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

BCBSNC Web Site bcbsnc.com/members/delhaizeamerica	To find a network provider by location or specialty, get general benefit information, search through our corporate medical policies to see medical criteria used to administer your benefits, obtain claim forms, access information about all the Blue Extras℠ discounts, "proof of coverage" portability certificates and more.
Member Services Web Site bcbsnc.com/members/delhaizeamerica	To enroll in a safe and secure customer service web site to: Check claim status, verify benefits and eligibility, change your address or request a new ID card.
BCBSNC Customer Service 1-888-709-7092 8 a.m-6 p.m., Monday-Friday, except holidays	For questions regarding your benefits, claim inquiries and new ID card requests.
Certification 1-800-672-7897	To request certification for out-of-network inpatient services.
Magellan Behavioral Health 1-800-359-2422	For mental health and substance abuse inpatient and outpatient pre-certification. Note: You do not need certification for office visits.
BlueCard® PPO Program 1-800-810-2583	To find a participating provider outside of North Carolina.
BCBSNC Health Management Programs 1-800-218-5295	For information about free programs for people who are pregnant or who have asthma, diabetes, congestive heart failure, migraine headaches, multiple sclerosis, rheumatoid arthritis, or other chronic conditions.
Medical Claims Filing: BCBSNC Claims Department PO Box 35 Durham, NC 27702-0035	Mail completed medical claims to this address.
Add/Remove Someone From Your Policy	See your benefit administrator and complete the proper form. For additional questions, call Customer Service at the number listed above.

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

Quick Reference - Blue Extras℠- Value-Added Programs

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

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

For information about discounts on hearing aids.

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

For information about our physical activity and wellness incentive program.

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

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

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

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

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

For information about discounts on chiropractic services.

Get Fit Blue℠
bcbsnc.com/members/delhaizeamerica

For information about nutrition and weight management discounts.

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

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

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

For information about discounts on corrective laser eye surgery.

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

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

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

Tips for Getting the Most Out of Your Health Care Benefits

1

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

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

2

Pick a primary care physician

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

3

Understand your health care plan

The more you know about your benefits, the easier it will be to take control of your health. Let BCBSNC help you understand your plan and use it effectively through our customer-friendly Web site (***bcbsnc.com/members/delhaizeamerica***), toll free Customer Service lines (1-888-709-7092), and The Blue Book.

4

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

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

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

BCBSNC MEMBER RIGHTS AND RESPONSIBILITIES

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

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

As a BCBSNC member, you should:

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

Benefit Booklet
For Employees of
Delhaize America
BCBSNC PPO 1000 Plan
for

Blue OPTIONS℠

Benefit Booklet

BlueCross BlueShield of North Carolina

An Independent Licensee of the Blue Cross and Blue Shield Association

Blue Options/011662/22II/01012011/09292011

BENEFIT BOOKLET

This benefit booklet describes the BCBSNC PPO 1000 *employee* health plan (the *Plan*). Blue Cross and Blue Shield of North Carolina provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Please read this benefit booklet carefully.

The benefit plan described in this booklet is an *employee* health benefit plan, subject to the Employee Retirement Income Security Act of 1974 (*ERISA*) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA). A summary of benefits, conditions, limitations and exclusions is set forth in this benefit booklet for easy reference.

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

Amendment And/Or Termination Of The Plan

The *Plan Sponsor* expects this *Plan* to be continued indefinitely, but the *Plan Sponsor* reserves the right to terminate the *Plan* at any time with respect to its *employees* by a written instrument signed by an officer of the *Plan Sponsor.* Such termination may be made without the consent of the *members*, or any other persons. The *Plan Sponsor* also reserves the right to amend the *Plan*, including reduction or elimination of benefits or *covered services*. Amendments shall be made only in accordance with the provisions of the *Plan*. The *Plan Administrator* will provide notice to *members* within sixty days of the adoption of any amendment that results in a material reduction in *covered services* or benefits. If the *Plan* is changed or terminated, your rights to covered benefits for expenses you actually incurred before the change or termination will not be affected.

TABLE OF CONTENTS

WELCOME TO BCBSNC PPO 1000 PLAN

Welcome to Blue Cross and Blue Shield of North Carolina's BCBSNC PPO 1000 Plan!

As a *member* of the BCBSNC PPO 1000 Plan, you will enjoy quality health care from a network of health care *providers* and easy access to *specialists*. You also have the freedom to choose health care *providers* who do not participate in the Blue Options network.

You may receive, upon request, information about the BCBSNC PPO 1000 Plan, its services and *doctors*, including this benefit booklet with a benefit summary, and a directory of *in-network providers*.

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

How To Use Your BCBSNC PPO 1000 Plan Benefit Booklet

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

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

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

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

> As you read this benefit booklet, keep in mind that any word you see in italics *(italics)* is a defined term and will appear in "Glossary" at the end of this benefit booklet. Common insurance terms involving your financial responsibility such as "coinsurance," "coinsurance maximum," "copayment," and "deductible" are defined in "Understanding Your Share Of The Cost."

You will also want to review the following sections of this benefit booklet:

- "How BCBSNC PPO 1000 Plan Works" explains the coverage levels available to you
- "When Coverage Begins And Ends" tells you, among other things, how and when to enroll in the *Plan*
- "What If You Disagree With A Decision?" explains the rights available to you when BCBSNC makes a decision and you do not agree.

Aviso Para *Afiliados* Que No Hablan Ingles

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

SUMMARY OF BENEFITS

This section provides a summary of your BCBSNC PPO 1000 benefits. A more complete description of your benefits is found in "*Covered Services*." General exclusions may also apply - please see "What Is Not Covered?" As you review the "Summary Of Benefits" chart, keep in mind:

- Coinsurance percentages shown in this section are the portion of the *allowed amount* that the *Plan* covers
- Deductible and coinsurance amounts are based on the *allowed amount*
- Services applied to the deductible also count toward any visit or day maximums
- To receive *in-network* benefits, you must receive care from a Blue Options IN-*network provider.* **However, in an *emergency*, or when *in-network providers* are not reasonably available as determined by BCBSNC's access to care standards, you may also receive *in-network* benefits for care from an *out-of-network provider*. Please see "*Out-Of-Network* Benefit Exceptions" and "*Emergency* Care" for more information. Access to care standards are available on the BCBSNC Web site at www.bcbsnc.com/members/delhaizeamerica or by calling BCBSNC Customer Service at the number listed on your *ID Card* or in "Whom Do I Contact?"**
- If you see an *out-of-network provider,* you will receive *out-of-network* benefits unless otherwise approved by BCBSNC.

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

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

Your actual expenses for *covered services* may exceed the stated coinsurance percentage or copayment amount because actual *provider* charges may not be used to determine the *Plan's* and *member's* payment obligations. For *out-of-network* benefits, you may be required to pay for charges over the *allowed amount,* in addition to any copayment or coinsurance amount.

BENEFIT PERIOD - January 1, 2011 through December 31, 2011

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

Provider's Office Benefits

Office visits for the evaluation and treatment of obesity are limited to a combined in- and *out-of-network maximum* of four visits per *benefit period*. Any services in excess of these *benefit period maximums* are not *Covered Services*.

Providers of Distinction	*In-network*	*Out-of-network*
80% after deductible	60% after deductible	50% after deductible

Includes office *surgery,* x-rays, and lab tests. Includes all services rendered by selected providers in the following specialities: Orthopedics, Gastroenterology and Cardiology. Refer to the www.bcbsnc.com/members/delhaizeamerica website and use the access code on the back of your ID card for a directory of preferred *specialists* in your area.

