	80% after deductible	60% after deductible

Outpatient Services

Physician Services and Hospital-based Services Clinic Services:	80% after deductible	60% after deductible	Hospital
	80% after deductible	60% after deductible	Outpatient
	80% after deductible	60% after deductible	Outpatient
Diagnostic Services:			
Outpatient lab tests and mammography	80% after deductible	60% after deductible	Outpatient
X-rays, ultrasounds and other tests, such as EEGs, EKGs and pulmonary function tests	80% after deductible	60% after deductible	diagnostic
Advanced Diagnostic Imaging received in any location, including in a physician's office*	80% after deductible	60% after deductible	

*Failure to pre-certify advanced diagnostic imaging (MRI, MRA, MRS, CT, CTA, Nuclear Cardiology Scans, Echocardiogram and PET) will result in the claim being denied.

Therapy Services

Physical Therapy, Speech Therapy, Occupational Therapy, Respiratory Therapy, Chiropractic services, dialysis, cardiac rehabilitation	80% after deductible	60% after deductible
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Combined *benefit period* maximum applies to home, office and *outpatient* settings.

60 visits per *benefit period* for Physical and Occupational Therapy

30 visits per *benefit period* for Speech Therapy

12 visits per *benefit period* for chiropractic

No visit limits on Respiratory Therapy, dialysis or cardiac rehabilitation

Chemotherapy / Radiation (no visit limits)	80% after deductible	60% after deductible
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Temporomandibular Joint Dysfunction (TMJ)	80% after deductible	60% after deductible
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Home Health Care and Private Duty Nursing 30 visits combined per <i>benefit period</i>	80% after deductible	60% after deductible
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Hospice Services	80% after deductible	80% after deductible
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Inpatient Hospital Services*

Physician Services	80% after deductible	60% after deductible
Hospital and Hospital-based Services	80% after deductible	60% after deductible

*If *certification* is not obtained for covered *out-of-network inpatient* admissions, allowed charges will be reduced by \$200.

	In-Network	Out-of-Network
Skilled Nursing Facility	80% after <i>deductible</i>	60% after <i>deductible</i>

Combined in- and out-of-network maximum of 100 days per benefit period. Services applied to the deductible count toward this day maximum.

Durable Medical Equipment	80% after <i>deductible</i>	60% after <i>deductible</i>
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Durable Medical Equipment charges are paid at 80% after *deductible* in-network or 60% after *deductible* out-of-network.

Diabetic Nutritional Counseling	80% after <i>deductible</i>	60% after <i>deductible</i>
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Prescription Drugs

Retail Mail Order	80% after <i>deductible</i>	No Coverage
	80% after <i>deductible</i>	No

Prescriptions for Specialty Drugs must generally be filled using the Alliance Rx Walgreens Prime Specialty Pharmacy Program. Please see the section of this document titled "Prescription Drugs" for more information.

Certain drugs require Prior Approval. Please see "Certification Requirements" for details.

Mental Health and Substance Abuse Services

Certification is required by Magellan Behavioral Health for *inpatient* and certain *outpatient* services. Mental Health and Substance Abuse Services are paid at 80% after *deductible* in-network or 60% after *deductible* out-of-network.

	In-Network	Out-of-Network
Mental Health Inpatient/ Outpatient Services	80% after <i>deductible</i>	60% after <i>deductible</i>
Mental Health Office Services (no pre-certification required)	80% after <i>deductible</i>	60% after <i>deductible</i>
Substance Abuse Inpatient/ Outpatient Services	80% after <i>deductible</i>	60% after <i>deductible</i>
Substance Abuse Office Services	80% after <i>deductible</i>	60% after <i>deductible</i>

COVERED SERVICES

Covered services described on the following pages are available at both the in-network and out-of-network benefit levels, when medically necessary, unless otherwise noted. If you have a question about whether a certain health care service is covered and you cannot find the information in "*Covered Services*," see "*Summary Of Benefits*" or call BLUE CROSS NC Customer Services at 800-621-8876.

Benefits for certain inpatient, skilled nursing facility services and all private duty nursing services require certification from BLUE CROSS NC in advance to be eligible for benefits at either level. Refer to "*Utilization Management*" for additional information.

Remember that exclusions and limitations apply to your coverage. Service-specific exclusions are stated along with the benefit description in "*Covered Services*." Exclusions that apply to many services are listed in "*What Is Not Covered?*" To understand the exclusions and limitations that apply to each service, read "*Covered Services*," "*Summary Of Benefits*" and "*What Is Not Covered?*"

Certain services are covered pursuant to BCBSNC medical and reimbursement policies, which are updated throughout the plan year. These policies lay out the procedure and criteria to determine whether a procedure, treatment, facility, equipment, drug or device is medically necessary and eligible for coverage, investigational or experimental, cosmetic, a convenience item, or requires prior review and certification by Blue Cross NC. The most up-to-date medical and reimbursement policies are available at bcbsnc.com, or call Blue Cross NC Customer Service at 800-621-8876.

Office Services

Care you receive from a doctor, physician assistant, nurse practitioner or nurse midwife as part of an office visit or house call is covered with a co-payment or co-insurance, except as otherwise noted in this benefit booklet. Some providers may receive items such as supplies or drugs from third parties. In these cases, you may be billed directly by the supplier. Benefit payments for these services will be based on the type of supplier and how the services are billed. Services provided through "Doctor on Demand" are also considered to be an office visit.

Some doctors or other providers may practice in outpatient clinics or provide hospital-based services in their offices. In these cases, services may be subject to the Outpatient Services benefit. See "*Summary Of Benefits*." For a listing of these providers, refer to the provider directory. Provider directories are available through your plan administrator, the BLUE CROSS NC website or by calling BLUE CROSS NC Customer Services at 800-621-8876.

Covered office services include care such as consultations, second surgical opinions, office surgery, diagnostic tests, medical supplies, rehabilitative therapy and allergy injections.

If you visit a PCP, you will be responsible for the PCP co-payment or co-insurance. If you visit a specialist, you will be responsible for the specialist co-payment or co-insurance. A co-payment will not apply if you only receive services, such as allergy shots or other injections, and are not charged for an office visit (however, co-insurance may apply).

Office Services Exclusions

- Self-injectable prescription drugs that can be self-administered, unless medical supervision of the injection is required. Please see "Prescription Drug Benefits."

Diagnostic Services

Diagnostic procedures help your physician find the cause and extent of your condition in order to plan for your care. Benefits may differ depending on where the service is performed and if the service is received with any other service or associated with a surgical procedure. See "Physician Office Services" or "Outpatient Diagnostic Services" in "Schedule Of Medical Benefits," depending on where services are received.

Separate benefits for interpretation of diagnostic services by the attending doctor are not provided in addition to benefits for that doctor's medical or surgical services, except as otherwise determined by BLUE CROSS NC.

Laboratory, Radiology And Other Diagnostic Testing

Laboratory studies are services such as diagnostic blood or urine tests or examination of biopsied tissue (that is, tissue removed from your body by a surgical procedure). Radiology services are diagnostic imaging procedures such as X-rays, ultrasounds, computed tomographic (CT) scans and magnetic resonance imaging (MRI) scans. Other diagnostic testing includes electroencephalograms (EEGs), electrocardiograms (ECGs), Doppler scans and pulmonary function tests (PFTs).

Sleep Studies

A Sleep Management Program is available to members which helps promote the use of home sleep studies as an alternative to lab-based sleep studies when clinically appropriate. This alternative is more convenient and comfortable for many members.

Certification for certain sleep studies must be obtained in advance from Blue Cross NC or services will not be covered. Blue Cross NC may delegate utilization management of sleep studies to another company not associates with Blue Cross NC. See "Delegated Utilization Management" for more information.

Advanced diagnostic imaging (MRI, MRA, MRS, CT, CTA, Nuclear Cardiology Scans, Echocardiography, PET, genetic testing and sleep studies (including associated durable medical equipment)) require pre-authorization when performed in an Outpatient or office setting.

Diagnostic Services Exclusions

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

Emergency And Urgent Care Services

Emergency Care

In the case of an emergency, the Plan provides benefits for emergency services. Please see "Definitions" for an

explanation of emergency services. Coverage for subsequent services to treat the condition will be as described in the non-emergency provisions of this booklet. Also, certification requirements apply to subsequent services. See "Prospective Reviews" for certification requirements.

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

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

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

What To Do In An Emergency

In an emergency, you should seek care from an emergency room or other similar facility. If necessary and available, call 911 or use other community emergency resources to obtain assistance in handling life-threatening emergencies.

No certification is required for emergency services.

If you go to an emergency room for treatment of an emergency, your benefit level will be the same, regardless of whether you use an in-network or out-of-network provider. However, when you seek services from an out-of-network provider you may be required to pay the entire bill at the time of service and file a claim with BLUE CROSS NC. In these situations, you will be reimbursed the billed amount minus the co-payment or co-insurance. If you are held for observation, outpatient benefits apply to all covered services provided. If you are admitted to the hospital from the emergency room, inpatient hospital benefits apply to all covered services provided.

If you are admitted as a hospital inpatient immediately following emergency services, your benefits will be paid like any other inpatient hospital or physician charges. Certification for inpatient hospitalization and other selected services following emergency services (including screening and stabilization) is required. See "Prospective Reviews." If you are admitted to an in-network hospital, the hospital will obtain certification for you. You may need to transfer to an in-network hospital once your condition has been stabilized in order to continue receiving in-network benefits.

Care Following Emergency Services

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

Urgent Care

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

What To Do When You Need Urgent Care

When you need urgent care, you may call your PCP or a specialist, or go to an urgent care provider.

Family Planning

Maternity Care

Maternity care benefits are available to all female members; maternity benefits for dependent children cover only treatment for complications of pregnancy. Maternity care includes prenatal care, labor and delivery and post-delivery care. Prenatal care is all care related to the pregnancy before the baby's birth. Post-delivery care is all care for the mother after the baby's birth that is related to the pregnancy. A co-payment or co-insurance may apply for the office visit to diagnose pregnancy; otherwise, deductible and co-insurance apply for the remainder of your maternity care benefits. If a member changes providers during pregnancy, terminates coverage during pregnancy, or the pregnancy does not result in delivery, one or more co-payments or additional co-insurance may be charged for pre-natal services depending upon how the services are billed by the provider.

Delivery

The Plan covers an inpatient hospital stay for you and your newborn, if enrolled, for 48 hours for a vaginal delivery or 96 hours for a cesarean section, without certification by BLUE CROSS NC. However, the Plan may pay for a shorter stay if the attending provider (e.g., your doctor or nurse midwife), after consultation with the mother, discharges the mother or newborn earlier. If the mother chooses a shorter stay, coverage is available for a home health visit for post-delivery follow-up care if received within 72 hours of discharge. Certification is required for inpatient stays extending beyond 48 hours following a vaginal delivery or 96 hours following a cesarean section. See "Utilization Management" for more information.

Statement Of Rights Under The Newborns' And Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your doctor, nurse midwife or physician assistant), after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, group health plans and health insurance issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, a plan or issuer may not, under federal law, require that a doctor or other health care provider obtain certification for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain certification. For information on certification, contact BLUE CROSS NC Customer Services at 800-621-8876.

Termination Of Pregnancy (Abortion)

Benefits for abortions are available only for therapeutic procedures.

Complications Of Pregnancy

Benefits for complications of pregnancy are available to all female members including dependent children. Please see "Definitions" for an explanation of complications of pregnancy.

Newborn Care

After coverage for the delivery as described above, your coverage includes benefits for the care of a newborn if enrolled for coverage as a dependent child, according to the rules in "Eligibility."

Benefits include newborn hearing screening ordered by a doctor to determine the presence of permanent hearing loss. Inpatient newborn care (well baby) requires only one benefit period deductible for both mother and baby. The newborn is covered under the mother's maternity benefits only during the first 48 hours after a vaginal delivery or 96 hours after delivery by cesarean section.

Sick Baby Care

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 covered only if the newborn is enrolled for coverage as a dependent child, according to the rules in "Eligibility." Both mother and baby must meet their individual benefit period deductibles if applicable.

Infertility And Sexual Dysfunction Services

Benefits are provided for certain services related to the diagnosis, treatment and correction of any underlying causes of infertility and sexual dysfunction for all members except dependent children. For information about coverage of infertility and sexual dysfunction prescription drugs, refer to "Prescription Drug Benefits."

Sterilization

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

Contraceptive Devices

This benefit is available for all members. Coverage includes the insertion or removal of and any medically necessary examination associated with the use of a covered contraceptive device. Covered contraceptive devices are intrauterine devices, diaphragms, injectable contraceptives and implanted hormonal contraceptives. Please see "Prescription Drug Benefits" for coverage of oral contraceptives and contraceptive patches.

Family Planning Exclusions

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

- Infertility and sexual dysfunction for dependent children.
- Elective abortions
- Benefits for infertility or reduced fertility that results from a prior sterilization procedure or when infertility or reduced fertility is the result of a normal physiological change such as menopause.

Facility Services

Outpatient Services

Benefits are provided for outpatient services received in a hospital, a hospital-based facility or an outpatient clinic. The following are covered services:

- Medical care provided by a doctor or other professional provider
- Observation
- General nursing care
- Drugs administered by the facility
- Diagnostic services
- Medical supplies
- Use of appliances and equipment ordinarily provided by the facility for the care and treatment of outpatients
- Operating room, recovery room and related services (outpatient surgery)
- Short-term rehabilitative therapies and other therapies.

Inpatient Hospital Services

The Plan provides coverage when you are admitted to a hospital as an inpatient. If you are admitted prior to the effective date, benefits will not be available for services received prior to the effective date. Certification must be obtained in advance from BLUE CROSS NC to receive full benefits. You should work with your doctor to make sure certification has been obtained. See "Utilization Management."

The following are covered services:

- Medical care provided by a doctor or other professional provider
- A semi-private room; or a private room if medically necessary or the hospital has only private rooms
- Use of the operating room, delivery room, recovery room, nursery and related services
- General nursing care
- Intensive care
- Critical care
- Drugs administered by the hospital
- Diagnostic services and medical supplies
- Use of appliances and equipment ordinarily provided by the hospital
- Short-term rehabilitative therapies and other therapies.

Ambulatory Surgical Centers

Benefits are provided for surgical services received in an ambulatory surgical center. The following are covered services:

- Medical care provided by a doctor or other professional provider
- General nursing care

- Drugs administered by the facility
- Diagnostic services
- Medical supplies
- Use of appliances and equipment ordinarily provided by the facility for the care and treatment of surgical procedures
- Operating, recovery room and related services
- Short-term rehabilitative therapies and other therapies.

Skilled Nursing Facilities

The Plan provides benefits for covered services received in a skilled nursing facility. Certification must be obtained in advance from BLUE CROSS NC or services will not be covered. You should work with your doctor to make sure that certification has been obtained. See "Utilization Management." Skilled nursing facility services are limited to a combined in-network and out-of-network day maximum per benefit period. Refer to "Schedule Of Medical Benefits."

Other Services

Ambulance Services

The Plan covers services in a ground ambulance traveling:

- From a member's home or scene of an accident or emergency to a hospital
- Between hospitals
- Between a hospital and a skilled nursing facility when such a facility is the closest one that can provide covered services appropriate to your condition. Benefits may also be provided for ambulance services from a hospital or skilled nursing facility to a member's home when medically necessary.

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

Ambulance Service Exclusion

- No benefits are provided primarily for the convenience of travel.
- Transportation to or from a doctor's office or dialysis center
- Transportation for the purpose of receiving services that are not considered covered services, even if the destination is an appropriate facility

Blood

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

Blood Exclusion

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

Certain Drugs Covered under Your Medical Benefit

The plan covers certain provider-administered specialty drugs that must be dispensed under a provider's supervision in an office, outpatient setting, or through home infusion. Provider-administered specialty drugs ordered or prescribed for a member by a provider must be adjudicated by the plan and these drugs are covered under your medical benefit rather than your prescription drug benefit. Coverage of some of these drugs may be limited to certain provider settings (such as office, outpatient, and ambulatory surgical center or provided by a home health agency). For a list of drugs covered under your medical benefit that are covered only at certain provider settings, visit BLUE CROSS NC's website at BlueConnectNC.com.

Clinical Trials

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

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

Clinical Trials Exclusions

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

Dental Treatment Covered Under Your Medical Benefit

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

- Accidental injury of the natural teeth, jaw, cheeks, lips, tongue, roof and floor of the mouth
- Congenital deformity, including cleft lip and cleft palate
- Disease due to infection or tumor, including oral tumors, oral cysts which are not related to teeth or associated dental procedures, and oral exostosis for reasons other than the preparation of dentures.
- Temporomandibular joint (TMJ) disease Therapeutic benefits for TMJ disease include splinting and use of intra-oral prosthetic appliances to reposition the bones. Surgical benefits for TMJ disease are limited to surgery performed on the temporomandibular joint. If TMJ is caused by malocclusion, benefits are provided for correction of malocclusion if surgical management of the TMJ is medically necessary. Please have your provider contact BLUE CROSS NC prior to receiving treatment for TMJ.

