Benefit Booklet
For Employees Participating In The North Carolina Bankers Association Health Benefit Trust
Plan 5250
for

BlueOPTIONS℠

HDHP

BlueCross BlueShield of North Carolina

An Independent Licensee of the Blue Cross and Blue Shield Association

This benefit booklet describes the health care benefits offered by the North Carolina Bankers Association Health Benefit Trust. Blue Cross and Blue Shield of North Carolina provides administrative services only and does not assume any financial risk or obligation with respect to claims.

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

NCBNKHDHP 5250, 3/21

BENEFIT BOOKLET

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 Trust Agreement, the Trust Agreement will control.

THE BENEFITS AND COVERAGES DESCRIBED HEREIN ARE PROVIDED THROUGH A TRUST FUND ESTABLISHED BY A GROUP OF EMPLOYERS (NORTH CAROLINA BANKERS ASSOCIATION HEALTH BENEFIT TRUST). EXCESS INSURANCE IS PROVIDED BY A LICENSED INSURANCE COMPANY TO COVER HIGH AMOUNT MEDICAL CLAIMS. THE TRUST FUND IS NOT SUBJECT TO ANY INSURANCE GUARANTY ASSOCIATION, ALTHOUGH THE TRUST FUND IS MONITORED BY THE NORTH CAROLINA DEPARTMENT OF INSURANCE. OTHER RELATED FINANCIAL INFORMATION IS AVAILABLE FROM YOUR EMPLOYER OR FROM THE NORTH CAROLINA BANKERS ASSOCIATION HEALTH BENEFIT TRUST. PARTICIPATING EMPLOYERS WILL BE RESPONSIBLE FOR FUNDING ALL CLAIMS INCURRED BY EMPLOYEES COVERED UNDER THE TRUST.

Important Cancellation Information - Please Read The Provision In This Benefit Booklet Entitled, "When Coverage Begins And Ends."

KnovaSolutions Wellness Program

General Information and Eligibility

Wellness program benefits are available to employees and their dependents, who are enrolled in the North Carolina Bankers Association Health Benefit Trust Plan. Participation is voluntary and confidential.

KnovaSolutions is a personal health, wellness and clinical prevention service based on the theme "Your Health, Your Decisions." It responds to four consumer needs:

- quality information
- an on-going relationship with a caring health professional
- support in developing and owning a health management plan that promotes self-responsibility
- active participation in medical care decisions.

KnovaSolutions delivers cognitive and preventive services that are targeted to the 5% of individuals/ families using 50% or more of health benefit costs. KnovaSolutions collaborates with other medical care providers, both primary care and medical specialists, and addresses the health needs of the whole person rather than a disease or health behavior. KnovaSolutions does not operate as an agent of insurance carriers or managed care organizations.

How the Plan Works

KnovaSolutions - The top 5% high-risk / high-cost employees are identified using sophisticated data analytics that incorporate health and pharmacy data.

These high risk individuals are contacted with a written communication and then telephonically by a clinical nurse/pharmacist team, and voluntarily enroll in the Wellness program.

A comprehensive "Health as Human Capital" assessment is performed and a trusted and caring clinical relationship is established during which each member develops a health management plan.

Health management plans are implemented, with emphasis on choice and prevention. There are no prescribed management directives: the program is based on listening, caring, clinical information and respect.

KnovaSolutions will distribute health education and information materials from time to time as it, in its sole discretion, determines. Information about additional materials or services provided under this program will be announced as they become available.

Covered Expenses

Services for KnovaSolutions are paid for at 100%, regardless of the number of phone calls an enrolled member makes during a calendar year.

How to File a Claim

You do not need to file a claim for KnovaSolutions. KnovaSolutions is paid for directly by the company for those participants currently enrolled in the health plan.

Confidentiality
Federal law places limits on the disclosure of a participant's personal health information. If you have specific questions about how KnovaSolutions protects a participant's privacy please contact:

HCMS Group LLC
1800 Carey Avenue, Suite 500
Cheyenne, WY 82001
307.638.0015
Attention: Compliance Officer

Termination
Eligibility in this program ends the day you cease to be enrolled in the NC Bankers Association Health Benefit Trust plan. Since this program is voluntary, you may also decline or terminate participation from the Program at any time.

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RECENT CHANGES

This section lists recent changes, which may include additions, deletions or revisions to your benefit booklet. These changes supersede language that appears elsewhere in your benefit booklet, and are effective at the start of your BENEFIT PERIOD (see "Summary of Benefits") unless otherwise noted.