In-network	*Out-of-network*
80% after deductible	50% after deductible

Includes office *surgery,* x-rays, and lab tests from all other *providers.*

Benefits	*In-network*	*Out-of-network*
CT scans, MRIs, MRAs and PET scans	$100 copayment, then 80% after deductible	$100 copayment, then 50% after deductible

Preventive Care **Services**

This benefit is only for services that indicate a diagnosis of preventive or wellness. For a list of services, see "*Preventive Care*" in "*Covered Services*".

Preventive Care	100%	50%

Well-baby and well-child benefits include doctor visit and exam. Adult routine physical exams, pap smears and gynecological exams - one per *benefit period*. Mammograms - one baseline mammogram covered between ages 35 and 39; then, one per *benefit period* beginning at age 40. Also includes benefits for PSA tests, colonoscopy and sigmoidoscopy.

Nutritional Counseling	100%	70%
Other *Preventive Care*	100%	**Benefits not available**

Benefits	*In-network*	*Out-of-network*
Therapy Services		
Short-Term Rehabiliative Therapies	80% after deductible	50% after deductible
Acupuncture Services	**Benefits not available**	80% after deductible
Combined in- and *out-of-network benefit period maximums* apply to home, office and outpatient settings. 60 visits per *benefit period* for physical/occupational therapy. 30 visits for speech therapy. 20 visits for chiropractic and acupuncture services combined. 60 visits per *benefit period* for speech therapy. Any visits in excess of these *benefit period maximums* are not *Covered Services*.		
Other Therapies	80% after deductible	50% after deductible
Includes chemotherapy, dialysis and cardiac rehabilitation provided in the office. See Outpatient Services for *Other Therapies* provided in an outpatient setting.		
***Infertility* Services**		
Primary Care Provider or *Specialist*	80% after deductible	50% after deductible
Advanced Reproductive Technology and Comprehensive *Infertility* Treatment	100%	100%
Includes artificial insemination and ART services. Combined in- and *out-of-network lifetime maximum* of $5,000 per *member* for *infertility* services, provided in all places of service. Any services in excess of this *lifetime maximum* are not *Covered Services*.		
Routine Eye Exam	100%	50%
One exam per benefit period, in and *out-of-network*.		
***Urgent Care* Centers and Emergency Room**		
***Urgent Care* Centers**	$50 copayment, then 80% after deductible	$50 copayment, then 80% after deductible
Preventive Care services received in an *Urgent Care* Center	100%	50%
This benefit is only for services that indicate a diagnosis of preventive or wellness. For a list of services, see "*Preventive Care*" in "*Covered Services*."		
Emergency Room Visit	$100 copayment, then 80% after deductible	$100 copayment, then 80% after deductible
The copayment will be waived if the patient is admitted to the *hospital* from the emergency room.		

Benefits	*In-network*	*Out-of-network*
***Ambulatory Surgical* Center**		
***Ambulatory Surgical* Services**	$100 copayment, then 80% after deductible	$100 copayment, then 50% after deductible
***Preventive Care* Services**	100%	50%
This benefit is only for services that indicate a diagnosis of preventive or wellness. For a list of covered services, see "*Preventive Care*" in "*Covered Services*."		
Outpatient		
Outpatient Services (except outpatient surgery)	80% after deductible	50% after deductible
Outpatient *Surgery*	$100 copayment, then 80% after deductible	$100 copayment, then 50% after deductible
Includes physician services, *hospital* and *hospital*-based services, *outpatient clinic* services, outpatient diagnostic services, and therapy services including *short-term rehabilitative therapies*, and *other therapies* including dialysis. See *Provider's* Office for visit maximums.		
***Preventive Care* Services**	100%	50%
This benefit is only for services that indicate a diagnosis of preventive or wellness. For a list of covered services, see "*Preventive Care* Services" in "*Covered Services*."		
Inpatient - Medical Tourism / *Providers* of Distinction - Procedural Benefit		
Providers of Distinction	***In-network***	***Out-of-network***
100%	80% after deductible	50% after deductible
NOTE: Please see Medical Travel Benefit under "Facility Services" in "*Covered Services*" for detailed information on benefits concerning medical travel and accomodations. If you are in a *hospital* as an *inpatient* at the time you begin a new *benefit period*, you may have to meet a new deductible for *covered services* from *doctors* or *other professional providers*. Preferred procedure inpatient benefit includes physician services, *hospital* and *hospital*-based services, for Hip Replacement, Knee Replacement, and Gastric Bypass. Refer to the www.bcbsnc.com/members/delhaizeamerica website and use the access code on the back of your ID card for a directory of preferred *specialists* in your area.		
In-network	***Out-of-network***	
80% after deductible	50% after deductible	
Includes in-network services from all other *providers.* Standard inpatient benefit Includes physician services, *hospital* and *hospital*-based services, and maternity delivery, prenatal and post-delivery care. NOTE: There is a $100 incentive through Blue Points for participating within the BCBSNC Maternity Management program, if enrolled by the 16th week of pregnancy. If you are in a *hospital* as an *inpatient* at the time you begin a new *benefit period*, you may have to meet a new deductible for *covered services* from *doctors* or *other professional providers*.		

Benefits	*In-network*	*Out-of-network*
Inpatient - *Providers* of Distinction / Specialist Benefit		
Providers of Distinction	***In-network***	***Out-of-network***
100%	60% after deductible	50% after deductible
NOTE: Please see Medical Travel Benefit under "Facility Services" in "*Covered Services*" for detailed information on benefits concerning medical travel and accomodations. If you are in a *hospital* as an *inpatient* at the time you begin a new *benefit period*, you may have to meet a new deductible for *covered services* from *doctors* or *other professional providers*. Preferred specialist inpatient benefit includes physician services, *hospital* and *hospital*-based services. Includes all services rendered by selected *providers* in the following specialities: Orthopedic Surgery, Gastroenterology and Cardiology. Refer to the www.bcbsnc.com/members/delhaizeamerica website and use the access code on the back of your ID card for a directory of preferred *specialists* in your area.		
In-network		***Out-of-network***
80% after deductible		50% after deductible
Includes in-network services from all other *providers.* Standard inpatient benefit Includes physician services, *hospital* and *hospital*-based services, and maternity delivery, prenatal and post-delivery care. NOTE: There is a $100 incentive through Blue Points for participating within the BCBSNC Maternity Management program, if enrolled by the 16th week of pregnancy. If you are in a *hospital* as an *inpatient* at the time you begin a new *benefit period*, you may have to meet a new deductible for *covered services* from *doctors* or *other professional providers*.		
Inpatient Services		
In-network		***Out-of-network***
80% after deductible		50% after deductible
Includes in-network services from all other *providers.* Standard inpatient benefit Includes physician services, *hospital* and *hospital*-based services, and maternity delivery, prenatal and post-delivery care. NOTE: There is a $100 incentive through Blue Points for participating within the BCBSNC Maternity Management program, if enrolled by the 16th week of pregnancy. If you are in a *hospital* as an *inpatient* at the time you begin a new *benefit period*, you may have to meet a new deductible for *covered services* from *doctors* or *other professional providers*.		