When any of the conditions listed above require surgical correction, the medical necessity review of the surgery will 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 your 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. See "Utilization Management" for certification requirements, unless treatment is for an emergency. Other dental services, including the charge for surgery, are not covered unless specifically covered by the Plan.

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

Dental Treatment Not Covered Under Your Medical Benefit

- Preventive dental care, diagnosis or treatment of or related to the teeth and gums
- Removal of teeth and intrabony cysts
- Orthodontic braces
- Occlusal (bite) adjustments
- Dentures and in-mouth appliances
- Dental Implants or other dental service including orthodontic services, except when required due to traumatic injury or accident
- Crowns and bridges
- Treatment for periodontal disease or cavities and disease due to infection or tumor
- Extractions
- Root canals
- Injury related to chewing or biting

No other dental services are covered except as specifically stated elsewhere in "Covered Services"

Diabetes-Related Services

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

Durable Medical Equipment

Benefits are provided for durable medical equipment and supplies required for operation of equipment when prescribed by a licensed provider. Equipment may be purchased or rented at the discretion of the Plan. If the purchase is approved, the Plan will pay for rental equipment up to the purchase price. 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. Refer to "Schedule Of Medical Benefits." Certain durable medical equipment items require prior authorization.

The following are examples of covered durable medical equipment:

- Wheel chairs
- Hospital beds
- MiniMed pumps
- Traction equipment
- Respiratory (inhalation) or suction machines.

Durable Medical Equipment Exclusions

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

Home Health Care

Home health care services are covered by the Plan when ordered by a doctor for a member who is homebound due to illness or injury and who needs part-time or intermittent skilled nursing care from a registered nurse (RN) or licensed practical nurse (LPN) and/or other skilled care services like short-term rehabilitative therapies. Usually, a home health agency coordinates the services your doctor orders for you. Services from a home health aide may be eligible for coverage only when the care provided supports a skilled service being delivered in the home. Home Health nursing requires prior authorization.

Benefits for the following will be provided to a homebound member:

- Professional services of a registered nurse (RN) or licensed practical nurse (LPN) to a maximum of eight hours a day
- Short-term rehabilitative therapies
- Medical supplies
- Oxygen and its administration
- Medical social service consultations
- Home health aide services, provided by someone other than a professional nurse, which are medical or therapeutic in nature and furnished to a member who is receiving covered nursing or therapy services

Home Health Care Exclusions

- Personal comfort or convenience items
- Dietitian services or meals
- Homemaker services, such as cooking and housekeeping
- Services provided by a close relative or member of your household
-

Home Infusion Therapy Services

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

The following are covered services:

- Professional services of an RN or LPN
- Specimen collection, laboratory testing and analysis

- Patient and family education
- Management of emergencies arising from home infusion therapy
- Prescribed drugs related to infusion services, and delivery of drugs and supplies

Hospice Services

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

The following are covered services:

- Professional services of an RN or LPN
- Medical services, equipment and supplies
- Prescribed drugs
- In-home laboratory services
- Medical social service consultations
- Inpatient hospice room, board and general nursing services
- Inpatient respite care, which is short-term care provided to the member only when necessary to relieve the family member or other persons caring for the individual
- Family counseling related to the member's terminal condition
- Dietitian services
- Pastoral services
- Bereavement services
- Educational services
- Home health aide services, provided by someone other than a professional nurse, which are medical or therapeutic in nature and furnished to a member who is receiving covered nursing or therapy services

Hospice Services Exclusions

- Homemaker services, such as cooking, housekeeping, food or meals

Lymphedema-Related Services

Coverage is provided for the diagnosis, evaluation, and treatment of lymphedema. These services must be provided by a licensed occupational or physical therapist or licensed nurse that has experience providing this treatment, or other licensed health care professional whose treatment of lymphedema is within their scope of practice. Benefits include medically necessary equipment, supplies and services such as complex decongestive therapy or self-management therapy and training. Gradient compression garments may be covered only with a prescription and when custom-fit for the patient.

Lymphedema-Related Services Exclusion

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

Medical Supplies

Coverage is provided for medical supplies such as ostomy supplies, catheters and oxygen. Diabetic supplies

(glucose monitoring strips, syringes and needles) are covered under your prescription drug benefit. Your benefit payments are based on where supplies are received, either as part of your medical supplies benefit or your prescription drug benefit. See "Schedule Of Medical Benefits" and "Prescription Drug Benefits."

Medical Supplies Exclusion

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

Orthotic Devices

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

Orthotic Devices Exclusions

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

Private Duty Nursing

The Plan provides benefits for private duty services of an RN or LPN. Private duty nursing provides more individual and continuous skilled care than can be provided in a skilled nursing visit through a home health agency. Certification must be obtained in advance from the Plan to receive full benefits. These services must be ordered by your doctor for a member who is receiving active care management and must be medically necessary. You should work with your doctor to make sure that certification has been obtained. See "Care Management."

Private Duty Nursing Exclusion

- Private duty nursing services provided by a close relative or a member of your household

Prosthetic Appliances

Your coverage provides benefits for the purchase, fitting, adjustments, repairs and replacement of prosthetic appliances following permanent loss of a body part. The prosthetic appliances must replace all or part of a body part or its function in order to be covered. 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 eyeglasses or contact lenses due to a prescription change after cataract surgery.

Prosthetic Appliances Exclusions

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

Preventive Care

Preventive Care covered under the Plan includes those services rated A or B by the United States Preventive Services Task Force, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention and guidelines supported by the Health Resources and Services Administration. A complete

listing of services and their frequency can be found at BlueConnectNC.com. Please note that prescriptions for birth control are not covered under the preventive care coverage. Covered prescriptions are paid under the prescription benefit (see Prescription Drugs).

Surgical Benefits

Surgical benefits by a professional or facility provider on an inpatient or outpatient basis are covered. These benefits include the services of the surgeon or medical specialist, assistant, and anesthetist or anesthesiologist, together with pre-operative and post-operative care. Surgical benefits include diagnostic surgery, such as biopsies, sigmoidoscopies and colonoscopies.

Such services include pre-operative physical examinations and any services related to the surgical procedure, including care of complications. This includes reconstructive surgery performed to correct congenital defects that result in functional impairment of newborn, foster and adoptive children. Multiple surgical procedures determined by BLUE CROSS NC to be incidental to the primary procedure will not be covered. Secondary procedures will be covered at half the allowed amount.

Anesthesia

Your anesthesia benefit includes coverage for general, spinal block anesthetics or monitored regional anesthesia ordered by the attending doctor and administered by or under the supervision of a doctor other than the attending surgeon or assistant at surgery. Your benefit only covers anesthesia charges for the primary surgical procedure performed. Your coverage does not provide additional benefits for local anesthetics. The following services are included as part of the anesthesia charge: administration of an anesthetic, drugs, materials, diagnostic laboratory services and monitoring. Benefits are not available for charges billed separately by the provider which are not eligible for additional reimbursement,

Mastectomy Benefits

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

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

See "Physician Office Services" or "Other Services" in "Schedule Of Medical Benefits," depending on where services are received. The decision to discharge the patient following mastectomy surgery is made by the attending physician in consultation with the patient.

Transgender Surgery

The Plan provides coverage for hormone therapy and gender reassignment surgery. Prior Review and Certification are required or services will not be covered.

The following male to female gender reassignment surgery services are covered:

- Breast augmentation (mammoplasty)
- Feminizing genitoplasty

- Vaginoplasty
- Intersex surgery male to female

The following female to male gender reassignment surgery services are covered:

- Intersex surgery female to male
- Subcutaneous mastectomy (chest masculinization)
- Masculinizing genitoplasty
- Metaidoplasty (post-testosterone stimulation of external genitals) performed under general anesthesia
- Testicular implants, placed six months after above surgery
- Phalloplasty (functional male organs constructed in a two or three stage procedure)
- Hysterectomy and bilateral salpingo-oophorectomy.

Transgender Surgery Exclusions

Services and procedures that are considered cosmetic and unrelated to the covered transgender surgery benefits:

- Cosmetic services that may be used to make a person look more feminine including but not limited to procedures such as: plastic surgery of the nose; face lift; neck lift; malar implants, lip enhancement; facial bone reduction; plastic surgery of the eyelids; liposuction of the waist; reduction of the thyroid cartilage; hair removal; hair transplants; and surgery of the larynx, including shortening or tightening of the vocal cords
- Cosmetic services that may be used to make a person look more masculine including but not limited to procedures such as: chin implants; nose implants; and lip reduction.
- Speech therapy
- Sperm banking and embryonic freezing
- Restylane injections
- Any services performed to reverse gender reassignment surgery.

Surgical Benefit Limitations

Vein treatments for endoveous procedures are limited to one procedure per limb per lifetime and sclerotherapy vein treatment is limited to three procedures per limb per lifetime.

Therapies

The Plan provides coverage for the following therapy services for an illness, disease or injury. A doctor or other professional provider must order these services.

Rehabilitative and Habilitative Therapies

The following therapies are covered:

- Occupational therapy and/or physical therapy up to a one-hour session per day
- Speech therapy

Benefits are limited to a combined in-network and out-of-network benefit period visit maximum for each of the two categories of therapies as follows:

- (1) Occupational and/or physical therapy, or any combination of these two therapies; and
- (2) Speech therapy.

These visit limits apply in all places of service except inpatient (e.g., outpatient, office and home therapies) regardless of the type of provider (chiropractors, other doctors, physical therapists). Rehabilitative and habilitative therapy received while an inpatient is not included in the benefit period maximum. Refer to "Schedule Of Medical Benefits" for additional information.

Other Therapies

The Plan covers:

- Cardiac rehabilitation therapy
- Pulmonary and respiratory therapy
- Dialysis treatment (three hemodialysis treatments per week, more treatments are available if medically necessary)
- Radiation therapy.
- Chemotherapy, including intravenous chemotherapy. For high dose chemotherapy with bone marrow or peripheral blood stem cell transplants follow transplant guidelines described in "Transplants."

Therapy Exclusion

- Cognitive therapy
- Group classes for pulmonary rehabilitation
- Applied Behavior Analysis (ABA) therapy

Transplants

The Plan provides benefits for transplants, including hospital and professional services for only those transplant procedures listed below. The Plan provides care management for transplant services and will help you find a hospital or Blue Quality Centers for Transplants that provides the transplant services required. Call BLUE CROSS NC Customer Services at 800-621-8876 to speak with a transplant coordinator. You must obtain certification from BLUE CROSS NC in advance for all transplant-related services in order to assure coverage of these services. See "Utilization Management." Grafting procedures associated with reconstructive surgery are not considered transplants.

- Heart
- Simultaneous pancreas and kidney
- Lung, single and bilateral
- Liver
- Combined heart and lung
- Cornea
- Pancreas
- Small bowel
- Kidney
- Simultaneous small bowel and liver

- Allogeneic bone marrow transplants
- Simultaneous liver and kidney
- High dose chemotherapy with bone marrow or peripheral blood stem cell rescue, including autologous (self-donor) and allogeneic (other donor) bone marrow transplant

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

- Benefits are provided for reasonable and necessary services related to the search for a donor up to a maximum of \$10,000 per transplant. However, other costs related to evaluation and procurement are covered up to the recipient member coverage limit.
- Both the recipient and the donor are entitled to benefits of this coverage when the recipient is a member. Benefits provided to the donor will be charged against the recipient's coverage.
- Benefits are payable only for covered services provided to the actual donor selected, and not for services provided to other prospective donors.

Some transplant services are investigational for some or all conditions or illnesses. Please see "Definitions" for an explanation of investigational.

Travel and lodging expenses and charges related to a search for a donor may be reimbursed based on BLUE CROSS NC guidelines that are available upon request from a transplant coordinator.

Transplants Exclusions

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

Important: Transplants will generally only be covered at a Blue Quality Center. You must contact BLUE CROSS NC before scheduling any transplant services except in the case of emergency.

Mental Health And Substance Abuse Services

Your coverage for inpatient and certain outpatient mental health and substance abuse services is coordinated through Magellan Behavioral Health. BLUE CROSS NC delegates administration of these benefits to Magellan Behavioral Health. Magellan Behavioral Health is not associated with BLUE CROSS NC. The Plan provides benefits for the treatment of mental illness and substance abuse by a hospital, doctor or other provider.

The Plan provides benefits for the treatment of mental illness and substance abuse by a hospital, residential treatment facility, doctor or other provider and includes, but is not limited to:

- Office visit services
- Outpatient services (includes partial-day/night hospitalization services (minimum of four hours per day and 20 hours per week), and intensive therapy services (less than four hours per day and minimum of nine hours per week))

Inpatient and residential treatment facility services (includes room and board and detoxification to treat substance abuse).

How To Access Mental Health And Substance Abuse Services

Your coverage for inpatient and certain outpatient services is coordinated through Magellan Behavioral Health. Prior review by Magellan Behavioral Health is not required for any office visit services or in emergency situations; however, please notify Magellan Behavioral Health of an emergency inpatient admission as soon as reasonably possible.

Prior review and certification are required for inpatient (including residential treatment facility services) or certain outpatient services, such as partial hospitalization and intensive therapy.

When you need inpatient or certain outpatient mental health or substance abuse treatment that requires prior review and certification, you should call a Magellan Behavioral Health customer service representative at 800-359-2422. The Magellan Behavioral Health customer service representative will refer you to an appropriate in-network provider and will give you the information about certification requirements. Although no certification is required for emergency situations, please notify Magellan Behavioral Health of your inpatient admission as soon as reasonably possible.

You should work with your doctor or other professional provider to make sure that certification has been obtained for partial-day/night, intensive therapy inpatient or residential treatment facility services. See "Utilization Management." The list of services that require certification may change from time to time. Failure to request prior review and receive certification may result in a penalty or denial of services. Contact Magellan Behavioral Health at 800-359-2422 for certification.

Mental Health And Substance Abuse Services Exclusions And Limitations

- Counseling with relatives about a patient with mental illness, alcoholism, drug addiction or chemical dependency

Prescription Drug Benefits

Your prescription drug benefits cover insulin or other self-administered injectable medications and prescription drugs, including contraceptive drugs and devices, for all members. Prescription drugs approved by the U.S. Food and Drug Administration (FDA) for short-term and long-term use in the treatment of clinical obesity are also covered.

Some Prescription drugs related to treatment of infertility and sexual dysfunction are also covered. Infertility drugs are limited to quantity lifetime maximums per member; see <https://www.BlueCrossNC.com/content/services/formulary/rxnotes.htm>.

Your prescription drug benefits also cover the following diabetic supplies: insulin needles, syringes, glucose testing strips, ketone testing strips and tablets, lancets and lancet devices.

You may receive your prescription drugs and diabetic supplies from a participating pharmacy only. When you visit a participating pharmacy, always present your BLUE CROSS NC ID card along with your prescription. You will pay the applicable co-insurance or co-payment. See "Schedule Of Medical Benefits" for the co-insurance amount that the Plan pays. If you fail to show your id card or the in-network pharmacy's records do not show

you as eligible for coverage, you will have to pay the full cost of the prescription and file a claim. In order to recover the full cost of the prescription minus any applicable copayment or coinsurance you owe, return to the in-network pharmacy within 14 days of receiving your prescription so that it can be reprocessed with your correct eligibility information and the pharmacy will make a refund to you if necessary. If you are unable to return to the pharmacy within 14 days, mail claims in time to be received within 18 months of the date of the service in order to receive in-network benefits. Claims not received within 18 months from the service date will not be covered, except in the absence of legal capacity of the member.

If you would like to receive an extended supply of prescription drugs through the mail, please have your provider write a new prescription for up to 90 days, and contact BLUE CROSS NC to ask for a home delivery order form. Prescription Drugs under the Consumer Option apply to the deductible.

Your prescription drug benefit has an open formulary or list of prescription drugs, divided into categories or tiers. BLUE CROSS NC determines the tier placement of prescription drugs in the formulary, and this determines the amount you pay.

Tier placement of prescription drugs in the formulary may be determined by: the effectiveness and safety of the drug, the cost of the drug, and/or the classification of the drug by the U.S. Food and Drug Administration (FDA) or nationally- recognized drug databases (e.g., Medispan).

The following information applies to the Select Option plan: The lowest cost prescription drugs, such as generics, are generally located on the lowest tiers (Tier 1 and Tier 2). Higher cost prescription drugs, such as brand-name prescription drugs are generally located on the higher tiers (Tier 3 and Tier 4). All tiers of the formulary may contain generic and brand-name prescription drugs. Specialty drugs, if applicable, are located on the highest tiers of the plan, even though they may be classified as generic, brand-name, biologic, or biosimilar prescription drugs. Visit BLUE CROSS NC's website at BlueConnectNC.com for additional information on the tier classification of prescription drugs.

The prescription drugs listed in the formulary or their tier placement may change from time to time due to a change in the cost of the drug and/or in the classification of the drug by the U.S. Food and Drug Administration (FDA) or nationally- recognized drug databases (e.g., Medispan).