Revisions to Adaptive Behavior Treatment (Effective January 1, 2022)

Effective January 1, 2022, the CORPORATION is requiring that PRIOR REVIEW and CERTIFICATION must be obtained in advance for ADAPTIVE BEHAVIOR TREATMENT or services will not be covered.

GETTING STARTED WITH BLUE OPTIONS

IMPORTANT INFORMATION REGARDING THE PLAN:

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

Getting Started

This benefit booklet provides important information about your benefits and can help you understand how to maximize them. It's important that you read the entire booklet. If you need help or more information, it tells you how to contact the CORPORATION in the "Who to Contact" section.

Notes on Words

As you read this benefit booklet, keep in mind that any word you see in small capital letters (SMALL CAPITAL LETTERS) is a defined term and appears in the "Glossary" at the end of this benefit booklet. The term "CORPORATION" refers to Blue Cross and Blue Shield of North Carolina ("Blue Cross NC").

This Booklet

This booklet tells you about:

- your COVERED SERVICES and exclusions or services that are not covered
- how the PLAN works
- how expenses for COVERED SERVICES are shared
- who is eligible to be covered under the PLAN and when this coverage starts and ends
- the UTILIZATION MANAGEMENT programs and the right to appeal the decision
- any Special Programs that may come with the PLAN.

PRIOR REVIEW and CERTIFICATION

Certain services require PRIOR REVIEW and CERTIFICATION in order for you to avoid a penalty or full denial of benefits. General categories of services requiring PRIOR REVIEW and CERTIFICATION are noted in "COVERED SERVICES." To determine if a specific service requires PRIOR REVIEW and CERTIFICATION, visit https://www.bluecrossnc.com/providers/medical-policies-and-coverage/search-medical-policy for the PRIOR REVIEW list, which is updated when new services are added or when services are removed. You can also call Customer Service. See "PRIOR REVIEW/Pre-Service" in "UTILIZATION MANAGEMENT" for information about the review process.

Exclusions and Limitations

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?"

No Assignment of Benefits

The benefits described in this benefit booklet are provided only for MEMBERS. These benefits, the right to receive payment under the PLAN, and the right to enforce any claim arising under the PLAN cannot be transferred or assigned to any other person or entity, including PROVIDERS. The CORPORATION will not recognize any such assignment, and any attempted assignment is void if performed without the CORPORATION'S prior written consent. PROVIDERS are not considered beneficiaries under the PLAN and do not have standing to sue under ERISA. The CORPORATION may pay a PROVIDER directly. For example, The CORPORATION pays IN-NETWORK PROVIDERS directly under applicable contracts with those PROVIDERS. However, any PROVIDER'S right to be paid directly is through such contract with The CORPORATION, and not through the PLAN. Under the PLAN, The CORPORATION has the sole right to determine whether payment for services is made to the PROVIDER, to the EMPLOYEE, or allocated among both. The CORPORATION'S decision to pay a PROVIDER directly in no way reflects or creates any rights of the PROVIDER under the PLAN, including but not limited to benefits, payments or procedures. For more information see "Additional Terms of Your Coverage."

More Information upon Request

You may receive, upon request, information about Blue Options, its services and DOCTORS, including printed copies of this benefit booklet with a benefit summary, and a directory of IN-NETWORK PROVIDERS.

Medical and Reimbursement Policies

Certain services are covered pursuant to the CORPORATION'S medical and reimbursement policies, which are updated throughout the plan year. These policies describe the procedure and criteria to determine whether a procedure, treatment, facility, equipment, drug or device is MEDICALLY NECESSARY and eligible for coverage, INVESTIGATIONAL or EXPERIMENTAL, COSMETIC, or a convenience item. The most up-to-date medical and reimbursement policies are available at **https://www.bluecrossnc.com/providers/medical-policies-and-coverage/search-medical-policy**, or call Customer Service at the number listed in "Who to Contact?"

Reduced or Waived Payments

From time to time, MEMBERS may receive a reduced or waived copayment, deductible and/or coinsurance on designated services, or therapies in connection with programs designed to reduce medical costs, or to encourage MEMBERS to seek appropriate, high quality, efficient care based on the CORPORATION'S criteria.