Benefits	*In-network*	*Out-of-network*
Gender Reassignment *Surgery*		
	80% after deductible	50% after deductible
Benefits for both male to female (MTF) and female to male (FTM) *surgery* are subject to a $10,000 *lifetime maximum*, except breast augmentation and bilateral salpingo-oophorectomy. Services in excess of this *lifetime maximum* are not *covered services*. See "*Covered Services*" for a detailed list of services covered under this benefit.		
Skilled Nursing Facility		
	80% after deductible	50% after deductible
Combined in- and *out-of-network* maximum of 100 days per *benefit period*. Services applied to the deductible count towards this day maximum. Any services in excess of this *benefit period maximum* are not *covered services*.		
Other Services		
	80% after deductible	50% after deductible
Includes *durable medical equipment*, *hospice* services, *medical supplies*, orthotic devices, private duty nursing, *prosthetic appliances*, and *home health* care. Orthotic devices for correction of *positional plagiocephaly* are limited to a *lifetime maximum* of $600. *Home health* care and private duty nursing services are limited to 100 days per *benefit period,* combined in- and *out-of-network*. *Home health visits* and private duty nursing services applied to the deductible count towards this day maximum. Any services in excess of these *benefit period* or *lifetime maximums* are not *covered services*.		
Ambulance	80% after deductible	80% after deductible
Food Supplement Benefit	80% no deductible	80% no deductible
Benefit is subject to a $3,000 maximum per *benefit period*. See Food Supplement Benefit under "Other Services" in "*Covered Services*" for more information.		
Wigs	80% after deductible	50% after deductible
Wigs subject to a $500 *benefit period maximum*, combined in- and *out-of-network*.		
Mental Health And Substance Abuse Services		
Mental Health Office Services	80% after deductible	50% after deductible
Mental Health Inpatient/Outpatient Services	80% after deductible	50% after deductible
Substance Abuse Office Services	80% after deductible	50% after deductible
Substance Abuse Inpatient/Outpatient Services	80% after deductible	50% after deductible

Benefits	*In-network*	*Out-of-network*
***Lifetime Maximum* and Deductible**		
The following deductibles and maximums apply to the services listed above in the "Summary Of Benefits" unless otherwise noted.		
Lifetime Maximum	Unlimited	Unlimited
Unlimited for all services, except orthotic devices for *positional plagiocephaly.* f you exceed any *lifetime maximum*, additional services of that type are not covered. In this case, you may be responsible for the entire amount of the *provider's* billed charge.		
Infertility Lifetime Maximum	$5,000	
Deductible		
Individual, per *benefit period*	$1,000	$2,000
Family, per *benefit period*	$2,000	$4,000
Charges for the following do not apply to the *benefit period* deductible: • inpatient newborn care for well baby.		
Total Out-Of-Pocket Maximum		
Individual, per *benefit period*	$4,000	$8,000
Family, per *benefit period*	$8,000	$16,000
The total out-of-pocket maximum, which consists of the deductible plus the coinsurance you pay, is the total you will pay for covered services.		
***Certification* Requirements**		
The *Plan* delegates administration of your mental health and substance abuse benefits to Magellan Behavioral Health. Magellan Behavioral Health is not associated with BCBSNC. *Prior review* and *certification* by Magellan Behavioral Health are required for inpatient and certain outpatient mental health and substance abuse services received from an *in-network provider,* except for *emergencies*. Please see the number in "Whom Do I Contact?"		

HOW BCBSNC PPO 1000 WORKS

BCBSNC PPO 1000 gives you the freedom to choose any *provider* - the main difference will be the cost to you.

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

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

	Prior review is not required for an *emergency* or for an inpatient hospital stay for 48 hours after a vaginal delivery or 96 hours after a cesarean section.	
Filing Claims	*In-network providers* in North Carolina are responsible for filing claims directly with BCBSNC.	You may have to pay the *out-of-network provider* in full and submit your own claim to BCBSNC; also see “How To File A Claim.”

Out-Of-Network **Benefit Exceptions**

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

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

Carry Your *Identification Card*

Your *ID card* identifies you as a Blue Options *member*. Be sure to carry your *ID card* with you at all times and present it each time you seek health care.

For *ID card* requests, please visit the BCBSNC Web site at **bcbsnc.com/members/delhaizeamerica** or call BCBSNC Customer Service at the number listed in "Whom Do I Contact?"

Making An Appointment

Call the *provider's* office and identify yourself as a Blue Options *member*. If you need nonemergency services after your *provider's* office has closed, please call your *provider's* office for their recorded instructions. You may also contact the nurse advice line, HealthLine Blue, for assistance.

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

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

It is important for you to maintain a relationship with a *PCP,* who will help you manage your health and make decisions about your health care needs. If you change *PCPs*, be sure to have your medical records transferred, especially immunization records, to provide your new *doctor* with your medical history. You should participate actively in all decisions related to your health care and discuss all treatment options with your health care *provider* regardless of cost or benefit coverage. *PCPs* are trained to deal with a broad range of health care issues and can help you to determine when you need a *specialist*. *Providers* from medical specialties such as family practice, internal medicine and pediatrics may participate as *PCP*s.

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

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

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

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

HealthLine Blue

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

How To File A Claim

When you file a claim, mail the completed claim form to:
For mental health and substance abuse services:
BCBSNC
Claims Department
PO Box 35
Durham, NC 27702-0035

For all other *medical services*:
BCBSNC
Claims Department
PO Box 35
Durham, NC 27702-0035

Mail claims in time to be received within 12 months of the date the service was provided. Claims not received within 12 months from the service date will not be covered, except in the absence of legal capacity of the *member*.

You may obtain a claim form, including international claim forms, by visiting the BCBSNC Web site at **bcbsnc.com/members/delhaizeamerica** or calling BCBSNC Customer Service at the number listed in "Whom Do I Contact?" For help filing a claim, call BCBSNC Customer Service or write to:
BCBSNC
Customer Service
PO Box 2291
Durham, NC 27702-2291

UNDERSTANDING YOUR SHARE OF THE COST

This section explains how you and BCBSNC share the cost of your health care.

Copayments

A copayment is a fixed dollar amount you must pay for some *covered services* at the time you receive them.

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

Deductibles

A deductible is the dollar amount you must incur for *covered services* in a *benefit period* before benefits are payable under the *Plan*. The deductible does not include coinsurance, charges in excess of the *allowed amount*, amounts exceeding any maximum, and expenses for noncovered services. If one or more *dependents* are covered under Blue Options, you each have an individual deductible and a combined family deductible.

Note these special rules:

- Charges for the following services do not apply to the medical *benefit period* deductible:
  - inpatient newborn care for well-baby.
  - *prescription drugs*.

Refer to "Summary Of Benefits" for your deductible amounts.

Coinsurance

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

BCBSNC PPO 1000 covers only those services that are *medically necessary*. Also keep in mind as you read this section:

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

Office Services

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

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

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

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

Office Services Exclusion

- Certain self-injectable *prescription drugs* that can be self-administered. The list of these drugs may change from time to time. See the BCBSNC Web site at **bcbsnc.com/members/delhaizeamerica** or call BCBSNC Customer Service for a list of these drugs excluded in the office.

Preventive Care

The *Plan* covers *preventive care* services that can help you stay safe and healthy.

When you receive covered *Preventive Care* services from an *in-network provider* in an office-based, outpatient or ambulatory surgical setting, or *urgent care* center, there is no cost to you. Please note, this benefit is only for services that indicate a diagnosis of preventive or wellness. Otherwise, services will be subject to your *in-network* benefit level for the location where services are received.

Some services are only available *in-network* as indicated below.

Please log on to the BCBSNC Web site at **bcbsnc.com/members/delhaizeamerica** or call Customer Service at the number in "Whom Do I Contact" for the most up-to-date information on *preventive care* that is covered under the *Plan*.

Preventive Care services include:

Bone Mass Measurement Services

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

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

Colorectal Screening

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

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

Gynecological Exam And Cervical Cancer Screening

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

Immunizations

Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) are covered. This benefit is only available *in-network,* except for meningococcal vaccine which is also available *out-of-network.*

Immunizations Exclusion

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

Newborn Hearing Screening

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

Nutritional Counseling

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

Ovarian Cancer Screening

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

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

> Please log on to the BCBSNC Web site at **bcbsnc.com/members/delhaizeamerica** and click the Health Resources tab and then Guidelines for Staying Healthy for the most up-to-date information or call BCBSNC at 1-877-275-9787.