From time to time, members may receive a reduced or waived copayment and/or coinsurance on designated drugs in connection with a program designed to reduce prescription drug costs or to encourage members to seek appropriate, high, quality, efficient care based on BLUE CROSS NC criteria.

Mandatory Generic (Select Option Only): If a generic form of the drug is available, the medical program requires employees and covered dependents to ask their physician if there is a generic drug option. The physician should give you the option of receiving the brand name version of the drug or the generic equivalent. You have the choice of which drug to receive. If you choose the generic drug, you will pay the lowest co-payment for a drug that is chemically identical to the brand name. If you choose to have the brand name drug, you will pay the co-payment at the higher tier plus the difference in the cost between the generic and brand name drug.

Certification Requirements

Some prescription drugs may require certification, also known as prior approval, in order to be covered. It is very important to make sure that prior approval is received before you go to the pharmacy. If you need a

prescription drug that requires prior approval, your provider should call BLUE CROSS NC to request prior approval. Additionally, some prescription drugs may be subject to quantity limits based on criteria developed by BLUE CROSS NC. Prior approval is required before excess quantities of these drugs will be covered. If you need quantities in excess of the limit for a drug that is subject to quantity limits, it is important to make sure that your provider has received prior approval before going to the pharmacy. To get a list of the prescription drugs that require prior approval to be covered or require prior approval for additional quantities, you may call BLUE CROSS NC at 800-621-8876 or visit the BLUE CROSS NC website at BlueConnectNC.com. BLUE CROSS NC may change the list of these prescription drugs from time to time.

Limitations

Coverage for certain drugs may be subject to a lifetime dollar maximum. Refer to "Summary Of Benefits." Some prescription drugs are subject to supply limits that restrict: (1) the amount dispensed per prescription, which may include the amount dispensed per day or for a defined time period; (2) the amount dispensed per lifetime; (3) the amount dispensed per month's supply; or (4) the amount dispensed per single co-payment. In these cases, excess quantities will not be covered. You may call BLUE CROSS NC for a list of these prescription drugs or visit the BLUE CROSS NC website at BlueConnectNC.com. The benefit for any prescription drug used for the purpose of smoking cessation is limited to 12 weeks of treatment and 24 weeks of treatment per lifetime.

Coverage will be provided for a restricted-access drug or device to a member without requiring prior review or certification or use of a nonrestricted formulary drug if a member's physician certifies in writing that the member has previously used an alternative nonrestricted-access drug or device and the alternative drug or device has been detrimental to the member's health or has been ineffective in treating the same condition and, in the opinion of the prescribing physician, is likely to be detrimental to the member's health or ineffective in treating the condition again.

If you have multiple prescriptions and need to align your refill dates you may need a prescription for less than a 30-day supply. If your doctor or pharmacy agrees to give you a prescription for less than a 30-day supply for this purpose you will only pay a prorated daily cost-sharing amount (any dispensing fee will not be prorated). This benefit is only available for drugs covered under your prescription drug benefit, received at an in-network pharmacy, and when prior review requirements have been met.

In addition, the drugs must:

- be used for treatment and management of chronic conditions and are subject to refills;
- NOT be a Schedule II or Schedule III controlled substance containing hydrocodone;
- be able to be split over short-fill periods; and
- not have quantity limits or dose optimization criteria that would be affected by aligning refill dates.

Pharmacy Network

The Plan provides prescription drug coverage through a network of pharmacies throughout the United States. The list of network pharmacies may change during your period of enrollment. Participating pharmacies are listed on the BLUE CROSS NC website at

BlueConnectNC.com. You may also contact BLUE CROSS NC at 800-621-8876 for information about a specific pharmacy.

Specialty Drugs

Certain medications are only available from the Plan through a specialty pharmacy called Alliance Rx Walgreens Prime Specialty. This pharmacy is designed to obtain these often expensive drugs at the best cost and to assure that participants receive the appropriate information regarding their drugs. You will not be able to fill a specialty drug prescription through a retail pharmacy after the first fill. More information about specialty drugs can be found on the BLUE CROSS NC website BlueConnectNC.com.

Prescription Drug Benefits Exclusions

- Any prescription drug not specifically covered in the Plan
- Any portion of the prescription drug or refill which exceeds the maximum supply for which benefits will be provided when dispensed under any one prescription
- Any drug which can be purchased over-the-counter without a prescription, even though a written prescription is provided
- Any drug that is therapeutically equivalent to an over-the-counter drug
- Any prescription drugs in excess of the stated quantity limits
- Any compounded drug that does not contain at least one ingredient that is defined as a prescription drug. Compounds containing non-FDA approved bulk chemical ingredients are excluded from coverage.
- Any prescription drug purchased to replace a lost, broken or destroyed prescription drug
- Drug Therapy for infertility is limited to quantity lifetime maximum per member. Please visit this site for the list of limitations: www.BlueCrossNC.com/content/services/formulary/rxnotes.htm
- A prescription drug that is contraindicated (should not be used) due to age, drug interaction, therapeutic duplications, dose greater than maximum recommended or other reasons as determined by FDA's approved product labeling.

- A medical device, unless specifically listed as a covered medical device in the formulary and written prescription is provided.
- A medication that has been repackaged – a pharmaceutical product that is removed from the original manufacturer container (Brand Originator) and repackaged by another manufacturer with a different NDC.

Please see the following pages for additional exclusions.

WHAT IS NOT COVERED? / EXCLUSIONS

Exclusions that are specific to a type of service are stated along with the benefit description in "Covered Services." Exclusions that apply to many services are listed in this section. To understand all of the exclusions that apply, read "Covered Services," "Schedule Of Medical Benefits" and "What Is Not Covered?" In addition, the Plan does not cover services, supplies, drugs or charges that are:

1. Not medically necessary
2. Investigational in nature or obsolete, including any service, drugs, procedure or treatment directly related to an investigational treatment, except as specifically covered by the Plan
3. Any experimental drug or any drug not approved by the U.S. Food and Drug Administration (FDA) for the applicable diagnosis or treatment. However, this exclusion does not apply to prescription drugs (1) specifically listed as covered drug in the formulary and a written prescription is provided; or (2)

used in covered phases II, III and IV clinical trials, or approved by the FDA for treatment of cancer, if prescribed for the treatment of any type of cancer for which the drug has been approved as effective in any one of the following:

- The National Comprehensive Cancer Network Drugs & Biologics Compendium
 - The Thomson Micromedex ® DRUGDEX ®
 - The Elsevier Gold Standard's Clinical Pharmacology
 - Any other authoritative compendia as recognized periodically by the United States Secretary of Health and Human Services.
4. Side effects, complications of non-covered services, and services that would not have been necessary if a non-covered service had not been received, except for emergency services in the case of an emergency
 5. Not prescribed or performed by or upon the direction of a doctor or other provider
 6. For any condition, disease, illness or injury that occurs in the course of employment, if the employee, employer or carrier is liable or responsible for the specific medical charge (1) according to a final adjudication of the claim under a state's workers' compensation laws, or (2) by an order of a state Industrial Commission or other applicable regulatory agency approving a settlement agreement
 7. For a health care professional to administer injectable prescription drugs which can be self-administered, unless medical supervision is required
 8. For inpatient admissions primarily for the purpose of receiving diagnostic services or a physical examination. Inpatient admissions primarily for the purpose of receiving therapy services are excluded except when the admission is a continuation of treatment following care at an inpatient facility for an illness or accident requiring therapy.
 9. Inpatient confinements that are primarily intended as a change of environment.
 10. For care in a self-care unit, apartment or similar facility operated by or connected with a hospital
 11. For custodial care, domiciliary care or rest cures, care provided and billed for by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility, home for the aged, infirmary, school infirmary, institution providing education in special environments, in residential treatment facilities, except for mental health and substance abuse treatment, or any similar facility or institution
 12. For respite care, whether in the home or in a facility or inpatient setting, except as specifically covered by the Plan
 13. Received prior to the member's effective date
 14. Received either before or after the coverage period of the Plan, regardless of when the treated condition occurred, and regardless of whether the care is a continuation of care received prior to the termination
 15. For telephone charges, charges for failure to keep a scheduled visit, charges for completion of a claim form, charges for obtaining medical records, and late payment charges
 16. Incurred more than 18 months prior to the member's submission of a claim to BLUE CROSS NC, except in the absence of legal capacity of the member
 17. For cosmetic services, including the removal of excess skin from the abdomen, arms or thighs, skin tag excisions, cryotherapy or chemical exfoliation for active acne scarring, superficial dermabrasion, injection of dermal fillers, services for hair transplants, skin tone enhancements or electrolysis except as specifically covered by the Plan
 18. For benefits that are provided by any governmental unit except as required by law
 19. For services that are ordered by a court that are otherwise excluded from benefits under this Plan
 20. For care that the provider cannot legally provide or legally charge or is outside the scope of license or certification or who is not recognized by BLUE CROSS NC as an eligible provider

21. Provided and billed by a licensed health care professional who is in training
22. Available to a member without charge
23. For care given to a member by a provider who is in a member's immediate family
24. For any condition suffered as a result of any act of war or while on active or reserve military duty
25. In excess of the allowed amount for services usually provided by one doctor, when those services are provided by multiple doctors
26. For palliative, cosmetic or routine foot care
27. For dental care, dentures, dental implants, oral orthotic devices, palatal expanders and orthodontics, except as specifically covered by the Plan
28. Dental appliances except when medically necessary for the treatment of temporomandibular joint disease or obstructive sleep apnea
29. Dental services provided in a hospital, except when a hazardous condition exists at the same time or covered oral surgery services are required at the same time as a result of a bodily injury
30. For any treatment or regimen, medical, pharmacological or surgical, for the purpose of reducing or controlling the weight of a member or for treatment of obesity, except for surgical treatment of morbid obesity, or as specifically covered by the Plan. Coverage for surgical treatment of morbid obesity is excluded except if obtained at a Blue Distinction Center for Bariatric Surgery.
31. Wigs, hair pieces and hair implants for any reason
32. Received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust or similar person or group
33. For sexual dysfunction unrelated to organic disease
34. Music therapy, recreational or activity therapy, and all types of animal therapy. Remedial reading and all forms of special education and supplies or equipment used similarly, except as specifically covered by the plan.
35. Hypnosis, except when used for control of acute or chronic pain
36. Acupuncture and acupressure
37. Surgery for psychological or emotional reasons
38. Travel, whether or not recommended or prescribed by a doctor or other licensed health care professional, except as specifically covered by the Plan
39. Convenience items, such as, but not limited to: Heating pads, hot water bottles, ice packs and personal hygiene and convenience items such as, but not limited to, urinary incontinence devices (including bed wetting devices) and equipment, and devices and equipment used for environmental control
40. 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
41. Air conditioners, furnaces, humidifiers, dehumidifiers, vacuum cleaners, electronic air filters and similar equipment
42. Physical fitness equipment, hot tubs, Jacuzzis, heated spas, pools or memberships to health clubs
43. Orthoptics, vision training and low vision aids
44. Fitting for eyewear, radial keratotomy and other refractive eye surgery, and related services to correct vision except for surgical correction of an eye injury. Also excluded are premium intraocular lenses or the services related to the insertion of premium lenses beyond what is required for insertion of conventional intraocular lenses, which are small, lightweight, clear disks that replace the distance focusing power of the eye's natural crystalline lens
45. Hearing aids, including implantable bone-anchored hearing aids (BAHA) or examinations for the fitting of hearing aids, except as specifically covered by the Plan
46. Routine hearing examinations, except as specifically covered by the Plan

47. Evaluation and treatment of developmental dysfunction and/or learning differences
48. Medical care provided by more than one doctor for treatment of the same condition
49. Take-home drugs furnished by a hospital or non-hospital facility
50. For maintenance therapy. Maintenance therapy includes services that preserve your present level of function or condition and prevent regression of that function or condition. Maintenance begins when the goals of the treatment plan have been achieved and/or when no further progress is apparent or expected to occur
51. For massage therapy services
52. For alternative medicine services, which are unproven preventive or treatment modalities generally described as alternative, integrative or complementary medicine, whether performed by a physician or any other provider
53. For services primarily for educational treatment including, but not limited to, books, tapes, pamphlets, seminars, classroom, Web or computer programs, individual or group instruction and counseling, except as specifically covered by the Plan
54. For genetic testing, except for high risk patients when the identification of a genetic abnormality correlates with the likelihood of a disease or condition, and when the therapeutic or diagnostic course would be determined by the outcome of the testing
55. Experimental service including services whose efficacy has not been established by controlled clinical trials, or are not recommended as a preventive service by the US Public Health Service, except as specifically covered by the Plan
56. Shoe lifts and shoes of any type, unless part of a brace
57. For any condition, disease, ailment, injury or diagnostic service to the extent that benefits are provided or persons are eligible for coverage under Title XVIII of the Social Security Act of 1965, including amendments, except as otherwise provided by federal law
58. For conditions that federal, state or local law requires to be treated in a public facility
59. For 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
60. Not specifically listed in this benefit booklet as a covered benefit, drug, service or supply
61. Services in excess of any benefit period maximum or lifetime maximum
62. Collection or storage of blood and stem cells taken from the umbilical cord and placenta for future use in fighting a disease
63. Standing frames
64. Services, supplies, drugs or equipment used for the control or treatment of stammering or stuttering
65. Custodial care designed essentially to assist an individual with activities of daily living, with or without routine nursing care and the supervisory care of a doctor. While some skilled services may be provided, the patient does not require continuing skilled services 24 hours daily. The individual is not under specific medical, surgical, or psychiatric treatment to reduce a physical or mental disability to the extent necessary to enable the patient to live outside either the institution or the home setting with substantial assistance and supervision, nor is there reasonable likelihood that the disability will be reduced to that level even with treatment. Custodial care includes, but is not limited to, help in walking, bathing, dressing, feeding, preparation of special diets and supervision over medications that could otherwise be self-administered. Such services and supplies are custodial as determined by BLUE CROSS NC without regard to the place of service or the provider prescribing or providing the services.
66. Services provided and billed by a lactation consultant
67. Breast pumps

68. Services that would not be necessary if a noncovered service had not been received, except for emergency services in the case of an emergency. This includes any services, procedures or supplies associated with cosmetic services, investigational services, services deemed not medically necessary, or elective termination of pregnancy, if not specifically covered by the Plan.

UTILIZATION MANAGEMENT

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

Care Management

Members with complicated and/or chronic medical needs may be eligible for care management services. Care management, also known as case management, encourages members with complicated or chronic medical needs, their providers, and the Plan to work together to identify the appropriate services 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 BLUE CROSS NC or by a representative of BLUE CROSS NC. Care management services are provided solely at the option of the Plan, and 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 BLUE CROSS NC Customer Services.

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

Continuity of Care

Continuity of care is a process that allows members with ongoing special conditions to continue receiving care from an out-of-network provider, when the member's employer changes health benefit plans or when their provider is no longer in the PPO network. If your PCP or specialist leaves the BLUE CROSS NC provider network and they are currently treating you for an ongoing special condition that meets BLUE CROSS NC continuity of care criteria, BLUE CROSS NC will notify you 30 days before the provider's termination, as long as BLUE CROSS NC 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 Plan's requirements for continuity of care. An ongoing special condition means:

- In the case of an acute illness, a condition that is serious enough to require medical care or treatment to avoid a reasonable possibility of death or permanent harm;
- In the case of a chronic illness or condition, a disease or condition that is life-threatening,

- degenerative or disabling, and requires medical care or treatment over a prolonged period of time;
- In the case of pregnancy, the second and third trimesters of pregnancy;
- In the case of a terminal illness, an individual has a medical prognosis that the member's life expectancy is six months or less.

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

- (1) 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;
- (2) Second trimester pregnancy which shall extend through the provision of postpartum care; and
- (3) Terminal illness which shall extend through the remainder of the individual's life with respect to care directly related to the treatment of the terminal illness.

Continuity of care requests will be reviewed by a medical professional based on the information provided about specific medical conditions. Claims for approved continuity of care services will be paid at the member's in-network benefit level. 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 BLUE CROSS NC Customer Services at 800- 621-8876 for additional information.

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 BLUE CROSS NC's adverse benefits 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 BLUE CROSS NC make a review of all noncertifications.
- Request a review of an adverse benefit determination through the appeals process. See "What If You Disagree With A Decision?"
- Have an authorized representative pursue payment of a claim or make an appeal on your behalf. An authorized representative may act on the member's behalf with the member's written consent. In the event you appoint an authorized representative, references to "you under the "Utilization Management" section mean "you" or your authorized representative" (i.e., the authorized representative may pursue your rights and shall receive all notices and benefit determinations).

BLUE CROSS NC's Responsibilities

As part of all UM decisions, BLUE CROSS NC will:

- Provide you and your provider with a toll-free telephone number (800-672-7897) to call UM review staff whenever certification of a health care service is needed.
- Limit what BLUE CROSS NC requests from you or your provider to information that is needed to certify the service in question.
- Request all information necessary to make the UM decision, including pertinent clinical information.