Common Insurance Terms

To help you become familiar with some common insurance terms concerning what you may owe after visiting your PROVIDER, see the chart below and the "Glossary:"

Deductible	The amount of money you must pay for COVERED SERVICES in a BENEFIT PERIOD before the PLAN begins to pay for COVERED SERVICES. The deductible does not include coinsurance, charges in excess of the ALLOWED AMOUNT, amounts exceeding any maximum, or charges for noncovered services.
Coinsurance	The sharing of charges by the PLAN and you for COVERED SERVICES, after you have met your BENEFIT PERIOD deductible. This is stated as a percentage. The coinsurance listed is your share of the cost of a COVERED SERVICE.
TOTAL OUT-OF-POCKET LIMIT	The TOTAL OUT-OF-POCKET LIMIT is the dollar amount you pay for COVERED SERVICES in a BENEFIT PERIOD before the PLAN pays 100% of COVERED SERVICES. It does not include charges over the ALLOWED AMOUNT, premiums, penalties, and charges for noncovered services.

Here is an example of what your costs could be for IN-NETWORK or OUT-OF-NETWORK services. These deductible and coinsurance amounts are for example only. This scenario is a total outpatient HOSPITAL bill of $5,000:

	IN-NETWORK	OUT-OF-NETWORK
A. Total Bill	$5,000	$5,000
B. ALLOWED AMOUNT	$4,250	$4,250
C. Deductible Amount	**$250**	**$500**
D. ALLOWED AMOUNT Minus deductible (B-C)	$4,000	$3,750
E. Coinsurance Amount (x% times D)	**(10%) $400**	**(30%) $1,125**
F. Amount You Owe Over ALLOWED AMOUNT	**$0** (IN-NETWORK charges limited to ALLOWED AMOUNT)	**$750** (difference between Total Bill and ALLOWED AMOUNT)
G. Total Amount You Owe (C+E+F)	**$650**	**$2,375**

Please note: The Blue Options HSA plan is intended to be a high deductible health plan ("HDHP") that qualifies its members to contribute to a Health Savings Account (HSA), unless its MEMBERS are otherwise ineligible under applicable federal requirements. Please consult a qualified tax advisor if you are unsure about your eligibility. In addition, the deductible and TOTAL OUT--OF--POCKET LIMIT amounts listed in the "Summary of Benefits" may be revised each year in accordance with Internal Revenue Service (IRS) rulings.

Toll-Free Phone Numbers, Website and Addresses

CORPORATION Website: **BlueCrossNC.com**	Find IN-NETWORK PROVIDERS and get information about top-performing facilities, and information and news about the CORPORATION.
Blue Connect Website: **BlueConnectNC.com**	Use the CORPORATION'S secure website to look at your PLAN, check benefits, eligibility, and claims status, download forms, manage your account, ask for new ID CARDS, get helpful wellness information and more.
Customer Service 1-877-275-9787 (toll free) TTY/TDD: 1-800-442-7028	For questions about your benefits, claims, new IDENTIFICATION CARDS (ID CARD) requests, or to voice a complaint.
PRIOR REVIEW and CERTIFICATION: MEMBERS call: 1-877-275-9787 (toll free) PROVIDERS, call: 1-800-214-4844 (toll free)	Some services need PRIOR REVIEW and CERTIFICATION by the CORPORATION. The list of these services may change from time to time. Up-to-date information about which services may need PRIOR REVIEW can be found online at **BlueConnectNC.com**.
Behavioral Health: 1-800-359-2422 (toll free)	For questions about your mental health and substance use disorder benefits and claims.

Out of North Carolina Care: 1-800-810-BLUE (2583) (toll free)	For help in obtaining care outside of North Carolina or the U.S., call this number or visit **bcbs.com**.
HealthLine BlueSM 1-877-477-2424 (toll free)	Talk to a nurse 24/7 to get timely information and help on a number of health-related issues. Nurses are on hand by phone in both English and Spanish.
MDLIVE: 1-888-657-9982 and **members.mdlive.ncvideodoc.com**	For 24/7 access to a DOCTOR regarding nonemergency medical issues, call or visit the website to ask for a consultation. DOCTORS will be able to diagnose and suggest a treatment that's appropriate.
Condition Care: 1-888-229-8510	Talk to a Condition Care Coach for information about programs and support for handling specific health conditions, such as asthma, diabetes, heart failure, coronary artery disease and COPD.
My Pregnancy: **www.bcbsnc.com/mypregnancy**	The maternity program will provide you with support for managing your pregnancy.
Businessolver: 1-877-547-6257 (toll free)	For help from your COBRA Administrator.
Medical Claims Filing: Blue Cross NC Claims Department PO Box 35 Durham, NC 27702-0035	Mail completed medical claims to this address.
Prescription Drugs	The CORPORATION does not administer your prescription drug benefits. See the Pharmacy Schedule of Benefits and Information.