Prostate Screening

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

Routine Physical Examinations And Screenings

Routine physical examinations and related diagnostic services and screenings are covered for *members* as recommended with an A or B rating by the United States Preventive Services Task Force (USPSTF). Preventive care and screenings for women as recommended by the Health Resource and Services Administration (HRSA) are also covered. This benefit is only available *in-network.*

Screening Mammograms

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

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

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

Well-Baby And Well-Child Care

These services are covered for each *member* including periodic assessments and immunizations as recommended by the Health Resources and Services Administration (HRSA). This benefit is only available *in-network.*

Diagnostic Services

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

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

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

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

Emergency Care

The *Plan* provides benefits for *emergency services*.

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

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

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

What To Do In An *Emergency*

In an *emergency,* you should seek care immediately from an emergency room or other similar facility. If necessary and available, call 911 or use other community *emergency* resources to obtain assistance in handling life-threatening *emergencies. Prior review* is not required for *emergency services.* If you are unsure if your condition is an *emergency*, you call HealthLine Blue and a HealthLine Blue nurse will provide information and support that may save you an unnecessary trip to the emergency room.

Urgent Care

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

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

Family Planning

Maternity Care

Maternity care benefits, including prenatal care, labor and delivery and post-delivery care, are available to all female *members*. NOTE: There is a $100 incentive through Blue Points for participating within the BCBSNC Maternity Management program, if enrolled by the 16th week of pregnancy.

	Mom	Newborn	Payment
Prenatal care	Care related to the pregnancy before birth		Coinsurance and any applicable deductible apply.
Labor & delivery services	No *prior review* required for inpatient *hospital* stay for 48 hours after a vaginal delivery or 96 hours after a cesarean section. Mothers choosing a shorter stay are eligible for a *home health* visit for post-delivery follow-up care if received within 72 hours of discharge.	No *prior review* required for *inpatient* well baby care for 48 hours after a vaginal delivery or 96 hours after a cesarean section. Benefits include newborn hearing screening ordered by a *doctor* to determine the presence of permanent hearing loss.	For first 48/96 hours, only one *benefit period* deductible is required for both mother and baby
Post-delivery services	All care for the mother after the baby's birth that is related to the pregnancy In order to avoid a penalty, *prior review* and *certification* are required for inpatient stays extending beyond 48/96 hours.	After the first 48/96 hours, whether inpatient (sick baby) or outpatient (well baby), the newborn must be enrolled for coverage as a *dependent child*, according to the rules in "When Coverage Begins and Ends." For inpatient services following the first 48/96 hours, *prior review* and *certification* are required in order to avoid a penalty.	The baby must meet the individual *benefit period* deductible, if applicable.

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

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

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

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

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

Termination Of Pregnancy (Abortion)

Benefits for abortion are available through the first 16 weeks of a pregnancy for all female *members*.

Complications Of Pregnancy

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

Infertility Services

Benefits are provided for certain services related to the diagnosis, treatment and correction of any underlying causes of *infertility* for all *members* except *dependent children*. Such services include conception by artificial means.

Refer to "Summary Of Benefits" for limitations that may apply.

Sterilization

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

Contraceptive Devices

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

Family Planning Exclusions

- The collection and storage of blood and stem cells taken from the umbilical cord and placenta for future use in fighting a disease
- Donor eggs and sperm
- Surrogate mothers
- Care or treatment of the following:
  - contraceptive devices
  - reversal of sterilization
  - *infertility* for *dependent children*
- Elective abortion after 16 weeks of pregnancy
- Treatment for *infertility* or reduced fertility that results from a prior sterilization procedure or a normal physiological change such as menopause.

Facility Services

Benefits are provided for:

- *Outpatient* services received in a *hospital*, a *hospital*-based facility, *non-hospital facility* or an *outpatient clinic*
- *Inpatient* services received in a *hospital* or *nonhospital facility*. You are considered an inpatient if you are admitted to the *hospital* or *nonhospital* facility as a registered bed patient for whom a room and board charge is made. Your *in-network provider* is required to use the Blue Options network *hospital* where he/she practices, unless that *hospital* cannot provide the services you need. If you are admitted before the *effective date,* benefits will not be available for services received prior to the *effective date*.

Prior review must be requested and *certification* must be obtained in advance from BCBSNC to avoid a penalty, except for maternity deliveries and *emergencies*. See "Maternity Care", if applicable and "*Emergency* Care."

- Surgical services received in an *ambulatory surgical center*
- *Covered services* received in a *skilled nursing facility*. *Skilled nursing facility* services are limited to a combined in- and *out-of-network* day maximum per *benefit period*.

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

Medical Travel Benefit

A medical travel benefit will be available to any Delhaize *member* that is seeking care under the Designated Procedural Benefit and is required to travel more than 100 miles in order to receive care. This benefit is available to the *member* and a single companion travel with the *member*.

Benefit includes reimbursement for the following items:

- Lodging Reimbursement:

  - $50 per night, per person. Reimbursement includes lodging for a person traveling with the patient. For example, if a parent is traveling with a sick child, up to $100 per night can be reimbursed as a medical lodging expense. NOTE: The nights that the patient is admitted to the hospital are not reimbursable under this benefit.
- Transportation Reimbursement:
  - Personal mileage expenses will be reimbursed using the standard IRS medical mileage rate currently in effect. NOTE: Airfare and rental car expenses will only be reimbursed on an exception basis.
- The medical travel benefit does NOT provide reimbursement for meals or any other incidental expenses.

Other Services

Ambulance Services

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

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

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

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

Ambulance Service Exclusion

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

Blood

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

Blood Exclusion

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

Clinical Trials

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

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

Clinical Trials Exclusions

- Clinical trials phase I
- Non-health care services, such as services provided for data collection and analysis

- *Investigational* drugs and devices and services that are not for the direct clinical management of the patient.

Dental Treatment Covered Under Your Medical Benefit

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

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

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

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

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

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

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

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

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

Dental Treatment Excluded Under Your Medical Benefit

Treatment for the following conditions:

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

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

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

Diabetes-Related Services

All *medically necessary* diabetes-related services, including equipment, supplies 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 *doctor*. Equipment may be purchased or rented at the discretion of the *Plan*. The *Plan* provides benefits for repair or replacement of the covered equipment. Benefits will end when it is determined that the equipment is no longer *medically necessary.* Certain *durable medical equipment* requires *prior review* and *certification* or services will not be covered.

Durable Medical Equipment Exclusions

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

Food Supplement

Coverage for both metabolic and enteral formulas is available when the *provider* issues a written order stating that the formula is *medically necessary* and has been proven effective for the patient's condition. For example: If the patient does not receive the formula, he/she may become malnourished or suffer from disorders, which left untreated, cause chronic disability, mental retardation or death.

Supplements and formulas taken electively, without a **provider's written order**, **are not covered.**

Supplements and formulas taken by healthy patients, including infants, are not covered. Infant formulas such as Enfamil, Enfamil with Iron, Similac and Similac with Iron are regular formulas for normal healthy children.

Conditions for which formulas have been proven effective include but are not limited to:

- inherited diseases of amino acid or organic acid metabolism; (e.g PKU, branch-chain ketonuria, galactosemia, homocystinuria)
- Crohn's Disease
  - gastroesophageal reflux with failure to thrive
  - disorder of gastrointestinal motility, such as chronic intestinal pseudo-obstruction
  - ulcerative colitis
  - multiple severe food allergies.

High Calorie or High Protein Enteral Formulas may be appropriate when patents are unable take in sufficient calories in regular food and the patient meets the criteria indicated in the general guidelines section of this policy.

Home Health Care

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

Home health care requires *prior review* and *certification* or services will not be covered.

See "Summary Of Benefits" for *home health* day limits.