- Provide you and your provider prompt notification of the UM decision consistent with the applicable law and the Plan.
- In the event BLUE CROSS NC does not receive sufficient information to certify coverage for a health care service within specified time frames, BLUE CROSS NC will notify you of an adverse benefit determination in writing. The notice will explain how you may appeal the adverse benefit determination.

Prospective Reviews (Pre-Service)

The Plan requires that certain health care services be reviewed before you receive them (prior review or pre-service review). If prior review is required by the plan, you or your provider must request prior review regardless of whether this health benefit plan is your primary or secondary coverage (see "Coordination of Benefits (overlapping coverage)"). If neither you nor your provider requests prior review and receives certification, this may result in an adverse benefit determination. The list of services that require prior review may change from time to time. General categories of services with this requirement are note in "Covered Services". You may also visit the BLUE CROSS NC website at BlueConnectNC.com or call BLUE CROSS NC Customer Services at 800-621-8876 for a detailed list of these services.

BLUE CROSS NC will make a decision on your request 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 BLUE CROSS NC receives all necessary information but no later than 15 calendar days from the date BLUE CROSS NC received the request. If your request is incomplete, then within five days from the date BLUE CROSS NC received your request, BLUE CROSS NC will notify you and your provider of how to properly complete your request. BLUE CROSS NC will notify you and your provider before the end of the initial 15-day period of the information needed and the date by which BLUE CROSS NC expects to make a decision. You will have 45 days to provide the requested information. As soon as BLUE CROSS NC receives the requested information, or at the end of the 45 days, whichever is earlier, BLUE CROSS NC will make a decision within three business days. BLUE CROSS NC will notify you and the provider of an adverse benefit determination in writing or electronically.

Urgent Prospective (Prior) Reviews

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 BLUE CROSS NC will notify you and your provider of its decision as soon as possible, taking into account the medical circumstances. BLUE CROSS NC will notify you and your provider of its decision within 72 hours after receiving the request. If BLUE CROSS NC needs additional information to process your urgent review, BLUE CROSS NC 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. BLUE CROSS NC will make a decision on your request within a reasonable time but no later than 48 hours after receipt of requested information or within 48 hours after the time period given to the provider to submit necessary clinical information, whichever comes first. An expedited review may be requested by calling BLUE CROSS NC Customer Services at 800-621-8876.

Concurrent Reviews

BLUE CROSS NC will also review health care services at the time you receive them. These types of reviews are called concurrent reviews. BLUE CROSS NC will communicate concurrent review decisions to the hospital or other facility as soon as possible but no later than 15 calendar days after receiving the request or three business days after receipt of all necessary clinical information. In the event of an adverse benefit determination, BLUE CROSS NC will notify you, your hospital's or other facility's UM department and your provider. Written confirmation of the decision will also be sent to your home by U.S. mail.

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

Urgent Concurrent Reviews

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. However, the decision will be no later than 24 hours after we receive the request.

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

If BLUE CROSS NC needs more information to process your urgent concurrent review, BLUE CROSS NC will notify the requesting hospital or other facility of the information needed as soon as possible but no later than 24 hours after we receive the request. The requesting hospital or other facility will then be given a reasonable amount of time, but not less than 72 hours, to provide the request information. BLUE CROSS NC will make a decision within 72 hours after receipt of the request.

Retrospective Reviews

BLUE CROSS NC also reviews the coverage of health care services after you receive them (called retrospective post-service reviews). Retrospective review may include a review to determine if services received in an emergency setting qualify as an emergency. BLUE CROSS NC will make all retrospective review decisions and notify you of its decision within a reasonable time, but no later than 30 days from the date BLUE CROSS NC received the request.

In the event of an adverse benefit determination, BLUE CROSS NC will notify you and your provider in writing within a reasonable time but no later than 30 calendar days from the date Blue Cross NC received the request. All decisions will be based on medical necessity and whether the service received was a benefit under this Plan. If additional information is needed before the end of the initial 30-day period, BLUE CROSS NC will notify you of the information needed. You will then have 90 days to provide the requested information. As soon as BLUE CROSS NC receives the requested information, or at the end of the 90 days, whichever is earlier, BLUE CROSS NC will make a decision within 15 calendar days. Services that were approved in advance by BLUE CROSS NC 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.

Further Review Of Utilization Management Decisions

In the event of an adverse benefit determination you have the right to request that the Plan review the decision through the appeals process. Refer to "What If You Disagree With A Decision?"

Delegated Utilization Management

BLUE CROSS NC delegates UM and the first level appeal for inpatient and outpatient mental health and substance abuse services to Magellan Behavioral Health. Magellan Behavioral Health is not associated with BLUE

CROSS NC. BLUE CROSS NC delegates UM decisions for Advanced Diagnostic Imaging and sleep studies to AIM Specialty Health. Claims determinations and second level appeals, if eligible, are provided by BLUE CROSS NC.

Evaluating New Technology

In an effort to allow for continuous quality improvement, BLUE CROSS NC has processes in place to evaluate new medical technology, procedures and equipment. These policies allow BLUE CROSS NC to determine the best services and products to offer members. They also help BLUE CROSS NC keep pace with the ever-advancing medical field. Prior to implementing any new or revised policies, BLUE CROSS NC reviews professionally supported scientific literature as well as state and federal guidelines, regulations, recommendations and requirements. BLUE CROSS NC 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 Utilization Management program, the Plan offers an appeals procedure for members. An appeal is another review of your case. If you want to appeal an adverse benefit determination you can request that BLUE CROSS NC review the decision. The appeal 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). Mental Health and Substance Abuse appeals have been delegated to a third party vendor. Please see below under "Delegated Appeals".

Steps To Follow In The Appeals Process

For each step in this process, there are set time frames for filing an appeal and for notifying you or your provider of the decision. The type of adverse benefit determination will determine the steps that you will need to follow in the appeals process. For all appeals, the review must be requested in writing, within 180 days of an adverse benefit determination. To request a form to submit a request for a review, visit BLUE CROSS NC's website at BlueConnectNC.com or call BLUE CROSS NC Customer Services at 800-621-8876.

Any request for review should include:

- Employee's ID number
- Patient's name
- Employee's name

- The nature of the appeal
- Any other information that may be helpful for the review.

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

BLUE CROSS NC
 Appeals Department
 P.O. Box 30055 Durham, NC 27702

After a request for review, a BLUE CROSS NC staff member who works in a separate department from the staff members who denied your first request will look at your appeal. The appeals staff members have not reviewed your case information before. The denial of the initial claim will not have an effect on the review. If a claims denial is based on medical judgment, including whether a particular treatment, drug or other item is experimental, investigational, or not medically necessary or appropriate, BLUE CROSS NC shall seek advice from a health care professional with an appropriate level of training and expertise in the field of medicine involved (as determined by BLUE CROSS NC). The health care professionals consulted have not reviewed your case of information before.

Timeline for Appeals

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

	First Level Appeal	Second Level Appeal	Expedited Appeal
<i>BLUE CROSS NC</i> Contacts You	Within 3 business days after receipt of request	Within 10 business days after receipt of request	N/A
Notice of Decision	30 days after receipt of request	7 days after the appeal meeting	72 hours after receipt of request by phone 4 days after receipt of request in writing

First Level Appeal

BLUE CROSS NC will provide you with the name, address and phone number of the appeals coordinator within three business days after receipt of a review request. BLUE CROSS NC 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 or oral evidence and testimony. BLUE CROSS NC asks that you send all of the written material you feel is necessary to make a decision. BLUE CROSS NC 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 reviewed by a licensed medical doctor who was not involved in the initial non-certification decision. You may receive, in advance, any new information or rationale that BLUE CROSS NC may use in making a decision so that you may have an opportunity to respond prior to the notice of an adverse benefit determination. BLUE CROSS NC will send you and your Provider notification of the decision within a reasonable time but no later

than 30 days from the date BLUE CROSS NC received the request. You may then request all information that was relevant to the review.

Second Level Appeal

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

Second Level Appeal Timeline

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

If you do not agree with the first level appeal decision, you have the right to a second level appeal. Second level appeals are not allowed for benefits or services that are clearly excluded by this benefit booklet, or quality of care complaints. Within ten business days after BLUE CROSS NC receives your request for a second level appeal, BLUE CROSS NC 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 from BLUE CROSS NC all information that applies to your appeal
- Participate in the second level appeal meeting
- Present your case to the review panel
- Submit supporting material before and during the review meeting
- Ask questions of any member of the review panel
- Be assisted or represented by a person of your choosing, including a family member, employer representative or attorney.
- Pursue other voluntary alternative dispute resolution options.

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

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

Notice of Decision

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

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

Expedited Appeals (Available only for non-certifications)

You have the right to a more rapid or expedited review of a denial of coverage if a delay: (i) would reasonably appear to seriously jeopardize your or your dependent's life, health or ability to regain maximum function; or (ii) in the opinion of your provider, would subject you or your dependent to severe pain that cannot be adequately managed without the requested care or treatment. You can request an expedited second level review even if you did not request that the initial review be expedited. To start the process of an expedited appeal, you can call BLUE CROSS NC Customer Services at 800-621-8876. 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. BLUE CROSS NC will communicate the decision by phone to you and your provider as soon as possible, taking into account the medical circumstances. The decision will be communicated no later than 72 hours after receiving the request. A written decision will be communicated within four days after receiving the request for the expedited appeal. Information initially given by telephone must also be given in writing.

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

Delegated Appeals

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

Magellan Behavioral Health
 Appeals Department
 P.O. Box 1619
 Alpharetta, GA 30009

Quality of Care Complaints

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

IMPORTANT INFORMATION ABOUT YOUR MEDICAL COVERAGE

Benefits To Which Members Are Entitled

The benefits described in this benefit booklet are provided only for members. These benefits, the right to receive payment under the Plan and the right to enforce any claim under the Plan cannot be transferred or assigned to any other person or entity, including providers. Providers are not considered beneficiaries under the Plan and do not have standing to sue under ERISA. Under the Plan, BLUE CROSS NC may pay a provider directly. For example, BLUE CROSS NC 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 BLUE CROSS NC, and not through the plan. Under the plan, BLUE CROSS NC has the sole right to determine whether payment for services is made to the provider, to the subscriber, or allocated among both. BLUE CROSS NC'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. BLUE CROSS NC 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 Blue Options coverage may be recovered by BLUE CROSS NC. BLUE CROSS NC may recover the amounts by deducting from a member's future claim payment. This can result in a reduction or elimination of a future claim payment. In addition, under certain circumstances, if BLUE CROSS NC pays the provider amounts that are your responsibility, such as deductible, copayments or coinsurance, BLUE CROSS NC 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 BLUE CROSS NC 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.

BLUE CROSS NC's Disclosure Of Protected Health Information (PHI)

The privacy of your protected health information is very important. BLUE CROSS NC will only use or disclose your protected health information in accordance with applicable privacy laws, including the Health Insurance Portability and Accountability Act (HIPAA).

Administrative Discretion

BLUE CROSS NC 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. BLUE CROSS NC medical policies are guides considered when making coverage determinations.

North Carolina Provider Reimbursement

BLUE CROSS NC 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. BLUE CROSS NC'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 BLUE CROSS NC and the provider. Under certain circumstances, a contracting provider may receive payments from BLUE CROSS NC greater than the charges for services provided to an eligible member, or BLUE CROSS NC 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 BLUE CROSS NC that affect their reimbursement for covered services provided to Blue Options members. These providers agree not to bill members for any charges higher than their agreed upon, contracted amount. In these situations, members will be responsible for the difference between the Blue Options allowed amount and the contracted amount. Out-of-network providers may bill you directly. If you are billed, you will be responsible for paying the bill and filing a claim with BLUE CROSS NC.

Right Of Recovery Provision (Subrogation)

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

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

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

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

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

required to pay the member any part of the recovery it may obtain, even if it files suit in the member's name.

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

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

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

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

The terms of this entire right of recovery provision shall apply and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted by any potentially responsible party and regardless of whether the settlement or judgment received by the member identifies the medical benefits the Plan provided or purports to allocate any portion of such settlement or judgment to payment of expense other than medical expenses. The Plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering or non-economic damages and/or general damages only. The Plan's claims will not be reduced due to your own negligence.

The member acknowledges that BLUE CROSS NC 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 BLUE CROSS NC's efforts to recover benefits paid by the Plan. It is the duty of the member to notify BLUE CROSS NC in writing of the member's intent to pursue a claim against any potentially responsible party, within 30 days of the date when any notice is given to any party, including an insurance

company or attorney, of the intention to pursue or investigate a claim to recover damages or obtain compensation due to injuries or illness sustained by the member. The member and their agents agree to provide the Plan or its representatives notice of any recovery the member or the member's agents obtain prior to receipt of such recovery funds or within 5 days if no notice was given prior to receipt. Further, the member and the member's agents shall provide notice prior to any disbursement of settlement or any other recovery funds obtained. The member shall provide all information requested by BLUE CROSS NC or its representative including, but not limited to, completing and submitting any applications or other forms or statements as BLUE CROSS NC may reasonably request and all documents related to or filed in a personal injury litigation.

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

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

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

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

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

Notice Of Claim

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

Notice of Benefit Determination

BLUE CROSS NC 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).

BLUE CROSS NC may take an extension of up to 15 more days to complete the benefits determination if additional information is needed. If BLUE CROSS NC takes an extension, BLUE CROSS NC 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 BLUE CROSS NC receives the requested information, or at the end of the 90 days, whichever is earlier, BLUE CROSS NC will make a decision within 15 days.

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

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

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

Limitation Of Actions

You must exhaust only the first level appeal process before bringing any legal action to recover benefits. Please see "What If You Disagree With A Decision?" for details regarding the grievance review process. No

legal action to recover benefits may be brought later than one year from the date your claim for benefits is denied at the end of the appeals process. If you choose to pursue a second level appeal, the one-year period for bringing a legal action will begin to run once that final second- level decision has been issued.

Coordination Of Benefits (Overlapping Coverage)

If a member is also enrolled in another group health plan, the Plan may coordinate benefits with the other plan. Coordination of benefits (COB) means that if a member is covered by more than one insurance plan, benefits under one plan are determined before the benefits are determined under the second group insurance plan. The plan that determines benefits first is called the primary plan. The other plan is called the secondary plan. Benefits paid by the secondary plan may be reduced to avoid paying benefits between the two plans that are greater than the cost of the health care service. Most group health insurance plans include a coordination of benefits provision. The rules by which a plan is determined primary or secondary are listed below.

When a person is covered by 2 group health plans,	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 <i>dependent</i> under the other	The plan covering the person as the participant is	√	
	The plan covering the person as a <i>dependent</i> is		√
The person is covered as a <i>child</i> 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 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		√
the <i>child's</i> health care coverage; or 3) divorced/separated or not living together and a court decree* states that both parents have responsibility for the <i>child's</i> health care coverage	<i>Note: When the parents have the same birthday, the plan that covered the parent longer is</i>	√	
The person is covered as a <i>child</i> 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		√
	<i>Note: The custodial parent is considered to be the parent awarded custody of a child by a court decree*; or in the absence of a court decree, the parent with whom the child resides more than one half of the calendar year.</i>		

Important Information About Your Medical Coverage

When a person is covered by 2 group health plans,	Then	Primary	Secondary
The person is covered as a <i>child</i> 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 BLUE CROSS NC has actual knowledge of those terms of the court decree, benefits</i>	√	
The person is covered as a laid-off or retired <i>member</i> or that <i>member's dependent</i> on one of the plans, including coverage under COBRA	The plan that covers a person other than as a laid-off or retired <i>member</i> or as that <i>member's dependent</i> is	√	
	The plan that covers a person as a laid-off or retired <i>member</i> or the <i>dependent</i> of a laid-off or retired <i>member</i> is		√
	<i>Note: This rule does not apply if it results in a conflict with any of the other rules for determining order of benefits</i>		
The person is the participant in two active group health plans and none of the rules above apply	The plan that has been in effect longer is	√	
	The plan that has been in effect the shorter amount of time is		√

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

Benefit Coordination

Please note that payment by BLUE CROSS NC under the Plan takes into account whether or not the provider is an In-Network provider. If the Plan is the secondary plan, and the member uses an In-Network provider, the Plan will coordinate up to the Plan allowed amount. The In-Network provider has agreed to accept the allowed amount as payment in full. BLUE CROSS NC may request information about the other plan from the member. A prompt reply will help BLUE CROSS NC process payments quickly. There will be no payment until primary coverage is determined. It is important to remember that even when benefits are coordinated with other group health plans, benefits for services covered under this Plan are still subject to program requirements, such as certification procedures.