Value-Added Programs

These programs are not covered benefits and are outside of the PLAN. The CORPORATION does not accept claims or reimburse for these goods or services, and MEMBERS are responsible for paying all bills. The CORPORATION may change or discontinue these programs at any time.

Blue365™

Keep your body - and budget - healthy

Staying healthy and active should be easy-and affordable. That's why the CORPORATION offers Blue365™. It's a simple way to save on everything you need for a well-balanced lifestyle.

Get deals, discounts and more:

- Fitness: gym memberships and fitness gear
- Personal Care: vision and hearing care
- Healthy Eating: weight loss and nutrition programs
- Lifestyle: travel and family activities
- Wellness: mind/body wellness tools and resources
- Financial health: Financial tools and programs

Join and save

Visit **www.BlueCrossNC.com/blue365**

Or call 1 (855) 511-BLUE (2583)

Important Notice from North Carolina Bankers Association Health Benefit Trust about Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with North Carolina Bankers Association Health Benefit Trust and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are three important things you need to know about your current coverage and Medicare's prescription drug coverage

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare prescription drug plan or join a Medicare Advantage Plan (like an HMO or PPO) that offer prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
2. **North Carolina Bankers Association Health Benefit Trust has determined that the prescription drug coverage offered by this HDHP is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from this HDHP. This is also important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.**
3. **You can keep your current HDHP coverage. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully - it explains your options.**

When Can You Join A Medicare Drug Plan?

You can join a Medicare prescription drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. However, if you decide to drop your current coverage with North Carolina Bankers Association Health Benefit Trust, since it is employer sponsored group coverage, you will be eligible for a two (2) month Special Enrollment Period to sign up for a Medicare prescription drug plan; however, you also may pay a higher premium (penalty) because you did not have creditable coverage under this HDHP.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

Since the coverage under this HDHP is not creditable, depending on how long you go without creditable prescription drug coverage, you may pay a penalty to join a Medicare drug plan.

Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

Non Cred HDHP 5250, 8/19

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current North Carolina Bankers Association Health Benefit Trust coverage may be affected. For those individuals who elect Part D coverage, coverage under the entity's plan will end for the individual and all covered dependents on the date that the Medicare Part D coverage begins.

If you do decide to join a Medicare drug plan and drop your current North Carolina Bankers Association Health Benefit Trust coverage, be aware that you and your dependents may not be able to get this coverage back.

For more information about this notice or your current prescription drug coverage . . .

Contact our office for further information or call the PLAN ADMINISTRATOR at 1-800-662-7044**. NOTE:** You will get this notice each year. You will also get it before the next period you can join a Medicare drug plan and if this coverage through **North Carolina Bankers Association Health Benefit Trust** changes. You also may request a copy of this notice at any time.

For more information about your options under Medicare prescription drug coverage . . .

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1--800--772--1213 (TTY 1--800--325--0778).

Name of Entity/Sender:	**Community Bank Services**
Contact--Position/Office:	Benefits Department
Address:	P.O. Box 19999, Raleigh, NC 27619
Phone Number:	800-662-7044

SUMMARY OF BENEFITS

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

- If applicable, multiple OFFICE VISITS or emergency room visits on the same day may result in multiple copayments
- Coinsurance percentages shown in this section are the part that you pay for COVERED SERVICES
- Amounts applied to deductible and coinsurance are based on the ALLOWED AMOUNT
- Amounts applied to the deductible also count toward any visit or day maximums
- 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
- If your benefit level for services includes deductible or coinsurance, your PROVIDER may collect an estimated amount of these at the time you receive services.
- If a MEMBER uses Health Savings Account (HSA) funds to pay their PROVIDER and the PROVIDER refunds money to the MEMBER as a result of an overestimation of the MEMBER'S deductible or coinsurance, the MEMBER must return this money to the HSA in order to avoid any tax impacts

Please Note: The list of IN-NETWORK PROVIDERS may change from time to time, so please verify that the PROVIDER is still in the PPO network before receiving care. Find a PROVIDER on the CORPORATION'S website at **BlueCrossNC.com** or call Customer Service at the number listed on your ID CARD or in "Who to 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 coinsurance amount.

BENEFIT PERIOD - June 1, 2021 through May 31, 2022
The 12-month period of benefit accumulation varies and is based on the EMPLOYER'S original effective date.
Coinsurance percentages shown are the part that you pay for COVERED SERVICES.