Home Health Care Exclusions

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

Home Infusion Therapy Services

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

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

Hospice Services

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

Hospice Services Exclusion

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

Lymphedema-Related Services

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

Lymphedema-Related Services Exclusions

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

Medical Supplies

Coverage is provided for *medical supplies*.

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

Medical Supplies Exclusion

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

Orthotic Devices

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

Orthotic Devices Exclusions

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

Private Duty Nursing

The *Plan* provides benefits for *medically necessary* private duty nursing services of an *RN* or *LPN* when ordered by your *doctor* for a *member* who is receiving active care management.

Private duty nursing provides more individual and continuous skilled care than can be provided in a skilled nursing visit through a *home health agency*.

See "Care Management."

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

Private Duty Nursing Exclusion

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

Prosthetic Appliances

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

Prosthetic Appliances Exclusions

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

Surgical Benefits

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

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

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

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

Anesthesia

Your anesthesia benefit includes coverage for general, spinal block, or monitored regional anesthesia ordered by the attending *doctor* and administered by or under the supervision of a *doctor* other than the attending surgeon or assistant at *surgery*. Benefits are not available for charges billed separately by the *provider* which are not eligible for additional reimbursement. Also, your coverage does not provide additional benefits for local anesthetics, which are covered as part of your surgical benefit.

Mastectomy Benefits

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

- Reconstruction of the breast on which the mastectomy has been performed
- *Surgery* and reconstruction of the non-diseased breast to produce a symmetrical appearance, without regard to the lapse of time between the mastectomy and the reconstructive *surgery*
- Prostheses and physical complications of all stages of the mastectomy, including lymphedemas. See *Provider's* Office, or for external prostheses, see *prosthetic appliances* in Other Services in the "Summary Of Benefits."

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

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

Temporomandibular Joint (TMJ) Services

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

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

Temporomandibular Joint (TMJ) Services Exclusions

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

Therapies

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

Short-Term Rehabilitative Therapies

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

- Occupational therapy and/or physical therapy
- Speech therapy.

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

Other Therapies

The *Plan* covers:

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

Therapy Exclusions

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

Transplants

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

A transplant is the surgical transfer of a human organ, bone marrow, tissue, or peripheral blood stem cells taken from the body and returned or grafted into another area of the same body or into another body.

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

If a transplant is provided from a living donor to the recipient *member* who will receive the transplant:
- Benefits are provided for reasonable and necessary services related to the search for a donor.
- Both the recipient and the donor are entitled to benefits of this coverage when the recipient is a *member.* Benefits provided to the donor will be charged against the recipient's coverage.

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

Transplants Exclusions

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

Mental Health And Substance Abuse Services

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

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

Office Visit Services

The following professional services are covered when provided in an office setting:
- Evaluation and diagnosis
- *Medically necessary* biofeedback and neuropsychological testing
- Individual and family counseling
- Group therapy.

Outpatient Services

Covered outpatient services when provided in a mental health or substance abuse treatment *facility* include:
- Each service listed in this section under *office visit* services
- Partial-day/night hospitalization services (minimum of four hours per day and 20 hours per week)
- Intensive therapy services (less than four hours per day and minimum of nine hours per week).

Certain outpatient services, such as partial hospitalization and intensive therapy, require *prior review* and *certification* or services will not be covered. Call Magellan Behavioral Health at the number listed in "Whom Do I Contact?" for a detailed list of these services. The list of services that require *prior review* may change from time to time.

Inpatient Services

Covered inpatient treatment services also include:

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

How To Access Mental Health And Substance Abuse Services

Prior review by Magellan Behavioral Health is not required for *office visit* services. Although *prior review* is not required for *emergency* situations, please notify Magellan Behavioral Health of your inpatient admission as soon as reasonably possible.

When you need inpatient or certain outpatient services that require *prior review* and *certification*, call a Magellan Behavioral Health customer service representative at the number listed in "Whom Do I Contact?" The Magellan Behavioral Health customer service representative can also help you find an appropriate *in-network* provider and give you information about *prior review* and *certification* requirements.

Mental Health And Substance Abuse Services Exclusions And Limitations

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

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

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

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

A

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

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

C

Claims not submitted to BCBSNC within 12 months of the date the charge was *incurred*, except in the absence of legal capacity of the *member*

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

Contraceptives, including oral contraceptives solely prescribed for the purpose of contraception.

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

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

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

Custodial care, which is care designed essentially to assist an individual with activities of daily living, with or without routine nursing care and the supervisory care of a *doctor*. While some skilled services may be provided, the patient does not require continuing skilled services 24 hours daily. The individual is not under specific medical, surgical, or psychiatric treatment to reduce a physical or mental disability to the extent necessary to enable the patient to live outside either the institution or the home setting with substantial assistance and supervision, nor is there reasonable likelihood that the disability will be reduced to that level even with treatment. Custodial care includes, but is not limited to, help in walking, bathing, dressing, feeding, preparation of special diets and supervision

over medications that could otherwise be self-administered. Such services and supplies are custodial as determined by BCBSNC without regard to the place of service or the *provider* prescribing or providing the services.

D

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

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

The following **drugs**:

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

E

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

The following **equipment**:

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

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

F

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

G

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

H

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

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

Hypnosis except when used for control of acute or chronic pain

I

Incurred more than 12 months prior to the *member's* submission of a claim to BCBSNC, except in the absence of legal capacity of the *member*

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

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

L

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

M

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

N

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

O

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

P

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

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

Ear **piercing**

R

The following **residential care** services:

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

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

S

Services or supplies that are:

- Not performed by or upon the direction of a *doctor* or *other provider*

- Available to a *member* without charge.

Sexual dysfunction unrelated to organic disease

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

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

T

The following types of **therapy**:

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

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

Treatment of temporomandibular joint (TMJ) pain

V

The following **vision** services:

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

Vitamins, food supplements or replacements, nutritional or dietary supplements, formulas or special foods of any kind

WHEN COVERAGE BEGINS AND ENDS

To be covered under the *Plan,* you must be an *employee* who has full-time *employee* classification. However, your *employer* may establish additional criteria you must meet before you are eligible for coverage. This may include satisfying a probationary period before your coverage begins.

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

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

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

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

- Your, your spouse's or your domestic partner's *dependent children* to their 26th birthday. Your *employer* may require proof that your *dependent child* meets the definition of *dependent child* as outlined in the "Glossary."
- A *dependent child* who is either mentally retarded or physically handicapped and incapable of self-support may continue to be covered under the *Plan* regardless of age if the condition exists and coverage is in effect when the child reaches the age of 26. The handicap must be medically certified by the child's *doctor* and may be verified annually by the *Plan*.

Important Reminder:

Keep in mind that you cannot receive coverage under this Plan as:

- Both an employee and a dependent; or
- A dependent of more than one employee.

Enrolling In The *Plan*

It is very important to consider when you apply for coverage and/or add *dependents*. Your *employer* allows you to apply for or make changes to your coverage during the open enrollment period, which is held once a year. For new hires, associates need to enroll 31 days in advance of their eligibility date. For changes (such as moving from part-time to full-time, adding *dependents*, etc) you will need to enroll yourself or your *dependent(s)* within 31 days of the date of when you are eligible. If you do not apply for coverage within 31 days of when you or your *dependents* first become eligible, you will have to wait for a future open enrollment period. Newly eligible children (newborns, adoptive children*, foster children*) and children added as a result of a court order, such as a Qualified Medical Child Support Order (QMCSO), are not restricted to the open enrollment period. See also "Adding Or Removing A *Dependent*."

You may also apply for coverage and/or add *dependents* in the *Plan* within a 31-day period following any of the qualifying events listed below unless otherwise noted. Coverage is effective no later than the first day of the first month following a completed request for enrollment. The following are considered qualifying events:

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

Adding Or Removing A *Dependent*

Do you want to add or remove a *dependent*? You must notify the *Plan Administrator* and provide any necessary information.