DEFINITIONS

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

ALLOWED AMOUNT - The maximum amount that BLUE CROSS NC determines is reasonable for covered services provided to a member. The allowed amount includes any BLUE CROSS NC payment to the provider, plus any deductible, coinsurance or copayment. For providers that have entered into an agreement with BLUE CROSS NC, the allowed amount is the negotiated amount that the provider has agreed to accept as payment in full. Except as otherwise specified in "Emergency Care", for providers that have not entered into an agreement with BLUE CROSS NC, 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 BLUE CROSS NC or through the BlueCard system that is applied to comparable providers for similar services under a similar health benefit plan. Where BLUE CROSS NC has not established an out-of-network fee schedule amount for the billed service, the allowed amount will be the lesser of the provider's billed charge or an amount established by BLUE CROSS NC or through the BlueCard system using a methodology that is applied to comparable providers who may have entered into an agreement with BLUE CROSS NC for similar services under a similar health benefit plan. Other than described above, Blue Cross NC will not pay the out-of-network provider's billed charge unless doing so is required in order to comply with North Carolina Statutes. Calculation of the allowed amount is based on several factors including BLUE CROSS NC's medical, payment and administrative guidelines. Under the guidelines, some procedures charged separately by the provider may be combined into one procedure for reimbursement purposes.

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

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

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

BLUE CROSS NC – Blue Cross and Blue Shield of North Carolina

BENEFIT PERIOD – The period of time, as stated in the Summary Plan Description, 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

BIOLOGIC – A complex large molecule drug produced from protein or living organisms. BIOSIMILAR - Prescription drug products approved by the U.S. Food and Drug Administration (FDA) that are subsequent

versions of previously approved biologic drugs, also known as follow-on biologics. Biosimilar drugs are manufactured after the patent and exclusivity protection of the biologic drug has expired.

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

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

CLOSE RELATIVE – The spouse, child, parent, sibling, grandparent, grandchild (whether by birth or by marriage/adoption) of the member

CO-INSURANCE – The sharing of charges by the Plan and the member for covered services received by a member, usually stated as a percentage of the allowed amount

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 present at birth regardless of their causation

CO-PAYMENT – The fixed-dollar amount that is due and payable by the member each time a covered service is provided

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

COVERED SERVICE(S) – A service, drug, supply or equipment specified in this benefit booklet for which

members are entitled to benefits in accordance with the terms and conditions of the Plan. Any services in excess of a benefit period maximum or lifetime maximum are not covered services

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

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

DEDUCTIBLE – The specified dollar amount for certain covered services that the member must incur before benefits are payable for the remaining covered services. The deductible does not include co-payments, member co-insurance, charges in excess of the allowed amount, amounts exceeding any maximum and expenses for non-covered services.

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

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

DEPENDENT – A member other than the employee as specified in “Eligibility”

DEPENDENT CHILD(REN)— The covered child(ren) of an employee or spouse up to the maximum dependent age, as specified in “Eligibility”

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

DISABILITY – The determination under the BB&T Corporation Disability Plan, or any other insured disability plan sponsored by a company purchased by BB&T, that the employee is no longer able to perform work functions. See the BB&T Corporation Disability Plan Summary Plan Description for more information.

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

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

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

EFFECTIVE DATE – The date on which coverage for a member begins, according to "Eligibility"

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

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

EMPLOYEE – Any individual employed by BB&T Corporation or its Affiliates who is scheduled to work 20 hours per week and is not a temporary employee. The term does not include independent contractors or other individuals not on the Company's payroll.

EMPLOYER – BB&T Corporation and Affiliates

ENROLLMENT DATE – The earlier of the date your coverage is effective or the date you begin any probationary period preceding the date your coverage is effective

EXPERIMENTAL – See Investigational

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

FORMULARY – The list of outpatient prescription drugs and insulin that are available to members

GENERIC – A Prescription Drug that has the same active ingredient as a Brand Name drug, has the same dosage form and strength as the Brand Name drug, and has the same mechanism of action in the body as the Brand Name drug. The classification of a Prescription Drug as a generic is determined by BLUE CROSS NC based on commercially available data resources, and other external classification sources, such as the U.S. Food and Drug Administration (FDA) and nationally-recognized drug databases.

GRIEVANCE – Grievances include dissatisfaction with decisions, policies or actions related to the availability, delivery or quality of health care services, or with the contractual relationship between the member and BLUE CROSS NC.

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/HOME CARE AGENCY – A non-hospital facility which is primarily engaged in providing home health care services, 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 BLUE CROSS NC.

HOSPICE – A non-hospital 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 BLUE CROSS NC.

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, name of the member and the member's covered dependents, applicable co-payments and/or co-insurance, and key phone numbers and addresses

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

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

IN-NETWORK – Designated as participating in the PPO network. BLUE CROSS NC's payment for in-network covered services is described in this benefit booklet as in-network benefits or in-network benefit levels

IN-NETWORK PROVIDER – A hospital, doctor, other medical practitioner or provider of medical services and supplies that has been designated as a [Product Name] provider by BLUE CROSS NC 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.

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

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

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

If a service or supply meets one or more of the criteria, it is deemed investigational except for clinical trials as described under the Plan. Determinations are made solely by BLUE CROSS NC 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 BLUE CROSS NC but are not determinative or conclusive.

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

LIFETIME MAXIMUM – The maximum amount of covered services that will be reimbursed on behalf of a member while he or she has coverage 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.

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

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

MEDICALLY NECESSARY (or MEDICAL NECESSITY) – Those covered services or supplies that are:

- a. Provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury or disease; and not for experimental, investigational or cosmetic purposes, except as specifically covered by the Plan;
- b. Necessary for and appropriate to the diagnosis, treatment, cure or relief of a health condition, illness, injury, disease or its symptoms;
- c. Within generally accepted standards of medical care in the community; and
- d. Not solely for the convenience of the insured, the insured's family, or the provider.
- e. For medically necessary services, BLUE CROSS NC may compare the cost-effectiveness of alternative services, settings or supplies when determining which of the services or supplies will be covered and in what setting medically necessary services are eligible for coverage.

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

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

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

NON-HOSPITAL 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 BLUE CROSS NC. All services performed must be within the scope of license or certification to be eligible for reimbursement.

OFFICE VISIT – Services provided in a provider's office, including, but not limited to the following:

- Medical care
- Surgery
- Diagnostic Services
- Rehabilitative and habilitative therapy services
- Medical supplies
- Mental health and substance abuse services (evaluation and diagnosis, group therapy, individual and family counseling).

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

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 BLUE CROSS NC. All services performed must be within the scope of license or certification to be eligible for reimbursement

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

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

OUT-OF-NETWORK – Not designated as participating in the PPO network, and not certified in advance by BLUE CROSS NC to be considered as in-network. Payment for out-of-network covered services is described in this benefit booklet as out-of-network benefits or out-of-network benefit levels

OUT-OF-NETWORK PROVIDER – A provider that has not been designated as a Blue Options provider by BLUE CROSS NC.

OUT-OF-POCKET MAXIMUM – The maximum amount of co-insurance that a member is obligated to pay for covered services per benefit period

OUTPATIENT – Pertaining to services received from a hospital or non-hospital facility by a member while not an inpatient

OUTPATIENT CLINIC(S) – An accredited institution/facility associated with or owned by a hospital. An outpatient clinic may bill for outpatient visits, including professional services and ancillary services, such as

diagnostic tests. These services may be subject to the Outpatient Services benefit. All services performed must be within the scope of the professional or facility license or certification to be eligible for reimbursement.

PLAN – the BB&T Corporation Health Care Plan

PLAN ADMINISTRATOR – The Employee Benefits Plan Committee

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 prescription drug issued by a doctor duly licensed to make such a request in the ordinary course of professional practice, or requiring such an order PRESCRIPTION DRUG— a drug that has been approved by the Food and Drug Administration (FDA) and is required, prior to being dispensed or delivered, to be labeled “Caution: Federal law prohibits dispensing without prescription,” or labeled in a similar manner, and is appropriate to be administered without the presence of a medical supervisor.

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

PRIMARY CARE PROVIDER (PCP) – An in-network provider who has been designated by BLUE CROSS NC 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, non-hospital facility, doctor or other provider, accredited, licensed or certified where required in the state of practice, performing within the scope of license or certification. All services performed must be within the scope of license or certification to be eligible for reimbursement.

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

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

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

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

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

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

RESTRICTED ACCESS DRUGS AND DEVICES – Covered prescription drugs or devices for which reimbursement is conditioned on: (1) BLUE CROSS NC giving prior approval to prescribe the drug or device or (2) the health care provider prescribing one or more alternative drugs or devices before prescribing the drug or device in question

ROUTINE FOOT CARE – Hygiene and preventive maintenance 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 psycho-physiological changes that usually characterize sexual response. Included are female sexual arousal disorder, male erectile disorder and hypoactive sexual desire disorder.

SKILLED NURSING FACILITY – A non-hospital 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 BLUE CROSS NC as specializing in an area of medical practice

SPECIALTY DRUG(S) – Those medications classified by BCBSNC that generally have unique indications or uses, or require special dosing or administration, or are typically prescribed by a specialist, or are significantly more expensive than alternative therapies. Specialty drugs may be self-administered or provider-administered and classified as generic, brand-name, biologic, or biosimilar.

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

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

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

TIER 1 DRUGS – The prescription drug tier which consists of the lowest cost tier of prescription drugs, most are generic.

TIER 2 DRUGS – The prescription drug tier which consists of medium-cost prescription drugs, most are generic and some brand-name prescription drugs.

TIER 3 DRUGS – The prescription drug tier which consists of higher-cost prescription drugs, most are brand-name prescription drugs, and some specialty drugs.

TIER 4 DRUGS – The prescription drug tier which consists of the highest-cost prescription drugs, most are specialty drugs.

TRANSPLANTS – The surgical transfer of a human organ or tissue taken from the body for grafting into another area of the same body or into another body; the removal and return into the same body or transfer into another body of bone marrow or peripheral blood stem cells. Grafting procedures associated with reconstructive surgery are not considered to be transplants. URGENT CARE— Services provided for a condition that occurs suddenly and unexpectedly, requiring prompt diagnosis or treatment, such that, in the absence of immediate care, the individual could reasonably be expected to suffer chronic illness or prolonged impairment, or require a more hazardous treatment. Examples of urgent care include sprains, some lacerations and dizziness.

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

VISUALLY NECESSARY – Those covered services or supplies that are:

- a. Provided for the diagnosis, treatment, cure or relief of a health condition, illness, injury or disease; and not for experimental, investigational or cosmetic purposes, except as specifically covered by the Plan;
- b. Necessary for and appropriate to the diagnosis, treatment, cure or relief of a health condition, illness, injury, disease or its symptoms;
- c. Within generally accepted standards of medical care in the community; and
- d. Not solely for the convenience of the insured, the insured's family or the provider.

WAITING PERIOD – the amount of time that must pass before an employee or dependent is eligible to be covered for benefits under the terms of the Plan

DENTAL CARE COVERAGE AND BENEFITS

Summary Of Coverage

The benefits provided by the Plan will be determined solely in accordance with the following schedule of Dental Care benefits, subject to all plan conditions, exclusions and limitations.

Calendar Year Maximum for Preventive, Basic and Major Services	\$1,000 per individual
Calendar Year <i>deductible</i> for Basic and Major Services	\$25 per individual \$75 per family
Lifetime Orthodontic Maximum	\$1,000 per individual

<u>COVERED EXPENSES</u>	<u>WAITING PERIOD</u>	<u>AMOUNT OF COVERAGE</u>
Preventive Services (Type 1 Procedures)	None	100% of Reasonable and Customary Charges; No <i>deductible</i>
Basic Services (Type 2 Procedures)	None	80% of Reasonable and Customary Charges; after <i>deductible</i>
Major Services (Type 3 Procedures)	Six Months	50% of Reasonable and Customary Charges; after <i>deductible</i>
Orthodontic Services (only for dependent children under age 19)	Twelve Months	50%; No <i>deductible</i>

Coverage must be in force the number of months shown under the waiting period before deductible credit will be given or benefits will be payable. You may be able to reduce your waiting period if you have prior coverage. Please contact the Human Systems Service Center at 800-716- 2455 for more information.

Preventive Charges Covered In Full

This plan pays 100%, with no deductible, of the reasonable and customary charges for preventive services. If your dentist's charges are higher than reasonable and customary charges, the additional amount is your responsibility.

Dental Care Benefits

The Dental Care coverage provides benefits for work included in a broad list of dental services, divided into "preventive" (or Type 1), "basic" (or Type 2), "major" (or Type 3) and "orthodontic" services.

The total amount payable for covered dental expenses in a calendar year for preventive, basic and major services will not exceed the Calendar Year Maximum Benefit. The Calendar Year Maximum Benefit is shown in the "Summary of Coverage" section.

The total amount payable for covered orthodontic expenses during your covered dependent's lifetime for orthodontic services will not exceed the Lifetime Orthodontic Maximum. The Lifetime Orthodontic Maximum is shown in the "Summary of Coverage" section.

Many dental conditions can be properly treated in more than one way. This coverage is designed to help pay dental expenses, but not on the basis of treatment that is more expensive than necessary for good dental care.

If two or more services are suitable for your condition, the benefit will be based upon that service which will produce a professionally satisfactory result as determined by the Benefit Services Manager.

Predetermination of Benefits

Your dentist can prepare a "pre-estimate" report that itemizes recommended services, shows the charge for each service, and is accompanied by supporting x-rays or other diagnostic records where required or requested by the Benefit Services Manager.

Pre-determination of benefits permits the review of the proposed treatment in advance and allows for resolution of any questions before, rather than after, the work has been done. Additionally, both you and the dentist will know in advance what charges are covered, your estimated benefits, and approximately how much you will owe, assuming you or the dependent remains covered.

Charges for any amount may be submitted to the Benefit Services Manager for review. The pre-treatment estimate will be returned to the dentist showing estimated benefits.

Eligible Charges

An "eligible charge" is a covered Type 1, Type 2, Type 3 or orthodontic dental service furnished to you or a covered dependent that is on the List of Dental Services.

A dental service not listed in the Schedule and not excluded from coverage may be submitted to the Benefit Services Manager for consideration. When submitting such expenses, the dental service should be identified in terms of the American Dental Association Uniform Code on Dental Procedures and Nomenclature. The Benefit Services Manager will determine if the expense is acceptable and is consistent with those listed dental services. Dental services which do not have uniform professional endorsement will not be accepted by the Benefit Services Manager as a covered dental expense.

The amount of the eligible charge made by a dentist may not exceed the Reasonable and Customary charge for the service.

A temporary dental service will be considered as a part of the final dental service. A charge will be considered to be incurred:

1. For an appliance, or modification of an appliance - on the date the impression is taken;
2. For a crown, bridge or gold restoration - on the date the tooth is prepared;
3. For a root canal therapy - on the date the pulp chamber is opened; or
4. For all other services - on the date the service is received.

PPO Network

The Plan utilizes a network of dentists managed by Ameritas. While you are not required to use an Ameritas participating dentist, you can reduce your out-of-pocket costs by seeking treatment with an in-network provider. Additional information about the network can be found at Ameritas.com.

Dental Rewards

The Plan offers you an opportunity to increase your benefits based on the way you use the Plan. You can increase your dental maximum benefit amount via Dental Rewards. Each year you submit at least one dental claim and keep your total claims paid at or below \$500, you qualify to carryover \$250 in benefit dollars to the following year. If you visit an Ameritas network provider, you earn an additional \$100 in rewards.

List Of Dental Services

The following list of dental procedures for which benefits are payable is based on the Current Dental Terminology © American Dental Association. No benefits are payable for a procedure that is not listed.

Type 1 Procedures

PAYMENT BASIS - NON PARTICIPATING PROVIDERS - Usual and Customary

PAYMENT BASIS - PARTICIPATING PROVIDERS - Maximum Allowable Charge BENEFIT PERIOD - Calendar Year

For Additional Limitations - See Limitations

ROUTINE ORAL EVALUATION

- D0120 Periodic oral evaluation - established patient.
- D0145 Oral evaluation for a patient under three years of age and counseling with primary caregiver.
- D0150 Comprehensive oral evaluation - new or established patient.
- D0180 Comprehensive periodontal evaluation - new or established patient.

COMPREHENSIVE EVALUATION: D0150, D0180

- Coverage is limited to 1 of each of these procedures per 1 provider.
- In addition, D0150, D0180 coverage is limited to 2 of any of these procedures per benefit period.
- D0120, D0145, also contribute(s) to this limitation.
- If frequency met, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency.

ROUTINE EVALUATION: D0120, D0145

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D0150, D0180, also contribute(s) to this limitation.
- Procedure D0120 will be considered for individuals age 3 and over. Procedure D0145 will be considered for individuals age 2 and under.

COMPLETE SERIES OR PANORAMIC

- D0210 Intraoral - complete series of radiographic images.
- D0330 Panoramic radiographic image.

COMPLETE SERIES/PANORAMIC: D0210, D0330

- Coverage is limited to 1 of any of these procedures per 3 year(s).

OTHER XRAYS

- D0220 Intraoral - periapical first radiographic image.
- D0230 Intraoral - periapical each additional radiographic image.
- D0240 Intraoral - occlusal radiographic image.
- D0250 Extra-oral - 2D projection radiographic image created using a stationary radiation source, and detector.
- D0251 Extra-oral posterior dental radiographic image.

PERIAPICAL: D0220, D0230

- The maximum amount considered for x-ray radiographic images taken on one day will be equivalent to an allowance of a D0210.