	IN-NETWORK	OUT-OF-NETWORK

Deductibles, TOTAL OUT-OF-POCKET LIMITS and Benefit Maximums

The following deductibles and maximums apply to the services listed below in the "Summary of Benefits" unless otherwise noted

Deductible

EMPLOYEE, per BENEFIT PERIOD	$5,250	$10,500
Family, per BENEFIT PERIOD	$10,500	$21,000

You have an aggregate deductible which means the deductible corresponds to the type of coverage you have chosen. The EMPLOYEE deductible applies if you selected EMPLOYEE-only coverage; otherwise, the family deductible applies. All covered family members contribute to the same family deductible. Once the family deductible is reached, it is met for all covered family members. However, no member in your family will have to pay more than $7,150 for the family IN-NETWORK deductible or $14,300 for the family OUT-OF-NETWORK deductible. IN-NETWORK services are credited to your IN-NETWORK deductible and OUT-OF-NETWORK services are credited to your OUT-OF-NETWORK deductible.

TOTAL OUT-OF-POCKET LIMIT

EMPLOYEE, per BENEFIT PERIOD	$5,250	$11,750
Family, per BENEFIT PERIOD	$10,500	$24,750

Charges over ALLOWED AMOUNTS, premiums, and charges for noncovered services do not apply to the TOTAL OUT-OF-POCKET LIMIT. You have an aggregate TOTAL OUT-OF-POCKET LIMIT which means your TOTAL OUT-OF-POCKET LIMIT is determined by your type of coverage. The EMPLOYEE TOTAL OUT-OF-POCKET LIMIT applies if you selected EMPLOYEE-only coverage; otherwise, the family TOTAL OUT-OF-POCKET LIMIT applies. All covered family members contribute to the same family TOTAL OUT-OF-POCKET LIMIT; however, if you have a family TOTAL OUT-OF-POCKET LIMIT, no member in your family will have to pay more than $7,150 toward the family IN-NETWORK TOTAL OUT-OF-POCKET LIMIT. Charges for IN-NETWORK services apply to your IN-NETWORK TOTAL OUT-OF-POCKET LIMIT and charges for OUT-OF-NETWORK services apply to your OUT-OF-NETWORK TOTAL OUT-OF-POCKET LIMIT.

LIFETIME MAXIMUMS per MEMBER Unlimited

Unlimited for all services unless otherwise noted below. Maximums are combined IN- and OUT-OF-NETWORK, unless noted otherwise. If you exceed any LIFETIME MAXIMUM, additional services of that type are not covered. In this case, you may be responsible for the entire amount of the PROVIDER'S billed charge.

Foot Orthotics	One set
INFERTILITY SERVICES (in any place of service)	Three ovulation induction cycles, with or without insemination
Orthotic Devices for POSITIONAL PLAGIOCEPHALY	One device (includes dynamic orthotic cranioplasty (DOC) bands and soft helmets)
Surgical Treatment of Morbid Obesity (bariatric surgery)	One SURGERY and covered only when performed at a Blue Distinction Center for Bariatric Surgery®
Vein Treatment	Endovenous or microfoam-sclerotherapy procedures—one procedure per limb Liquid-sclerotherapy tributary vein treatment—three procedures per limb
Wigs	One wig following cancer treatment

	IN-NETWORK	OUT-OF-NETWORK

BENEFIT PERIOD MAXIMUMS per MEMBER
Maximums are per BENEFIT PERIOD and combined IN- and OUT-OF-NETWORK, unless noted otherwise. Any services in excess of these benefit maximums are not COVERED SERVICES.

ADAPTIVE BEHAVIOR TREATMENT	Limited to $40,000 for MEMBERS up to age 19
Dialysis Treatment	Three hemodialysis treatments per week, more hemodialysis treatments are available if MEDICALLY NECESSARY
Evaluation and Treatment of Obesity	Four visits, applies to office and outpatient setting
Hearing Aids	When covered, one hearing aid per hearing impaired ear every 36 months for MEMBERS under age 22, and $2,500 per hearing-impaired ear every 36 months for MEMBERS ages 22 and older
REHABILITATIVE THERAPY and HABILITATIVE SERVICES (applies to home, office and outpatient setting, regardless of type of PROVIDER (chiropractors, other DOCTORS, physical therapists))	30 visits for physical/occupational therapy. 30 visits for chiropractic services. 30 visits for speech therapy.
Skilled Nursing Facility	60 days

PREVENTIVE CARE Services

For PREVENTIVE CARE services that are not mandated by federal or state law, benefits will depend on where the services are received. This benefit is only for services that your PROVIDER indicates a primary diagnosis of preventive or wellness on the claim that is submitted to the CORPORATION. Also see "PREVENTIVE CARE" in "COVERED SERVICES."