For coverage to be effective on the date the *dependent* becomes eligible, any election changes must be made within 31 days after the *dependent* becomes eligible.

However, if you are adding a newborn child, a child legally placed for adoption or a *foster child*, and adding the *dependent child* would not change your coverage type or premiums, the change will be effective on the date the child becomes eligible (the date of birth for a newborn, the date of placement for adoption for adoptive children, or the date of placement of a *foster child* in your home), as long as coverage was effective on that date. In these cases, notice is not required by the *Plan Administrator* within 31 days after the child becomes eligible, but it is important to provide notification as soon as possible.

Dependents may be removed from coverage by contacting the *Plan Administrator* and by completing the proper form. *Dependents* must be removed from coverage when they are no longer eligible, such as when a child is no longer eligible due to age, or when a spouse is no longer eligible due to legal separation, divorce or death. Failure to timely notify your *Plan Administrator* of the need to remove a dependent could result in loss of eligibility for continuation of coverage.

Qualified Medical Child Support Order

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

Types Of Coverage

These are the types of coverage available:

- Employee-only coverage - The *Plan* covers only you
- Employee-spouse coverage - The *Plan* covers you and your spouse or domestic partner
- Employee-children coverage - The *Plan* covers you and your *dependent children*
- Family coverage - The *Plan c*overs you, your spouse or domestic partner and your *dependent children*.

Reporting Changes

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

Continuing Coverage

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

Medicare

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

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

Continuation Under Federal Law

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

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

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

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

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

Your COBRA Administrator contact information is:
SHPS
11405 Bluegrass Pkwy
Louisville, KY 40299
1-888-556-3341

If you are a retired employee and your *employer* allows coverage to extend to retirees under this *Plan*, and you, your spouse and your *dependents* lose coverage resulting from a bankruptcy proceeding against your *employer*, you may qualify for continuation coverage under COBRA. Contact the *Plan Administrator* for conditions and duration of continuation coverage.

In addition, you and/or your *dependents*, who are determined by the Social Security Administration to be disabled, may be eligible to extend their 18-month period of continuation coverage, for a total maximum of 29 months. The disability has to have started at some time before the 60th day of continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Notice must be provided to the COBRA Administrator within 60 days of the determination of disability by the Social Security Administration

and prior to the end of the original 18-month period of continuation coverage. In addition, notice must be provided to the COBRA Administrator within 30 days after the later of the date of determination that the individual is no longer disabled or the date of the initial notification of this notice requirement.

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

- Divorce or end of Domestic Partner relationship
- Legal separation
- Ineligibility of a *dependent child*.

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

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

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

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

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

Certificate Of Creditable Coverage

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

You may call BCBSNC Customer Service at 1-877-275-9787 (toll free), Monday through Friday 8:00 a.m. - 6:00 p.m. except holidays.

Termination Of *Member* Coverage

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

Your coverage will terminate on the lastest of the following dates:

- the date the *Plan* is terminated;
- the date the *Plan* is amended to terminate the coverage of the class of associates of which you are a member;
- with respect to any coverage for which you cease to be a member of the class or classes of associates eligible for such membership;
- the payroll period ending date for the period for which your last contribution is made, if you fail to make any required contribution towards the cost of coverage when due;
- the date you cease to be eligible for group medical benefits; or

- the date your active employment with the *Employer* is terminated.

Your *dependents'* coverage will terminate on the latest of the following dates:

- the payroll period ending date for the period for which your last contribution is made, if you fail to make any required contribution towards the cost of coverage for your *dependents* when due;
- the date your coverage is terminated; or

the date a *dependent* (other than a spouse) turns 26 years of age or ceases to be eligible as a *dependent.*

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

- Fraud or intentional misrepresentation of a material fact by a *member* or *dependent.* However, if such termination is made retroactively to the effective date of your policy (called a rescission), you will be given 30 days advance written notice of this rescission and may submit an appeal ; see "What If You Disagree With Our Decision?" If your policy is rescinded any premiums paid will be returned unless BCBSNC deducts the amount for any claims paid.
- A *member* has been convicted of (or a restraining order has been issued for) communicating threats of harm to BCBSNC personnel or property
- A *member* permits the use of his or her or any other *member's ID card* by any other person not enrolled under this *Plan*, or uses another person's *ID card*
- Nonpayment of premiums
- Terminiation of the particular coverage option
- Termination of all group health coverage.

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

Rights And Responsibilities Under The *UM* Program

Your *Member* Rights

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

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

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

BCBSNC's Responsibilities

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

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

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

Prior Review (Pre-Service)

The *Plan* requires that certain health care services receive *prior review* as noted in "*Covered Services*." These types of reviews are called pre-service reviews. If neither you nor your *provider* requests *prior review* and receives *certification,* this may result in an *adverse benefit determination*. The list of services that require *prior review* may change from time to time.

> General categories of services with this requirement are noted in "*Covered Services.*" You may also visit the BCBSNC Web site at **bcbsnc.com/members/delhaizeamerica** or call BCBSNC Customer Service at the number listed in "Whom Do I Contact?" for a detailed list of these services.

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

Expedited Prospective Review

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

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

Concurrent Reviews

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

BCBSNC will communicate concurrent review decisions to the *hospital* or other facility within three business days after BCBSNC receives all necessary information but no later than 15 days after the request. In the event of an *adverse benefit determination,* BCBSNC will notify you, your *hospital's* or other facility's *UM* department and your *provider.* Written confirmation of the decision will also be sent to your home by U.S. mail. For concurrent reviews, the *Plan* will remain responsible for *covered services* you are receiving until you or your representatives have been notified of the *adverse benefit determination*.

Expedited Concurrent Review

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

Retrospective Reviews (Post-Service)

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

Care Management

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

Continuity Of Care

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

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

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

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

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

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

Delegated *Utilization Management*

BCBSNC delegates *UM* and the first level appeal for inpatient and outpatient mental health and substance abuse services to Magellan Behavioral Health. Magellan Behavioral Health follows the Utilization Management process described in this member guide. Magellan Behavioral Health is not associated with BCBSNC. Claims determinations, first and second level appeal are provided by BCBSNC.

Evaluating New Technology

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

In addition to the *UM* program, BCBSNC offers an appeals process for *members*. If you want to appeal an *adverse benefit determination*, you have the right to request that BCBSNC review the decision through the appeals process. The appeals process is voluntary and may be requested by the *member* or an authorized representative acting on the *member's* behalf with the *member's* written consent. In the event you appoint an authorized representative, references to "you" under this section mean "you or your authorized representative" (i.e., the authorized representative may pursue your rights and shall receive all notices and benefit determinations).

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

Steps To Follow In The Appeals Process

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

Any request for review should include:

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

To request a form to submit a request for review, visit the BCBSNC Web site at **bcbsnc.com/members/delhaizeamerica** or call BCBSNC Customer Service at the number listed in "Whom Do I Contact?"

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

In addition, *members* may also receive assistance with *adverse benefit determinations* from the Managed Care Patient Assistance Program by contacting:
Managed Care Patient Assistance Program
Consumer Protection Division, Office of the Attorney General
9001 Mail Service Center
Raleigh, NC 27699-9001
Fax: 1-919-733-6276
Tel: 1- 919-733-6272
Tel (toll free in NC): 1-866-867-6272
Email: MCPA@ncdoj.gov

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

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

Quality of Care Complaints

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

First Level Appeal

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

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

due to a *noncertification*, your appeal will be evaluated by a licensed medical doctor who was not involved in the initial *noncertification* decision. You may receive, in advance, any new information that BCBSNC may use in making a decision or any new or additional rationale so that you have an opportunity to respond prior to the notice of an *adverse benefit determination*.