BITEWINGS

- D0270 Bitewing - single radiographic image.
- D0272 Bitewings - two radiographic images.
- D0273 Bitewings - three radiographic images.
- D0274 Bitewings - four radiographic images.
- D0277 Vertical bitewings - 7 to 8 radiographic images.

BITEWINGS: D0270, D0272, D0273, D0274

- Coverage is limited to 4 bitewing film(s) per Benefit Period.
- D0277, also contribute(s) to this limitation.
- The maximum amount considered for x-ray radiographic images taken on one day will be equivalent to an allowance of a D0210.

VERTICAL BITEWINGS: D0277

- Coverage is limited to 1 of any of these procedures per 1 benefit period.
- The maximum amount considered for x-ray radiographic images taken on one day will be equivalent to an allowance of a D0210.

PROPHYLAXIS (CLEANING) AND FLUORIDE

- D1110 Prophylaxis - adult.
- D1120 Prophylaxis - child.
- D1206 Topical application of fluoride varnish.
- D1208 Topical application of fluoride-excluding varnish.
- D9932 Cleaning and inspection of removable complete denture, maxillary.
- D9933 Cleaning and inspection of removable complete denture, mandibular.
- D9934 Cleaning and inspection of removable partial denture, maxillary.
- D9935 Cleaning and inspection of removable partial denture, mandibular.

FLUORIDE: D1206, D1208

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- Benefits are considered for persons age 17 and under. PROPHYLAXIS: D1110, D1120

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D4910, also contribute(s) to this limitation.
- An adult prophylaxis (cleaning) is considered for individuals age 14 and over. A child prophylaxis (cleaning) is considered for individuals age 13 and under. Benefits for prophylaxis (cleaning) are not available when performed on the same date as periodontal procedures.

PROSTHODONTIC PROPHYLAXIS: D9932, D9933, D9934, D9935

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- Not allowed when done on the same date as periodontal services.

SEALANT

D1351 Sealant - per tooth.

D1352 Preventive resin restoration in a moderate to high caries risk patient-permanent.

D1353 Sealant repair - per tooth.

SEALANT: D1351, D1352, D1353

- Coverage is limited to 1 of any of these procedures per 3 year(s).
- Benefits are considered for persons age 14 and under.
- Benefits are considered on permanent molars only.
- Coverage is allowed on the occlusal surface only.

SPACE MAINTAINERS

D1510 Space maintainer - fixed - unilateral.

D1515 Space maintainer - fixed - bilateral.

D1520 Space maintainer - removable - unilateral.

D1525 Space maintainer - removable - bilateral.

D1550 Re-cement or re-bond space maintainer.

D1555 Removal of fixed space maintainer.

SPACE MAINTAINER: D1510, D1515, D1520, D1525

- Benefits are considered for persons age 15 and under.
- Coverage is limited to space maintenance for unerupted teeth, following extraction of primary teeth. Allowances include all adjustments within 6 months of placement date.

APPLIANCE THERAPY

D8210 Removable appliance therapy.

D8220 Fixed appliance therapy.

APPLIANCE THERAPY: D8210, D8220

- Coverage is limited to the correction of thumb-sucking.

TYPE 2 PROCEDURES

PAYMENT BASIS - NON PARTICIPATING PROVIDERS - Usual and Customary PAYMENT BASIS - PARTICIPATING PROVIDERS - Maximum Allowable Charge BENEFIT PERIOD - Calendar Year

For Additional Limitations - See Limitations

LIMITED ORAL EVALUATION

D0140 Limited oral evaluation - problem focused.

D0170 Re-evaluation - limited, problem focused (established patient; not post-operative visit).

D0171 Re-evaluation - post-operative office visit.

LIMITED ORAL EVALUATION: D0140, D0170

- Coverage is allowed for accidental injury only. If not due to an accident, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency.

ORALPATHOLOGY/LABORATORY

D0472 Accession of tissue, gross examination, preparation and transmission of written report.

D0473 Accession of tissue, gross and microscopic examination, preparation and transmission of written report.

D0474 Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report.

ORAL PATHOLOGY LABORATORY: D0472, D0473, D0474

- Coverage is limited to 1 of any of these procedures per 12 month(s).
- Coverage is limited to 1 examination per biopsy/excision.

AMALGAM RESTORATIONS (FILLINGS)

D2140 Amalgam - one surface, primary or permanent.

D2150 Amalgam - two surfaces, primary or permanent.

D2160 Amalgam - three surfaces, primary or permanent.

D2161 Amalgam - four or more surfaces, primary or permanent.

AMALGAM RESTORATIONS: D2140, D2150, D2160, D2161

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2990, D9911, also contribute(s) to this limitation.

RESIN RESTORATIONS (FILLINGS)

D2330 Resin-based composite - one surface, anterior.

D2331 Resin-based composite - two surfaces, anterior.

D2332 Resin-based composite - three surfaces, anterior.

D2335 Resin-based composite - four or more surfaces or involving incisal angle (anterior).

D2391 Resin-based composite - one surface, posterior.

D2392 Resin-based composite - two surfaces, posterior.

D2393 Resin-based composite - three surfaces, posterior.

D2394 Resin-based composite - four or more surfaces, posterior.

D2410 Gold foil - one surface.

D2420 Gold foil - two surfaces.

D2430 Gold foil - three surfaces.

D2990 Resin infiltration of incipient smooth surface lesions.

COMPOSITE RESTORATIONS: D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2990

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2140, D2150, D2160, D2161, D9911, also contribute(s) to this limitation.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

GOLD FOIL RESTORATIONS: D2410, D2420, D2430

- Gold foils are considered at an alternate benefit of an amalgam/composite restoration.

STAINLESS STEEL CROWN (PREFABRICATED CROWN)

- D2390 Resin-based composite crown, anterior.
- D2929 Prefabricated porcelain/ceramic crown - primary tooth.
- D2930 Prefabricated stainless steel crown - primary tooth.
- D2931 Prefabricated stainless steel crown - permanent tooth.
- D2932 Prefabricated resin crown.
- D2933 Prefabricated stainless steel crown with resin window.
- D2934 Prefabricated esthetic coated stainless steel crown - primary tooth.

STAINLESS STEEL CROWN: D2390, D2929, D2930, D2931, D2932, D2933, D2934

- Replacement is limited to 1 of any of these procedures per 12 month(s).
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

RECEMENT

- D2910 Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration.
- D2915 Re-cement or re-bond indirectly fabricated or prefabricated post and core.
- D2920 Re-cement or re-bond crown.
- D2921 Reattachment of tooth fragment, incisal edge or cusp.
- D6092 Re-cement or re-bond implant/abutment supported crown.
- D6093 Re-cement or re-bond implant/abutment supported fixed partial denture.
- D6930 Re-cement or re-bond fixed partial denture.

SEDATIVE FILLING

- D2940 Protective restoration.
- D2941 Interim therapeutic restoration - primary dentition.

PULP CAP

- D3110 Pulp cap - direct (excluding final restoration).

ENDODONTICSMISCELLANEOUS

- D3220 Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament.
- D3221 Pulpal debridement, primary and permanent teeth.
- D3222 Partial Pulpotomy for apexogenesis - permanent tooth with incomplete root development.
- D3230 Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration).

- D3240 Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration).
- D3333 Internal root repair of perforation defects.
- D3351 Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.).
- D3352 Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.).
- D3353 Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.).
- D3357 Pulpal regeneration - completion of treatment.
- D3430 Retrograde filling – per root.
- D3450 Root amputation - per root.
- D3920 Hemisection (including any root removal), not including root canal therapy.

ENDODONTICS MISCELLANEOUS: D3333, D3430, D3450, D3920

- Procedure D3333 is limited to permanent teeth only.

ENDODONTIC THERAPY (ROOT CANALS)

- D3310 Endodontic therapy, anterior tooth.
- D3320 Endodontic therapy, bicuspid tooth.
- D3330 Endodontic therapy, molar.
- D3332 Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth.
- D3346 Retreatment of previous root canal therapy - anterior.
- D3347 Retreatment of previous root canal therapy - bicuspid.
- D3348 Retreatment of previous root canal therapy - molar.

ROOT CANALS: D3310, D3320, D3330, D3332

- Benefits are considered on permanent teeth only.
- Allowances include intraoperative radiographic images and cultures but exclude final restoration.

RETREATMENT OF ROOT CANAL: D3346, D3347, D3348

- Coverage is limited to 1 of any of these procedures per 12 month(s).
- D3310, D3320, D3330, also contribute(s) to this limitation.
- Benefits are considered on permanent teeth only.
- Coverage is limited to service dates more than 12 months after root canal therapy. Allowances include intraoperative radiographic images and cultures but exclude final restoration.

SURGICALENDODONTICS

- D3355 Pulpal regeneration - initial visit.
- D3356 Pulpal regeneration - interim medication replacement.
- D3410 Apicoectomy - anterior.
- D3421 Apicoectomy - bicuspid (first root).
- D3425 Apicoectomy - molar (first root).
- D3426 Apicoectomy (each additional root).
- D3427 Periradicular surgery without apicoectomy.

SURGICALPERIODONTICS

- D4210 Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per

quadrant.

D4211 Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant.

D4240 Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant.

D4241 Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant.

D4260 Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant.

D4261 Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant.

D4263 Bone replacement graft - retained natural tooth - first site in quadrant.

D4264 Bone replacement graft - retained natural tooth - each additional site in quadrant.

D4265 Biologic materials to aid in soft and osseous tissue regeneration.

D4270 Pedicle soft tissue graft procedure.

D4273 Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft.

D4274 Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area).

D4275 Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant or edentulous tooth position in graft.

D4276 Combined connective tissue and double pedicle graft, per tooth.

D4277 Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft.

D4278 Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant or edentulous tooth position in same graft site.

D4283 Autogenous connective tissue graft procedure (including donor and recipient surgical sites) - each additional contiguous tooth, implant or edentulous tooth position in same graft site.

D4285 Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) - each additional contiguous tooth, implant or edentulous tooth position in same graft site.

BONE GRAFTS: D4263, D4264, D4265

- Each quadrant is limited to 1 of each of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

GINGIVECTOMY: D4210, D4211

- Each quadrant is limited to 1 of each of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease. OSSEOUS SURGERY: D4240, D4241, D4260, D4261
- Each quadrant is limited to 1 of each of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

TISSUE GRAFTS: D4270, D4273, D4275, D4276, D4277, D4278, D4283, D4285

- Each quadrant is limited to 2 of any of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

NON-SURGICAL PERIODONTICS

- D4341 Periodontal scaling and root planing - four or more teeth per quadrant.
- D4342 Periodontal scaling and root planing - one to three teeth, per quadrant.
- D4381 Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report.

CHEMOTHERAPEUTIC AGENTS: D4381

- Each quadrant is limited to 2 of any of these procedures per 2 year(s). PERIODONTAL

SCALING & ROOT PLANING: D4341, D4342

- Each quadrant is limited to 1 of each of these procedures per 2 year(s).

FULL MOUTH DEBRIDEMENT

D4355 Full mouth debridement to enable comprehensive evaluation and diagnosis.

FULL MOUTH DEBRIDEMENT: D4355

- Coverage is limited to 1 of any of these procedures per 5 year(s).

PERIODONTAL MAINTENANCE

D4910 Periodontal maintenance.

PERIODONTAL MAINTENANCE: D4910

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D1110, D1120, also contribute(s) to this limitation.
- Coverage is contingent upon evidence of full mouth active periodontal therapy. Benefits are not available if performed on the same date as any other periodontal procedure.

NON-SURGICAL EXTRACTIONS

- D7111 Extraction, coronal remnants - deciduous tooth.
- D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal).

SURGICAL EXTRACTIONS

- D7210 Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated.
- D7220 Removal of impacted tooth - soft tissue.
- D7230 Removal of impacted tooth - partially bony.
- D7240 Removal of impacted tooth - completely bony.
- D7241 Removal of impacted tooth - completely bony, with unusual surgical complications.
- D7250 Removal of residual tooth roots (cutting procedure).
- D7251 Coronectomy-intentional partial tooth removal.

OTHER ORAL SURGERY

- D7260 Oroantral fistula closure.
- D7261 Primary closure of a sinus perforation.
- D7270 Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.
- D7272 Tooth transplantation (includes reimplantation from one site to another and splinting and/or

stabilization).

D7280 Exposure of an unerupted tooth.

D7282 Mobilization of erupted or malpositioned tooth to aid eruption.

D7283 Placement of device to facilitate eruption of impacted tooth.

D7310 Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.

D7311 Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.

D7320 Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.

D7321 Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.

D7340 Vestibuloplasty - ridge extension (secondary epithelialization).

D7350 Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue).

D7410 Excision of benign lesion up to 1.25 cm.

D7411 Excision of benign lesion greater than 1.25 cm.

D7412 Excision of benign lesion, complicated.

D7413 Excision of malignant lesion up to 1.25 cm.

D7414 Excision of malignant lesion greater than 1.25 cm.

D7415 Excision of malignant lesion, complicated.

D7440 Excision of malignant tumor - lesion diameter up to 1.25 cm.

D7441 Excision of malignant tumor - lesion diameter greater than 1.25 cm.

D7450 Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm.

D7451 Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm.

D7460 Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm.

D7461 Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm.

D7465 Destruction of lesion(s) by physical or chemical method, by report.

D7471 Removal of lateral exostosis (maxilla or mandible).

D7472 Removal of torus palatinus.

D7473 Removal of torus mandibularis.

D7485 Reduction of osseous tuberosity.

D7490 Radical resection of maxilla or mandible.

D7510 Incision and drainage of abscess - intraoral soft tissue.

D7520 Incision and drainage of abscess - extraoral soft tissue.

D7530 Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue.

D7540 Removal of reaction producing foreign bodies, musculoskeletal system.

D7550 Partial ostectomy/sequestrectomy for removal of non-vital bone.

D7560 Maxillary sinusotomy for removal of tooth fragment or foreign body.

D7910 Suture of recent small wounds up to 5 cm.

D7911 Complicated suture - up to 5 cm.

D7912 Complicated suture - greater than 5 cm.

D7960 Frenulectomy-also known as frenectomy or frenotomy-separate procedure not incidental to another procedure.

D7963 Frenuloplasty.

D7970 Excision of hyperplastic tissue - per arch.

- D7972 Surgical reduction of fibrous tuberosity.
- D7980 Sialolithotomy.
- D7983 Closure of salivary fistula.

REMOVAL OF BONE TISSUE: D7471, D7472, D7473

- Coverage is limited to 5 of any of these procedures per 1 lifetime.

BIOPSY OF ORAL TISSUE

- D7285 Incisional biopsy of oral tissue - hard (bone, tooth).
- D7286 Incisional biopsy of oral tissue - soft.
- D7287 Exfoliative cytological sample collection.
- D7288 Brush biopsy - transepithelial sample collection.

PALLIATIVE

- D9110 Palliative (emergency) treatment of dental pain - minor procedure.

PALLIATIVE TREATMENT: D9110

- Not covered in conjunction with other procedures, except diagnostic x-ray radiographic images.

ANESTHESIA-GENERAL/IV

- D9219 Evaluation for deep sedation or general anesthesia.
- D9223 Deep sedation/general anesthesia - each 15 minute increment.
- D9243 Intravenous moderate (conscious) sedation/analgesia - each 15 minute increment.

GENERAL ANESTHESIA: D9223, D9243

- Coverage is only available with a cutting procedure. Verification of the dentist's anesthesia permit and a copy of the anesthesia report are required. A maximum of four (D9223 or D9243) will be considered.

PROFESSIONAL CONSULT/VISIT/SERVICES

- D9310 Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician.
- D9430 Office visit for observation (during regularly scheduled hours) - no other services performed.
- D9440 Office visit - after regularly scheduled hours.
- D9930 Treatment of complications (post-surgical) - unusual circumstances, by report.

CONSULTATION: D9310

- Coverage is limited to 1 of any of these procedures per 1 provider.

OFFICE VISIT: D9430, D9440

- Procedure D9430 is allowed for accidental injury only. Procedure D9440 will be allowed on the basis of services rendered or visit, whichever is greater.

OCCLUSAL ADJUSTMENT

- D9951 Occlusal adjustment - limited.
- D9952 Occlusal adjustment - complete.

OCCLUSAL ADJUSTMENT: D9951, D9952

- Coverage is considered only when performed in conjunction with periodontal procedures for the treatment of periodontal disease.

MISCELLANEOUS

D0486 Laboratory accession of transepithelial cytologic sample, microscopic examination, preparation and transmission of written report.

D2951 Pin retention - per tooth, in addition to restoration.

D9911 Application of desensitizing resin for cervical and/or root surfaces, per tooth.

DESENSITIZATION: D9911

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2990, also contribute(s) to this limitation.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

Type 3 Procedures

PAYMENT BASIS - NON PARTICIPATING PROVIDERS - Usual and Customary

PAYMENT BASIS - PARTICIPATING PROVIDERS - Maximum Allowable Charge BENEFIT PERIOD - Calendar Year

For Additional Limitations - See Limitations

INLAY RESTORATIONS

D2510 Inlay - metallic - one surface.