Federally-mandated PREVENTIVE CARE Services	No Charge	**Benefits not available**

Available in an office-based, outpatient, or ambulatory surgical setting, or URGENT CARE center. For the most up-to-date list of PREVENTIVE CARE services that are covered under federal law, including general preventive services and screenings, immunizations, well-baby/well-child care, and women's PREVENTIVE CARE, see the CORPORATION'S website at **www.bluecrossnc./preventive** or call Customer Service at the number in "Who to Contact?" Nutritional counseling visits are covered IN-NETWORK at no cost to you and are also available OUT-OF-NETWORK at 30% after deductible. Routine eye exams are covered IN-NETWORK at no cost to you and OUT-OF-NETWORK at 30% after deductible as non-mandated PREVENTIVE CARE. For coverage of prescription contraceptive drugs and devices, certain preventive over-the-counter medications, and preventive medications, see the Schedule of Prescription Drug Benefits.

State-mandated PREVENTIVE CARE Services	No Charge	30% after deductible

The following services are state-mandated and required to be offered both IN- and OUT-OF-NETWORK: gynecological exams, cervical cancer screening, ovarian cancer screening, screening mammograms, colorectal screening, bone mass measurement, prostate-specific antigen tests, and newborn hearing screening.

	IN-NETWORK	OUT-OF-NETWORK
PROVIDER'S Office		
OFFICE VISIT Services		
PRIMARY CARE PROVIDER or SPECIALIST	0% after deductible	30% after deductible
Includes office SURGERY, x-rays, diagnostic imaging and lab tests.		
Therapy Services		
MDLIVE Telehealth	0% after deductible	Not Applicable
Telehealth services are also available from a local IN-NETWORK or OUT-OF-NETWORK PROVIDER; see "Office Services" in "COVERED SERVICES."		
REHABILITATIVE THERAPY and HABILITATIVE SERVICES	0% after deductible	30% after deductible
OTHER THERAPIES	0% after deductible	30% after deductible
Includes chemotherapy, dialysis and cardiac rehabilitation. See Outpatient for OTHER THERAPIES provided in an outpatient setting.		
INFERTILITY Services	0% after deductible	30% after deductible
URGENT CARE Centers		
URGENT CARE Centers	0% after deductible	0% after deductible
Emergency Room and Ambulance		
Emergency Room Visit	0% after deductible	0% after deductible
Ambulance Services	0% after deductible	0% after deductible
AMBULATORY SURGICAL CENTER		
Ambulatory Surgical Services	0% after deductible	30% after deductible

	IN-NETWORK	OUT-OF-NETWORK
Outpatient Services		
Outpatient Services Includes physician services, HOSPITAL and HOSPITAL-based services, OUTPATIENT CLINIC services, outpatient diagnostic services, and therapy services including REHABILITATIVE THERAPY and HABILITATIVE SERVICES, and OTHER THERAPIES including dialysis; see BENEFIT PERIOD MAXIMUMS for visit maximums.	0% after deductible	30% after deductible
Outpatient diagnostic mammography (physician and HOSPITAL-based services) See PREVENTIVE CARE Services for coverage of screening mammograms and 3D mammograms.	0% after deductible	30% after deductible
Inpatient Services Includes physician services, HOSPITAL and HOSPITAL-based services, and maternity delivery, prenatal and post-delivery care. If you are in a HOSPITAL as an inpatient at the time you begin a new BENEFIT PERIOD, you may have to meet a new deductible for COVERED SERVICES from DOCTORS or OTHER PROFESSIONAL PROVIDERS.	0% after deductible	30% after deductible
SKILLED NURSING FACILITY	0% after deductible	30% after deductible
Other Services Includes DURABLE MEDICAL EQUIPMENT, HOSPICE services, MEDICAL SUPPLIES, orthotic devices, private duty nursing, PROSTHETIC APPLIANCES, hearing aids, orthotic devices, wigs, and home health care.	0% after deductible	30% after deductible
Mental Health And Substance Use Disorder Services		
Mental Health Office Services	0% after deductible	30% after deductible
Mental Health Inpatient, RESIDENTIAL TREATMENT FACILITY and /Outpatient Services	0% after deductible	30% after deductible
Substance Use Disorder Office Services	0% after deductible	30% after deductible
Substance Use Disorder Inpatient, RESIDENTIAL TREATMENT FACILITY and /Outpatient Services	0% after deductible	30% after deductible