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

Second Level Appeal

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

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

- Name, address and telephone number of the appeals coordinator
- A statement of your rights, including the right to:
  - request and receive all information that applies to your appeal from BCBSNC
  - attend the second level appeal meeting
  - present your case to the review panel
  - submit supporting material before and at the review meeting
  - ask questions of any member of the review panel
  - be assisted or represented by a person of your choosing, including a family member, an *employer* representative, or an attorney
  - Receive instructions on how to request an external, independent review from an independent review organization (IRO) upon completion of this review if not satisfied with the decision (available for *noncertifications* only)
  - pursue other voluntary alternative dispute resolution options.

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

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

Notice Of Decision

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

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

Expedited Appeals (Available only for *Noncertifications*)

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

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

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

External Review

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

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

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

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

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

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

- You are or were covered under the *Plan* at the time the health care item or service was requested or, in the case of a retrospective review, were covered under the *Plan* at the time the health care item or service was provided;
- The *adverse benefit determination* or the final *adverse benefit determination* does not relate to your failure to meet the requirements for eligibility under the terms of the *Plan* (e.g., worker classification or similar determination);
- You have exhausted the *Plan's* internal appeal process unless you are not required to exhaust the internal appeals process; and
- You provided all the information and forms required to process an external review.

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

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

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

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

Delegated Appeals

BCBSNC delegates responsibility for the first level appeal for inpatient and outpatient mental health and substance abuse services to Magellan Behavioral Health. Magellan Behavioral Health follows the Utilization Management process described in this member guide. Magellan Behavioral Health is not associated with BCBSNC. Please forward written appeals to:
Magellan Behavioral Health
Appeals Department
PO Box 1619
Alpharetta, GA 30009

Claims determinations, first and second level appeal are provided by BCBSNC..

Benefits To Which *Members* Are Entitled

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

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

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

Any amounts paid by the *Plan* for noncovered services or that are in excess of the benefit provided under your BCBSNC PPO 1000 coverage may be recovered by BCBSNC. BCBSNC may recover the amounts by deducting from a *member's* future claims payment. This can result in a reduction or elimination of future claims payments.

Amounts paid by the *Plan* for work-related accidents, injuries, or illnesses covered under state workers' compensation laws will be recovered upon final adjudication of the claim or an order of the applicable state agency approving a settlement agreement. It is the legal obligation of the *member*, the *employer* or the workers' compensation insurer (whoever is responsible for payment of the medical expenses) to notify BCBSNC in writing that there has been a final adjudication or settlement.

In addition, under certain circumstances, if BCBSNC pays the *provider* amounts that are your responsibility, such as deductible, copayments or coinsurance, BCBSNC may collect such amounts directly from you.

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

BCBSNC's Disclosure Of Protected Health Information (PHI)

BCBSNC takes your privacy seriously and handles all PHI as required by state and federal laws and regulations and accreditation standards. BCBSNC has developed a privacy notice that explains the procedures.

To obtain a copy of the privacy notice, visit the BCBSNC Web site at **bcbsnc.com/members/delhaizeamerica** or call BCBSNC Customer Service at the number listed in "Whom Do I Contact?"

Administrative Discretion

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

Provider Reimbursement

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

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

Services Received Outside Of North Carolina

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

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

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

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

This "negotiated price" can be:

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

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

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

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

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

Right Of Recovery Provision

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

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

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

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

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

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

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

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

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

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

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

Notice Of Claim

The *Plan* will not be liable for payment of benefits unless proper notice is furnished to BCBSNC that *covered services* have been provided to a *member*. If the *member* files the claim, written notice must be given to BCBSNC within 12 months after the *member incurs* the *covered service,* except in the absence of legal capacity of the *member.* The notice must be on an approved claim form and include the data necessary for BCBSNC to determine benefits.

Notice Of Benefit Determination

BCBSNC will provide an explanation of benefits determination to the *member* or the *member's* authorized representative within 30 days of receipt of a notice of claim. BCBSNC may take an extension of up to 15 more days to complete the benefits determination if additional information is needed. If BCBSNC takes an extension, BCBSNC will notify the *member* or the *member's* authorized representative of the extension and of the information needed. You will then have 90 days to provide the requested information. As soon as BCBSNC receives the requested information, or at the end of the 90 days, whichever is earlier, BCBSNC will make a decision within 15 days.

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

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

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

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

Limitation Of Actions

Since the *Plan* is subject to *ERISA*, you must only exhaust the first level appeal process following the Notice of Claim requirement. Please see "What If You Disagree With A Decision?" for details regarding the appeal process. No legal action may be taken later than three years from the date services are *incurred.* However, if you are authorized to pursue an action in federal court under *ERISA*, and you choose to pursue a second level appeal review, the three-year limitation is temporarily suspended until that review has been resolved.

Coordination Of Benefits (Overlapping Coverage)

If a *member* is also enrolled in another group health plan, the *Plan* may coordinate benefits with the other plan.

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

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

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

Note: Payment by BCBSNC under the *Plan* takes into account whether or not the provider is a *participating provider*. If the *Plan* is the secondary plan, and the *member* uses a *participating provider*, the *Plan* will coordinate up to the *allowed amount*. The *participating provider* has agreed to accept the *allowed amount* as payment in full.

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

Programs Outside Your Regular Benefits

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

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

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

Health Information Services

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

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

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

AMBULATORY SURGICAL CENTER
A *nonhospital facility* with an organized staff of *doctors*, which is licensed or certified in the state where located, and which:
a) Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an outpatient basis
b) Provides nursing services and treatment by or under the supervision of *doctors* whenever the patient is in the facility
c) Does not provide inpatient accommodations
d) Is not other than incidentally, a facility used as an office or clinic for the private practice of a *doctor* or *other provider*.

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

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

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

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

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

COSMETIC

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

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

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

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

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

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

DEPENDENT CHILD(REN)
A child under age 26 who is the *employee's* biological child, a stepchild who lives with the *employee,* a legally adopted child (or child placed with the *member* and/or spouse for adoption), a *foster child,* or any other child for whom legal guardianship has been awarded to *employee* and/or spouse.

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

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

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

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

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

placing the health of an individual or with respect to a pregnant woman, the health of the pregnant woman or her unborn child in serious jeopardy, serious physical impairment to bodily functions, serious dysfunction of any bodily organ or part, or death. Heart attacks, strokes, uncontrolled bleeding, poisonings, major burns, prolonged loss of consciousness, spinal injuries, shock, and other severe, acute conditions are examples of emergencies.

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

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

EMPLOYER
Delhaize America

ERISA
The Employee Retirement Income Security Act of 1974.

EXPERIMENTAL
See *Investigational*.

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

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

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

HOME HEALTH AGENCY
A *nonhospital facility* which is primarily engaged in providing home health care services, medical or therapeutic in nature, and which:
a) Provides skilled nursing and other services on a visiting basis in the *member's* home,
b) Is responsible for supervising the delivery of such services under a plan prescribed by a *doctor*,
c) Is accredited and licensed or certified in the state where located,
d) Is certified for participation in the Medicare program, and
e) Is acceptable to BCBSNC.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PLAN
The *employer* health benefit plan established by Delhaize America to provide health benefits for participants.

PLAN ADMINISTRATOR
Delhaize America

PLAN SPONSOR
Food Lion LLC,C/O Delhaize America Shared Services Group,LLC

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.

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

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

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

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

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

PROVIDER OF DISTINCTION
A designation and Specialists in North Carolina who have demonstrated effectiveness in the delivery of care based on a balance of measures of clinical quality and efficiency. Please note, Specialists in other states may be added.