D2520 Inlay - metallic - two surfaces.

D2530 Inlay - metallic - three or more surfaces.

D2610 Inlay - porcelain/ceramic - one surface.

D2620 Inlay - porcelain/ceramic - two surfaces.

D2630 Inlay - porcelain/ceramic - three or more surfaces.

D2650 Inlay - resin-based composite - one surface.

D2651 Inlay - resin-based composite - two surfaces.

D2652 Inlay - resin-based composite - three or more surfaces.

INLAY: D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652

- Inlays will be considered at an alternate benefit of an amalgam/composite restoration and only when resulting from caries (tooth decay) or traumatic injury.

ONLAY RESTORATIONS

D2542 Onlay - metallic - two surfaces.

D2543 Onlay - metallic - three surfaces.

D2544 Onlay - metallic - four or more surfaces.

D2642 Onlay - porcelain/ceramic - two surfaces.

D2643 Onlay - porcelain/ceramic - three surfaces.

- D2644 Onlay - porcelain/ceramic - four or more surfaces.
- D2662 Onlay - resin-based composite - two surfaces.
- D2663 Onlay - resin-based composite - three surfaces.
- D2664 Onlay - resin-based composite - four or more surfaces.

ONLAY: D2542, D2543, D2544, D2642, D2643, D2644, D2662, D2663, D2664

- Replacement is limited to 1 of any of these procedures per 8 year(s).
- D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794 also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.
- Benefits will not be considered if procedure D2390, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

CROWNS SINGLE RESTORATIONS

- D2710 Crown - resin-based composite (indirect).
- D2712 Crown - 3/4 resin-based composite (indirect).
- D2720 Crown - resin with high noble metal.
- D2721 Crown - resin with predominantly base metal.
- D2722 Crown - resin with noble metal.
- D2740 Crown - porcelain/ceramic substrate.
- D2750 Crown - porcelain fused to high noble metal.
- D2751 Crown - porcelain fused to predominantly base metal.
- D2752 Crown - porcelain fused to noble metal.
- D2780 Crown - 3/4 cast high noble metal.
- D2781 Crown - 3/4 cast predominantly base metal.
- D2782 Crown - 3/4 cast noble metal.
- D2783 Crown - 3/4 porcelain/ceramic.
- D2790 Crown - full cast high noble metal.
- D2791 Crown - full cast predominantly base metal.
- D2792 Crown - full cast noble metal.
- D2794 Crown - titanium.

CROWN: D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794

- Replacement is limited to 1 of any of these procedures per 8 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

- Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.
- Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.
- Benefits will not be considered if procedure D2390, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

CORE BUILD-UP

D2950 Core buildup, including any pins when required.

CORE BUILDUP: D2950

- A pretreatment is strongly suggested for D2950. This is reviewed by our dental consultants and benefits are allowed when diagnostic data indicates significant tooth structure loss.

POST AND CORE

D2952 Post and core in addition to crown, indirectly fabricated.

D2954 Prefabricated post and core in addition to crown.

FIXED CROWN AND PARTIAL DENTURE REPAIR

D2980 Crown repair necessitated by restorative material failure.

D2981 Inlay repair necessitated by restorative material failure.

D2982 Onlay repair necessitated by restorative material failure.

D2983 Veneer repair necessitated by restorative material failure.

D6980 Fixed partial denture repair necessitated by restorative material failure.

D9120 Fixed partial denture sectioning.

CROWN LENGTHENING

D4249 Clinical crown lengthening - hard tissue.

PROSTHODONTICS - FIXED/REMOVABLE (DENTURES)

D5110 Complete denture - maxillary.

D5120 Complete denture - mandibular.

D5130 Immediate denture - maxillary.

D5140 Immediate denture - mandibular.

D5211 Maxillary partial denture - resin base (including any conventional clasps, rests and teeth).

D5212 Mandibular partial denture - resin base (including any conventional clasps, rests and teeth).

D5213 Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).

D5214 Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).

D5221 Immediate maxillary partial denture - resin base (including any conventional clasps, rests and teeth).

D5222 Immediate mandibular partial denture - resin base (including any conventional clasps, rests and teeth).

D5223 Immediate maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).

D5224 Immediate mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).

- D5225 Maxillary partial denture - flexible base (including any clasps, rests and teeth).
- D5226 Mandibular partial denture - flexible base (including any clasps, rests and teeth).
- D5281 Removable unilateral partial denture - one piece cast metal (including clasps and teeth).
- D5670 Replace all teeth and acrylic on cast metal framework (maxillary).
- D5671 Replace all teeth and acrylic on cast metal framework (mandibular).
- D5810 Interim complete denture (maxillary).
- D5811 Interim complete denture (mandibular).
- D5820 Interim partial denture (maxillary).
- D5821 Interim partial denture (mandibular).
- D5863 Overdenture - complete maxillary.
- D5864 Overdenture - partial maxillary.
- D5865 Overdenture - complete mandibular.
- D5866 Overdenture - partial mandibular.
- D6110 Implant/abutment supported removable denture for edentulous arch - maxillary.
- D6111 Implant/abutment supported removable denture for edentulous arch - mandibular.
- D6112 Implant/abutment supported removable denture for partially edentulous arch - maxillary.
- D6113 Implant/abutment supported removable denture for partially edentulous arch - mandibular.
- D6114 Implant/abutment supported fixed denture for edentulous arch - maxillary.
- D6115 Implant/abutment supported fixed denture for edentulous arch - mandibular.
- D6116 Implant/abutment supported fixed denture for partially edentulous arch - maxillary.
- D6117 Implant/abutment supported fixed denture for partially edentulous arch - mandibular.

COMPLETE DENTURE: D5110, D5120, D5130, D5140, D5863, D5865, D6110, D6111, D6114, D6115

- Replacement is limited to 1 of any of these procedures per 8 year(s).
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months after placement date. Procedures D5863, D5865, D6110, D6111, D6114 and D6115 are considered at an alternate benefit of a D5110/D5120.
- PARTIAL DENTURE: D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5281, D5670, D5671, D5864, D5866, D6112, D6113, D6116, D6117
- Replacement is limited to 1 of any of these procedures per 8 year(s).
- D6010, D6040, D6050, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months of placement date. Procedures D5864, D5866, D6112, D6113, D6116 and D6117 are considered at an alternate benefit of a D5213/D5214.

DENTURE ADJUSTMENTS

- D5410 Adjust complete denture - maxillary.
- D5411 Adjust complete denture - mandibular.
- D5421 Adjust partial denture - maxillary.
- D5422 Adjust partial denture - mandibular.

DENTURE ADJUSTMENT: D5410, D5411, D5421, D5422

- Coverage is limited to dates of service more than 6 months after placement date.

DENTURE REPAIR

- D5510 Repair broken complete denture base.
- D5520 Replace missing or broken teeth - complete denture (each tooth).

- D5610 Repair resin denture base.
- D5620 Repair cast framework.
- D5630 Repair or replace broken clasp-per tooth.
- D5640 Replace broken teeth - per tooth.

ADD TOOTH/CLASP TO EXISTING PARTIAL

- D5650 Add tooth to existing partial denture.
- D5660 Add clasp to existing partial denture-per tooth.

DENTURE REBASES

- D5710 Rebase complete maxillary denture.
- D5711 Rebase complete mandibular denture.
- D5720 Rebase maxillary partial denture.
- D5721 Rebase mandibular partial denture.

DENTURE RELINES

- D5730 Reline complete maxillary denture (chairside).
- D5731 Reline complete mandibular denture (chairside).
- D5740 Reline maxillary partial denture (chairside).
- D5741 Reline mandibular partial denture (chairside).
- D5750 Reline complete maxillary denture (laboratory).
- D5751 Reline complete mandibular denture (laboratory).
- D5760 Reline maxillary partial denture (laboratory).
- D5761 Reline mandibular partial denture (laboratory).

DENTURE RELINE: D5730, D5731, D5740, D5741, D5750, D5751, D5760, D5761

- Coverage is limited to service dates more than 6 months after placement date.

TISSUE CONDITIONING

- D5850 Tissue conditioning, maxillary.
- D5851 Tissue conditioning, mandibular.

IMPLANTS

- D6010 Surgical placement of implant body: endosteal implant.
- D6040 Surgical placement: eposteal implant.
- D6050 Surgical placement: transosteal implant.
- D6051 Interim abutment.
- D6055 Connecting bar-implant supported or abutment supported.
- D6056 Prefabricated abutment - includes placement.
- D6057 Custom abutment - includes placement.

IMPLANT: D6010, D6040, D6050

- Replacement is limited to 1 of any of these procedures per 8 year(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6094, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.

- Benefits for procedures D6051, D6055, D6056 and D6057 will be contingent upon the implant being covered. Replacement for procedures D6056 and D6057 are limited to 1 of any of these procedures per 10 years.

IMPLANT SERVICES

- D6052 Semi-precision attachment abutment.
- D6080 Implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments.
- D6090 Repair implant supported prosthesis, by report.
- D6091 Replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment.
- D6095 Repair implant abutment, by report.
- D6100 Implant removal, by report.
- D6190 Radiographic/surgical implant index, by report.

IMPLANT SERVICES: D6052, D6080, D6090, D6091, D6095, D6100, D6190

- Coverage for D6080 is limited to 1 in a 12 month period. Coverage for D6090, D6091, D6052 and D6095 is limited to service dates more than 6 months after placement date. Coverage for D6190 is limited to 1 per arch in a 24 month period.

PROSTHODONTICS - FIXED

- D6058 Abutment supported porcelain/ceramic crown.
- D6059 Abutment supported porcelain fused to metal crown (high noble metal).
- D6060 Abutment supported porcelain fused to metal crown (predominantly base metal).
- D6061 Abutment supported porcelain fused to metal crown (noble metal).
- D6062 Abutment supported cast metal crown (high noble metal).
- D6063 Abutment supported cast metal crown (predominantly base metal).
- D6064 Abutment supported cast metal crown (noble metal).
- D6065 Implant supported porcelain/ceramic crown.
- D6066 Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal).
- D6067 Implant supported metal crown (titanium, titanium alloy, high noble metal).
- D6068 Abutment supported retainer for porcelain/ceramic FPD.
- D6069 Abutment supported retainer for porcelain fused to metal FPD (high noble metal).
- D6070 Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal).
- D6071 Abutment supported retainer for porcelain fused to metal FPD (noble metal).
- D6072 Abutment supported retainer for cast metal FPD (high noble metal).
- D6073 Abutment supported retainer for cast metal FPD (predominantly base metal).
- D6074 Abutment supported retainer for cast metal FPD (noble metal).
- D6075 Implant supported retainer for ceramic FPD.
- D6076 Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal).
- D6077 Implant supported retainer for cast metal FPD (titanium, titanium alloy or high noble metal).
- D6094 Abutment supported crown - (titanium).
- D6194 Abutment supported retainer crown for FPD - (titanium).
- D6205 Pontic - indirect resin based composite.

D6210 Pontic - cast high noble metal.
D6211 Pontic - cast predominantly base metal.
D6212 Pontic - cast noble metal.
D6214 Pontic - titanium.
D6240 Pontic - porcelain fused to high noble metal.
D6241 Pontic - porcelain fused to predominantly base metal.
D6242 Pontic - porcelain fused to noble metal.
D6245 Pontic - porcelain/ceramic.
D6250 Pontic - resin with high noble metal.
D6251 Pontic - resin with predominantly base metal.
D6252 Pontic - resin with noble metal.
D6545 Retainer - cast metal for resin bonded fixed prosthesis.
D6548 Retainer - porcelain/ceramic for resin bonded fixed prosthesis.
D6549 Resin retainer - for resin bonded fixed prosthesis.
D6600 Retainer inlay - porcelain/ceramic, two surfaces.
D6601 Retainer inlay - porcelain/ceramic, three or more surfaces.
D6602 Retainer inlay - cast high noble metal, two surfaces.
D6603 Retainer inlay - cast high noble metal, three or more surfaces.
D6604 Retainer inlay - cast predominantly base metal, two surfaces.
D6605 Retainer inlay - cast predominantly base metal, three or more surfaces.
D6606 Retainer inlay - cast noble metal, two surfaces.
D6607 Retainer inlay - cast noble metal, three or more surfaces.
D6608 Retainer onlay - porcelain/ceramic, two surfaces.
D6609 Retainer onlay - porcelain/ceramic, three or more surfaces.
D6610 Retainer onlay - cast high noble metal, two surfaces.
D6611 Retainer onlay - cast high noble metal, three or more surfaces.
D6612 Retainer onlay - cast predominantly base metal, two surfaces.
D6613 Retainer onlay - cast predominantly base metal, three or more surfaces.
D6614 Retainer onlay - cast noble metal, two surfaces.
D6615 Retainer onlay - cast noble metal, three or more surfaces.
D6624 Retainer inlay - titanium.
D6634 Retainer onlay - titanium.
D6710 Retainer crown - indirect resin based composite.
D6720 Retainer crown - resin with high noble metal.
D6721 Retainer crown - resin with predominantly base metal.
D6722 Retainer crown - resin with noble metal.
D6740 Retainer crown - porcelain/ceramic.
D6750 Retainer crown - porcelain fused to high noble metal.
D6751 Retainer crown - porcelain fused to predominantly base metal.
D6752 Retainer crown - porcelain fused to noble metal.
D6780 Retainer crown - 3/4 cast high noble metal.
D6781 Retainer crown - 3/4 cast predominantly base metal.
D6782 Retainer crown - 3/4 cast noble metal.
D6783 Retainer crown - 3/4 porcelain/ceramic.
D6790 Retainer crown - full cast high noble metal.
D6791 Retainer crown - full cast predominantly base metal.
D6792 Retainer crown - full cast noble metal.

D6794 Retainer crown - titanium.

D6940 Stress breaker.

FIXED PARTIAL CROWN: D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794

- Replacement is limited to 1 of any of these procedures per 8 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.
- Benefits will not be considered if procedure D2390, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL INLAY: D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624

- Replacement is limited to 1 of any of these procedures per 8 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.
- Benefits will not be considered if procedure D2390, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL ONLAY: D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634

- Replacement is limited to 1 of any of these procedures per 8 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.
- Benefits will not be considered if procedure D2390, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL PONTIC: D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252

- Replacement is limited to 1 of any of these procedures per 8 year(s).
- D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5281, D6010, D6040, D6050, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6094, D6194, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

IMPLANT SUPPORTED CROWN: D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6094

- Replacement is limited to 1 of any of these procedures per 8 year(s).
- D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5281, D6194, D6205, D6210, D6211, D6212, D6214, D6240,
- D6241, D6242, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

IMPLANT SUPPORTED RETAINER: D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6194

- Replacement is limited to 1 of any of these procedures per 8 year(s).
- D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5281, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6094, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

BONE AUGMENTATION

D6104 Bone graft at time of implant placement.

D7950 Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla - autogenous or nonautogenous, by report.

D7951 Sinus augmentation with bone or bone substitutes via a lateral open approach.

D7952 Sinus augmentation via a vertical approach.

D7953 Bone replacement graft for ridge preservation - per site.

BONE AUGMENTATION: D6104, D7950, D7951, D7952, D7953

- Each quadrant is limited to 1 of any of these procedures per 5 year(s).
- Coverage of D6104, D7950, D7951, D7952 and D7953 is limited to the treatment and placement of endosteal implant D6010, D6040 eposteal implant or D6050 transosteal implant.

Dental Coverage Limitations and Exclusions

Covered Expenses will not include and benefits will not be payable for expenses incurred:

1. For Type 3 Procedures in the first 6 months the person is covered under this plan; unless the Member is covered on January 1, 2017.
2. For initial placement of any prosthetic crown, appliance, or fixed partial denture for the first 12 months that a person is covered, unless such placement is needed because of the extraction of one or more teeth while the covered person is covered under this plan. But the extraction of a third molar (wisdom tooth) will not qualify under the above. Any such prosthetic crown, appliance, or fixed partial denture must include the replacement of the extracted tooth or teeth.
3. For appliances, restorations, or procedures to:
 - a. alter vertical dimension;
 - b. restore or maintain occlusion; or
 - c. splint or replace tooth structure lost as a result of abrasion or attrition.
4. For any procedure begun after the covered person's coverage under this plan terminates; or for any prosthetic dental appliances installed or delivered more than 90 days after the Member's coverage under this Plan terminates.
5. To replace lost or stolen appliances.
6. For any treatment which is for cosmetic purposes.
7. For any procedure not shown in the Table of Dental Procedures. (There may be additional frequencies and limitations that apply, please see the Table of Dental Procedures for details.)
8. For orthodontic treatment under this benefit provision. (If orthodontic expense benefits have been included in this plan, please refer to the Schedule of Benefits and Orthodontic Expense Benefits provision found on 9260).
9. For which the Covered person is entitled to benefits under any worker's compensation or similar law, or charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.
10. For charges which the Covered person is not liable or which would not have been made had no coverage been in force.
11. For services that are not required for necessary care and treatment or are not within the generally accepted parameters of care.
12. Because of war or any act of war, declared or not.