CERTIFICATION Requirements

Certain services, regardless of the location, require PRIOR REVIEW and CERTIFICATION by the CORPORATION in order to receive benefits. See "COVERED SERVICES" and "PRIOR REVIEW (Pre-Service)" in "UTILIZATION MANAGEMENT." The CORPORATION delegates PRIOR REVIEW and CERTIFICATION for particular benefits to other companies not associated with the CORPORATION . Please see **https://www.bluecrossnc.com/providers/medical-policies-and-coverage/search-medical-policy** for a detailed list of these companies and benefits. While some benefits have been identified under "COVERED SERVICES," the list of benefits and/or companies may change from time to time; for the most up-to-date information visit **https://www.bluecrossnc.com/providers/medical-policies-and-coverage/search-medical-policy**. The CORPORATION delegates administration of mental health and substance abuse benefits to Magellan Behavioral Health. Magellan Behavioral Health is not associated with the CORPORATION. **Failure to request PRIOR REVIEW and receive CERTIFICATION may result in allowed charges being reduced by 25% or a full denial of benefits. See "COVERED SERVICES" and "PRIOR REVIEW (Pre-Service)" in "Utilization Management."** To request PRIOR REVIEW, please see the number in "Who to Contact?"

HOW BLUE OPTIONS WORKS

This section provides information about choosing services at the most cost-effective benefit level. It tells you about:

Table of Contents:	Key Words:
- Most Cost-Effective Benefit Level - OUT-OF-NETWORK Benefit Exceptions - Bundled Care and Payments Program - Carry your IDENTIFICATION CARD - Role of a PRIMARY CARE PROVIDER (PCP) or SPECIALIST	- PRIMARY CARE PROVIDER/SPECIALIST - ALLOWED AMOUNT vs. Billed Amount - Referrals - After-hours care - Care outside of North Carolina - PRIOR REVIEW - Filing claims

Most Cost-Effective Benefit Level

As a MEMBER of the North Carolina Bankers Association Health Benefit Trust with a Blue Options plan administered by the CORPORATION, you enjoy quality health care from a network of health care PROVIDERS and easy access to SPECIALISTS. You also have the freedom to choose health care PROVIDERS who do not participate in the PPO network - the main difference will be the cost to you. Benefits are available for services from an IN- or OUT-OF-NETWORK PROVIDER that is recognized by the CORPORATION as eligible. For a list of eligible PROVIDERS, see the CORPORATION'S website at **BlueCrossNC.com**. The CORPORATION contracts with a broad network of North Carolina PROVIDERS to deliver COVERED SERVICES to MEMBERS of the PLAN. IN-NETWORK PROVIDERS include:

- DOCTORS - classified as PRIMARY CARE PROVIDERS or SPECIALISTS
- OTHER PROVIDERS - health care professionals, such as physical therapists, occupational therapists, audiologists, speech pathologists, clinical social workers and nurse practitioners
- HOSPITALS - both general and specialty HOSPITALS
- NONHOSPITAL FACILITIES - such as SKILLED NURSING FACILITIES, AMBULATORY SURGICAL CENTERS and chemical dependency treatment facilities.

Here is 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 the CORPORATION, or a PROVIDER participating in the BlueCard® program. ANCILLARY PROVIDERS outside North Carolina are considered IN-NETWORK only if they contract directly with the Blue Cross or Blue Shield plan in the state where services are received, even if they participate in the BlueCard® program. See “Glossary” for a description of ancillary providers and the criteria for determining where services are received. The list of IN-NETWORK PROVIDERS may change from time to time. IN-NETWORK PROVIDERS are listed on the CORPORATION'S website at **BlueCrossNC.com** or call Customer Service at the number listed in "Who to Contact?"	OUT-OF-NETWORK PROVIDERS are not designated as a PPO PROVIDER by the CORPORATION. Also see "OUT-OF-NETWORK Benefit Exceptions."
ALLOWED AMOUNT vs. Billed Amount	If the billed amount for COVERED SERVICES is greater than the ALLOWED AMOUNT, you are not responsible for the difference. You only pay any applicable copayment, deductible, coinsurance, and non-covered expenses. (See Filing Claims below for additional information.)	You may be responsible for paying any charges over the ALLOWED AMOUNT in addition to any applicable copayment, deductible, coinsurance, non-covered expenses and CERTIFICATION penalty amounts, if any, except for EMERGENCY SERVICES in the case of an EMERGENCY.
After-hours Care	If you need nonemergency services after your PROVIDER'S office has closed, please call your PROVIDER'S office for their recorded instructions.	
Referrals	The CORPORATION does not require you 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 benefit level.	If you are in an area that has participating PROVIDERS and you choose a PROVIDER outside the network, you will receive the lower OUT-OF-NETWORK benefit. Also see "OUT-OF-NETWORK Benefit Exceptions."
PRIOR REVIEW	IN-NETWORK PROVIDERS in North	OUT-OF-NETWORK PROVIDERS are not obligated by contract to request PRIOR REVIEW by the CORPORATION.