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

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

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

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

SHORT-TERM REHABILITATIVE THERAPY

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

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

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

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

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

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

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

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

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

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

BCBSNC Web Site

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

BCBSNC Customer Service

For questions about your benefits or claims, *ID card* requests, or to voice a complaint:
BCBSNC Customer Service.....1-888-709-7092 (toll free)

Mental Health And Substance Abuse Services

BCBSNC delegates the administration of these benefits to Magellan Behavioral Health, which is not associated with BCBSNC. You must contact this vendor directly and request *prior review* for inpatient and certain outpatient services, except for *office visit* services and in *emergencies.* In the case of an *emergency*, please notify the vendor as soon as reasonably possible:
Magellan Behavioral Health.....1-800-359-2422 (toll free)

Out Of North Carolina Care

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

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

HealthLine Blue℠

To receive confidential, up-to-date health information 24 hours a day from specially trained nurses:
HealthLine Blue.....1-877-477-2424 (toll free)

COBRA Administrator

SHPS.....888-556-3341

11405 Bluegrass Pkwy
Louisville, KY 40299

Prior Review

Some services require *prior review* and *certification* by BCBSNC. The list of these services may change from time to time. Please visit the BCBSNC Web site at **bcbsnc.com/members/delhaizeamerica** or call BCBSNC Customer Service at the number listed above for current information about which services require *prior review*. See "Prospective Review/*Prior Review*" in "*Utilization Management*" for information about the review process. To request *prior review*, call:
Providers.....1-800-672-7897 (toll free)
Members.....1-877-275-9787 (toll free)

Summary *Plan* Description

The following information, together with this benefit booklet, is intended to be the Summary *Plan* Description required by Section 102 of the Employee Retirement Income Security Act of 1974 (*ERISA*):

Name and Number of *Plan(s)*

Plan Number 506 - The Food Lion, LLC Group Benefit Plan

Name, Address and Telephone Number of *Plan Sponsor*

Food Lion, LLC
c/o Delhaize America Shared Services Group, LLC
145 Pleasant Hill Road
Scarborough, ME 04074
1-207-883-2911

Other *Employers* Adopting the Plan(s)

Delhaize America, LLC	Risk Management Services, Inc	Kash N Karry Food Stores, Inc
J.H. Harvey LLC	Delhaize America Shared Services Group, LLC	Bottom Dollar Food Holding, LLC
Bottom Dollar Food Southeast, LLC	Bottom Dollar Food, Northeast, LLC	Delhaize America Distribution, LLC
Delhaize America Transportation, LLC	Delhaize America Supply Chain Services, LLC	Commonwealth Food Lion, Inc

Employer* Identification Number of *Plan Sponsor

56-2173154

Identification of *Plan Administrator*

Delhaize America, LLC Benefit Plans Fiduciary Committee
145 Pleasant Hill Road
Scarborough, ME 04074
1-207-883-2911

Identification of Claims Administrator:

The *Plan Administrator* has delegated discretionary authority over benefit determinations and claims administration to the following Claims Administrators:
Blue Cross and Blue Sheild of North Carolina
PO Box 2291
Durham, NC 27702-2291
1-888-709-7092

Magellan Behavioral Health
PO Box 1619
Alpharetta, GA 30009
1-800-359-2422

Group Health Welfare Benefits

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

Type of *Plan Administration*

The medical, mental health and substance abuse benefits are provided in accordance with the provisions of administrative service agreements with the Claims Administrators.

Contributions to the Cost of the *Plan(s)*

The benefits offered under the medical program are self-insured and funded by payments from the general assets of the employer. The associates' contribution toward the cost of these programs is set by, and may be changed by, the employer.

Financial Records

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

Agent for Service of Legal Process

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

ERISA Rights Statement

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

- Examine, without charge, at the *Plan Administrator's* office and at other specified locations, such as worksites, all *Plan* documents, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the *Plan* with the U.S. Department of Labor.
- Obtain, upon written request to the *Plan Administrator*, copies of documents governing the operation of the *Plan*, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary *Plan* Descriptions. The *Plan Administrator* may make a reasonable charge for the copies.
- Receive a summary of the *Plan's* financial report. The *Plan Administrator* is required by law to furnish each *member* with a copy of this summary annual report.
- 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.
- A certificate of creditable coverage, free of charge, from BCBSNC or the *Plan Administrator* when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage.

In addition to creating rights for *members, ERISA* imposes duties upon the people who are responsible for the operation of the *Plan*. The people who operate the *Plan*, called "fiduciaries" of the *Plan,* have a duty to do so prudently and in the interest of you and other *members* and beneficiaries. No one, including your *employer* or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under *ERISA*. If your claim for a welfare benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have your claim reviewed and reconsidered. Under *ERISA*, there are steps you can take to enforce the above rights. For instance, if you request materials from the *Plan* and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the *Plan Administrator* to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the *Plan Administrator*. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the *Plan's* decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that the *Plan* fiduciaries misuse the *Plan's* money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

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

and responsibilities under *ERISA* by calling the publications hotline of the Employee Benefits Security Administration.

Value-Added Programs

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

AUDIOBlue℠
Hearing aid discount program

BluePOINTS℠
Physical activity and wellness incentive program

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

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

Chiropractic Services
Discounts on chiropractic services

GETFITBlue℠
Nutrition and weight management

HEALTHLINEBlue℠
24-hour health information

OPTICBlue℠
Discounts on corrective laser eye surgery

VITABlue℠
Discounts on vitamins, minerals and herbal supplements

℠ Marks of the Blue Cross and Blue Shield Association.

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

BlueEXTRAS℠

AUDIOBlue℠

Hearing aid discount program

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

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

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

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

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

BluePOINTS℠

Physical activity and wellness incentive program

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

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

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

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

℠ Marks of the Blue Cross and Blue Shield Association.

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

BluePoints℠ for Teens
BluePoints℠ for Kids

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

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

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

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

Chiropractic Services

Discounts on chiropractic services

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

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

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

The chiropractic discount is available to you if:

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

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

GetFitBlue℠

Nutrition and weight management

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

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

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

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

HealthLineBlue℠

24-hour health information

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

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

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

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

OPTICBlue℠

Discounts on corrective laser eye surgery

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

Vision care

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

Laser eye surgery

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

Mail-order program

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

Visit **bcbsnc.com/members/delhaizeamerica** to find a provider or learn more about your vision discounts.

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

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

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

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

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

VITA Blue℠

Discounts on vitamins, minerals and herbal supplements

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

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

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

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

℠ Marks of the Blue Cross and Blue Shield Association.

1 The Hartman Group, 2001.

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

3 BCBSNC market research, April 2000.

BlueCross BlueShield of North Carolina

MEMBER'S AUTHORIZATION REQUEST FORM
COMMERCIAL OPERATIONS / IDC

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

MEMBER WHOSE INFORMATION WILL BE DISCLOSED:

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

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

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

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

FIRST NAME | M.I. | LAST NAME

RELATIONSHIP TO MEMBER:

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

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

☐ ALL Information Requested ☐ Enrollment Information ☐ Benefit Information ☐ Premium Payment Information ☐ Explanation of Benefits (EOB) Information

☐ All Claims Information ☐ All Services from a Specific Health Care Provider(s) *(List Provider's Name)*: _____

☐ Other *(Please List Specific PHI and/or Date Ranges)*: _____

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

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

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

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

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

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

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

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

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

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

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

_____

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

RETURN THIS AUTHORIZATION TO:

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

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BCBSNC PPO 1000
011662 PPO1 01/01/11 092911

BlueOPTIONS℠

Delhaize America
BCBSNC PPO 1000 Plan

Group Effective Date:
January 1, 2011

BlueCross BlueShield of North Carolina

An Independent Licensee of the Blue Cross and Blue Shield Association