The following provides information regarding the claims review process and your rights to request a review of

any part of a claim that is denied. Please note that certain state laws may also require specified claims payment procedures as well as internal appeal procedures and/or independent external review processes. Therefore, in addition to the review procedures defined below, you may also have additional rights provided to you under state law.

Claims For Benefits

Claims may be submitted by mailing the completed claim form along with any requested information to:

Ameritas Life Insurance Corp.
PO Box 82520
Lincoln, NE 68501

Notice Of Decision Of Claim

We will evaluate your claim promptly after we receive it.

Dental Utilization Review Program

Generally, utilization review means a set of criteria designed to monitor the use of, or evaluate the medical necessity, appropriateness, or efficiency of health care services. We have established a utilization review program to ensure that any guidelines and criteria used to evaluate the medical necessity of a health care service are clearly documented and include procedures for applying such criteria based on the needs of the individual patients. The program was developed in conjunction with licensed dentists and is reviewed at least annually to ensure that criteria are applied consistently and are current with dental technology, evidence-based research and any dental trends.

We will provide you written notice regarding the payment under the claim within 30 calendar days following receipt of the claim. This period may be extended for an additional 15 days, provided that we have determined that an extension is necessary due to matters beyond our control, and notify you, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which we expect to render a decision. If the extension is due to your failure to provide information necessary to decide the claim, the notice of extension shall specifically describe the required information we need to decide the claim.

If we request additional information, you will have 45 days to provide the information. If you do not provide the requested information within 45 days, we may decide your claim based on the information we have received.

If we deny any part of your claim, you will receive a written notice of denial containing:

- a. The reasons for our decision.
- b. Reference to the parts of the Group Plan on which our decision is based.
- c. Reference to any internal rule or guideline relied upon in making our decision, along with your right to receive a copy of these guidelines, free of charge, upon request.
- d. A statement that you may request an explanation of the scientific or clinical judgment we relied upon to exclude expenses that are experimental or investigational, or are not necessary or accepted according to generally accepted standards of Dental practice.
- e. A description of any additional information needed to support your claim and why such information is necessary.

- f. Information concerning your right to a review of our decision.
- g. Information concerning your right to bring a civil action for benefits under section 502(a) of ERISA following an adverse benefit determination on review.

If all or part of a claim is denied, you may request a review in writing within 180 days after receiving notice of the benefit denial.

You may send us written comments or other items to support your claim. You may review and receive copies of any non-privileged information that is relevant to your appeal. There will be no charge for such copies. You may request the names of the experts we consulted who provided advice to us about your claim.

The appeal review will be conducted by the Plan's named fiduciary and will be someone other than the person who denied the initial claim and will not be subordinate to that person. The person conducting the review will not give deference to the initial denial decision. If the denial was based in whole or in part on a medical judgment, including determinations with regard to whether a service was considered experimental, investigational, and/or not medically necessary, the person conducting the review will consult with a qualified health care professional. This health care professional will be someone other than the person who made the original judgment and will not be subordinate to that person. Our review will include any written comments or other items you submit to support your claim.

We will review your claim promptly after we receive your request.

If your appeal is about urgent care, you may call Toll Free at 877-897-4328, and an Expedited Review will be conducted. Verbal notification of our decision will be made within 72 hours, followed by written notice within 3 calendar days after that.

If your appeal is about benefit decisions related to clinical or medical necessity, a Standard Consultant Review will be conducted. A written decision will be provided within 30 calendar days of the receipt of the request for appeal.

If your appeal is about benefit decisions related to coverage, a Standard Administrative Review will be conducted. A written decision will be provided within 60 calendar days of the receipt of the request for appeal.

If we deny any part of your claim on review, you will receive a written notice of denial containing:

- a. The reasons for our decision.
- b. Reference to the parts of the Group Plan on which our decision is based.
- c. Reference to any internal rule or guideline relied upon in making our decision along with your right to receive a copy of these guidelines, free of charge, upon request.
- d. Information concerning your right to receive, free of charge, copies of non-privileged documents and records relevant to your claim.
- e. A statement that you may request an explanation of the scientific or clinical judgment we relied upon to exclude expenses that are experimental or investigational, or are not necessary or accepted according to generally accepted standards of Dental practice.
- f. Information concerning your right to bring a civil action for benefits under section 502(a) of ERISA.

Certain state laws also require specified internal appeal procedures and/or external review processes. In addition to the review procedures defined above, you may also have additional rights provided to you under state law.

Please review your certificate of coverage for such information, call us, or contact your state regulatory agency for assistance. In any event, you need not exhaust such state law procedures prior to bringing civil action under Section 502(a) of ERISA.

Any request for appeal should be directed to:

Quality Control
P.O. Box 82657
Lincoln, NE 68501-2657.

VISION CARE COVERAGE AND BENEFITS

Vision Care benefits under the Plan are provided through Vision Service Plan (VSP). The benefits provided by the Plan will be determined solely in accordance with the following schedule of Vision Care benefits, subject to all Plan conditions, exclusions and limitations.

Schedule Of Benefits

GENERAL

This Schedule lists the vision care services and vision care materials to which Covered Persons of VSP are entitled, subject to any Co-payments and other conditions, limitations and/or exclusions stated herein. Vision care services and vision care materials may be received from any licensed optometrist, ophthalmologist or dispensing optician, whether Member Doctors or Non-Member Providers.

When benefits are received from Member Doctors, benefits appearing in the first column below are applicable subject to any Co-payment(s) as stated below. When benefits are available and received from Non-Member Providers, you are reimbursed for such benefits according to the schedule in the second column below less any applicable Co-payment.

PLAN AND SCHEDULE:

PLAN B

EXAMINATION: ONCE EACH 12 MONTHS

LENSES: ONCE EACH 12 MONTHS

FRAMES: ONCE EACH 24 MONTHS

PLAN BENEFITS

MEMBER DOCTOR

**NON-MEMBER BENEFIT
PROVIDER BENEFIT**

VISION CARE SERVICES

Vision Examination	Covered in Full	Up to \$50.00
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VISION CARE MATERIALS

Lenses		
Single Vision	Covered in Full	Up to \$50.00
Lined Bifocal	Covered in Full	Up to \$75.00
Lined Trifocal	Covered in Full	Up to \$100.00
Lenticular	Covered in Full	Up to \$125.00

Polycarbonate lenses for children will be covered in full when obtained from a Member Doctor.

Frames	Covered up to \$150.00	Up to \$80.00
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CONTACT LENSES

Visually Necessary		
Professional Fees and Materials	Covered in Full	Up to \$210.00

Elective*		
Materials	Covered up to \$150.00	Up to \$150.00

When contact lenses are obtained, the Covered Person shall not be eligible for lenses and frames again for 12 months.

****Up to a \$60.00 copay applies to contact lens exam (evaluation and fitting).***

Additional benefits may be available at Costco retail locations and at other affiliate locations. Please see the VSP website for additional information. The Costco Frame Allowance is \$80.00.

Procedure For Using The Plan

1. When you desire to receive Plan Benefits from a Member Doctor, contact VSP or a Member Doctor. A list of names, addresses and phone numbers of Member Doctors in your geographic location can be obtained from VSP.
2. If you are eligible for vision care program benefits, VSP will provide Benefit Authorization directly to the Member Doctor. If you contact the Member Doctor directly, you must identify yourself as a VSP member so the doctor knows to obtain Benefit Authorization from VSP.
3. When such Benefit Authorization is provided by VSP and services are performed prior to the expiration date of the Benefit Authorization, this will constitute a claim against the vision program in spite of your termination of coverage or the termination of the vision program. Should you receive

services from a Member Doctor without such Benefit Authorization or obtain services from a provider who is not a Member Doctor, you are responsible for payment in full to the provider.

4. You pay only the Co-payment (if any) to a Member Doctor for services covered by the vision program. VSP will pay the Member Doctor directly according to their agreement with the doctor. The current benefit schedule does not require a Co-payment. If you are eligible for and obtain Plan Benefits from a Non-Member Provider, you should pay the provider his/her full fee. You will be reimbursed by VSP in accordance with the Non-Member Provider reimbursement schedule shown, less any applicable Co-payments.
5. In the event of termination of a Member Doctor's membership in VSP, VSP will remain liable to the Member Doctor for services rendered to you at the time of termination and permit the Member Doctor to continue to provide you with benefits until the services are completed or until VSP makes reasonable and appropriate arrangements for the provision of such services by another authorized doctor.

Benefit Authorization Process

Prior Authorization Certain Plan Benefits require VSP's prior authorization before such benefits are covered. VSP's prior authorization determinations are based upon criteria developed by optometric and ophthalmic consultants and approved by VSP's Utilization Management Committee and Board of Directors.

Initial Determination: VSP will approve or deny requests for prior authorization of services within fifteen (15) calendar days of receipt of the request from the Covered Person's doctor. In the event that a prior authorization cannot be resolved within the time indicated, VSP may, if necessary, extend the time for decision by no more than fifteen (15) calendar days.

Appeals: If VSP denies the doctor's request for prior authorization, the doctor, Covered Person or the Covered Person's authorized representative may request an appeal of the denial. Please refer to the section on Claim Appeals, below, for details on how to request an appeal. VSP shall provide the requestor with a final review determination within thirty (30) calendar days from the date the request is received. A second level appeal, and other remedies as described below, are also available. VSP shall resolve any second level appeal within thirty (30) calendar days. The Covered Person may designate any person, including the provider, as the Covered Person's authorized representative.

For more information regarding VSP's criteria for authorizing or denying benefits, please contact VSP's Customer Service Department.

Benefits And Coverages

Through its Member Doctors, VSP provides benefits to Covered Persons as may be Visually Necessary or Appropriate, subject to the limitations, exclusions and Co-payments described herein. When you wish to obtain benefits from a Member Doctor, you should contact the Member Doctor of your choice, identify yourself as a VSP member, and schedule an appointment. If you are eligible for benefits, VSP will provide Benefit Authorization for you directly to the Member Doctor prior to your appointment.

1. Eye Examination: A complete initial vision analysis which includes an appropriate examination of visual functions, including the prescription of corrective eyewear where indicated.

2. Lenses: The Member Doctor will order the proper lenses necessary for your visual welfare. The doctor shall verify the accuracy of the finished lenses.
3. Frames: The Member Doctor will assist in the selection of frames, properly fit and adjust the frames, and provide subsequent adjustments to frames to maintain comfort and efficiency.
4. Contact lenses: Unless otherwise indicated on the enclosed insert, contact lenses are available under this Plan in lieu of all other lens and frame benefits described herein for the current eligibility period.

Visually Necessary contact lenses, together with necessary professional services, will be provided as indicated below. Coverage for Visually Necessary contact lenses, regardless of whether they are obtained from a Member Doctor or Non-Member Provider, are subject to review and authorization from VSP's Optometric Consultants.

If you select contact lenses for other than Visually Necessary circumstances, they will be considered Elective contact lenses. When Elective contact lenses are obtained from a Member Doctor, there is a copay of up to \$60.00 for the contact lens exam (evaluation and fitting). Contact lens materials are provided at the Member Doctor's usual and customary charges with an allowance of \$150.00.

5. If you elect to receive vision care services from a Member Doctor, benefits are provided subject only to your payment of any applicable Co-payment. If you choose to obtain benefits from a Non-Member Provider, you should pay the Non-Member Provider his/her full fee. VSP will reimburse you in accordance with the reimbursement schedule shown. There is no assurance that the schedule will be sufficient to pay for the examination or materials. Availability of the services under the Non-Member Provider reimbursement schedule is subject to the same time limits and Co-payments as those described for Member Doctor services. Services obtained from a Non-Member Provider are in lieu of obtaining services from a Member Doctor and count toward plan benefit frequencies. Non-member claims may be submitted to VSP online at www.vsp.com or sent by mail to VSP, Attention: Out-of-Network Claims, PO Box 385018, Birmingham, AL 35238-5018
6. Additional Discount: Each Covered Person shall be entitled to receive a 20% discount toward the purchase of additional complete pairs of prescription glasses (lenses, lens options and frames) from a Member Doctor. Additional pair means any complete pair of prescription glasses purchased beyond the benefit frequency allowed by the vision program. Additionally, each Covered Person shall be entitled to receive a 15% discount off the Member Doctor's professional fees for contact lens evaluations and fittings. Contact lens materials are provided at the doctor's usual and customary charges. Discounts are applied to the Member Doctor's usual and customary fees for such services and are available within twelve (12) months of the covered eye examination from the Member Doctor who provided the covered eye examination.

Exclusions And Limitations Under Vision Coverage

This vision service program is designed to cover visual needs rather than cosmetic materials. If you select any of the following extras, the program will pay the basic cost of the allowed lenses, and you will be responsible for the additional cost for the options.

1. Blended lenses
2. Oversize lenses
3. Photochromic lenses
4. Tinted lenses except pink #1 or #2
5. The laminating of a lens or lenses
6. Cosmetic lenses
7. Optional cosmetic processes
8. UV (ultraviolet) protected lenses

Not Covered

There is no benefit for professional services or materials connected with:

1. Orthoptics or vision training and any associated supplemental testing; plano lenses (less than ± 3.8 diopter power); or two pair of glasses in lieu of bifocals.
2. Replacement of lenses and frames furnished under this program which are lost or broken except at the normal intervals when services are otherwise available.
3. Medical or surgical treatment of the eyes.
4. Corrective vision treatment of an Experimental Nature.
5. Costs for services and/or materials above benefit allowances indicated.
6. Services/materials not indicated as covered benefits.

Liability In Event Of Non-Payment

In the event VSP fails to pay the provider, you shall not be liable to the provider for any sums owed by the vision plan other than those not covered by the Plan.

Complaints And Grievances

If a Covered Person ever has a question or problem, the Covered Person's first step is to call VSP's Customer Service Department. The Customer Service Department will make every effort to answer the Covered Person's question and/or resolve the matter informally. If a matter is not initially resolved to the satisfaction of a Covered Person, the Covered Person may communicate a complaint or grievance to VSP orally or in writing by using the complaint form that may be obtained upon request from the Customer Service Department. Complaints and grievances include disagreements regarding access to care, or the quality of care, treatment or service. Covered Persons also have the right to submit written comments or supporting documentation concerning a complaint or grievance to assist in VSP's review. VSP will resolve the complaint or grievance within thirty (30) days after receipt, unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but no later than one hundred twenty (120) days after VSP's receipt of the complaint or grievance. If VSP determines that resolution cannot be achieved within thirty (30) days, a letter will be sent to the Covered Person to indicate VSP's expected resolution date. Upon final resolution, the Covered Person will be notified of the outcome in writing.

Claim Payments and Denials

- A. Initial Determination: VSP will pay or deny claims within thirty (30) calendar days of the receipt of the claim from the Covered Person or Covered Person's authorized representative. In the event that a claim cannot be resolved within the time indicated VSP may, if necessary, extend the time for decision by no more than fifteen (15) calendar days.

- B. Request for Appeals: If a Covered Person's claim for benefits is denied by VSP in whole or in part, VSP will notify the Covered Person in writing of the reason or reasons for the denial. Within one hundred eighty (180) days after receipt of such notice of denial of a claim, the Covered Person may make a verbal or written request to VSP for a full review of such denial. The request should contain sufficient information to identify the Covered Person for whom a claim for benefits was denied, including the name of the VSP Enrollee, Member Identification Number of the VSP Enrollee, the Covered Person's name and date of birth, the name of the provider of services and the claim number. The Covered Person may state the reasons the Covered Person believes that the claim denial was in error. The Covered Person may also provide any pertinent documents to be reviewed. VSP will review the claim and give the Covered Person the opportunity to review pertinent documents, submit any statements, documents or written arguments in support of the claim, and appear personally to present materials or arguments. The Covered Person or the Covered Person's authorized representative should submit all requests for appeals to:

VSP
Member Appeals 3333 Quality Drive
Rancho Cordova, CA 95670 800-877-7195

VSP's determination, including specific reasons for the decision, shall be provided and communicated to the Covered Person within thirty (30) calendar days after receipt of a request for appeal from the Covered Person or Covered Person's authorized representative.

If the Covered Person disagrees with VSP's determination, he/she may request a second level appeal within sixty (60) calendar days from the date of the determination. VSP shall resolve any second level appeal within thirty (30) calendar days.

When the Covered Person has completed all appeals mandated by the Employee Retirement Income Security Act of 1974 (ERISA), additional voluntary alternative dispute resolution options may be available, including mediation and arbitration. The Covered Person should contact the U.S. Department of Labor or the State insurance regulatory agency for details. Additionally, under ERISA Section 502(a)(1)(B), the Covered Person has the right to bring a civil (court) action when all available levels of reviews of denied claims, including the appeal process, have been completed, the claims were not approved in whole or in part, and the Covered Person disagrees with the outcome.

Termination Of Benefits

Plan benefits will cease on the date of cancellation of this program whether the cancellation is by Group or by VSP due to nonpayment of Premium.

If service is being rendered to you as of the termination date of the program, such service shall be continued to completion, but in no event beyond six (6) months after the termination date of the program.