	Carolina are responsible for requesting PRIOR REVIEW when necessary. IN-NETWORK PROVIDERS outside of North Carolina, except for Veterans' Affairs (VA) and military providers, are responsible for requesting PRIOR REVIEW for inpatient FACILITY SERVICES. For all other COVERED SERVICES received outside of North Carolina you are responsible for ensuring that you or your PROVIDER requests PRIOR REVIEW by the CORPORATION even if you see an IN-NETWORK PROVIDER. See "Who to Contact?" for information on who to call for PRIOR REVIEW and to obtain CERTIFICATION for mental health and substance use disorder services and all other medical services. 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.	You are responsible for ensuring that you or your OUT-OF-NETWORK PROVIDER requests PRIOR REVIEW by the CORPORATION. Failure to request PRIOR REVIEW and obtain CERTIFICATION may result in a partial or full denial of benefits. If PRIOR REVIEW is not requested and CERTIFICATION is not obtained for covered OUT-OF-NETWORK inpatient admissions (including for mental health or substance use disorder services), allowed charges will be reduced by 25%, then deductible and coinsurance will be applied. However, PRIOR REVIEW is not required for an EMERGENCY or for an inpatient HOSPITAL stay for 48 hours after a vaginal delivery or 96 hours after a Cesarean section.
Filing Claims	IN-NETWORK PROVIDERS in North Carolina are responsible for filing claims directly with the CORPORATION.	You may have to pay the OUT-OF-NETWORK PROVIDER in full and submit your own claim to the CORPORATION. Mail claims in time to be received within 18 months of the date the service was provided. Claims not received within 18 months of the service date will not be covered, except in the absence of legal capacity of the MEMBER.

OUT-OF-NETWORK Benefit Exceptions

In an EMERGENCY, in situations where IN-NETWORK PROVIDERS are not reasonably available as determined by the CORPORATION'S access to care standards, or in continuity of care situations, OUT-OF-NETWORK benefits will be paid at the IN-NETWORK benefit level. However, you may be responsible for charges billed separately by the PROVIDER which are not eligible for additional reimbursement. If you are billed by the PROVIDER, you are responsible for paying the bill and filing a claim with the CORPORATION.

For more information, see one of the following sections: "EMERGENCY and Ambulance Services" in "COVERED SERVICES" or "Continuity of Care" in "UTILIZATION MANAGEMENT." For information about the CORPORATION'S access to care standards, see the CORPORATION'S website at **BlueCrossNC.com** and type "access to care" in the search bar. If you believe an IN-NETWORK PROVIDER is not reasonably available, you can help assure that

benefits are paid at the correct benefit level by calling the CORPORATION before receiving care from an OUT-OF-NETWORK PROVIDER.

Bundled Care and Payments Program

The CORPORATION is working with a select group of high-quality PROVIDERS to deliver coordinated care and simplified billing. All your care is coordinated for you, and all costs for services are billed together – saving time and reducing paperwork. Visit **BlueCrossNC.com/bundle** for more information and to see the list of PROVIDERS participating in this program. You'll also want to verify that these PROVIDERS are in the Blue Options network by visiting **BlueConnectNC.com** or calling Customer Service at the number listed in "Who to Contact?" The list of SURGERIES and specialties, and participating PROVIDERS under this program may change from time to time.

Carry Your ID CARD

Your ID CARD identifies you as a MEMBER of the North Carolina Bankers Association Health Benefit Trust with a Blue Options plan administered by the CORPORATION. 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 CORPORATION'S website at **BlueCrossNC.com** or call Customer Service at the number listed in "Who to Contact?'

The Role of a PRIMARY CARE PROVIDER (PCP) or SPECIALIST

The CORPORATION is strongly committed to continuously improving your quality of care and reducing the cost of using health care services. Maintaining a relationship with a PCP, who will help you manage your health and make decisions about your health care needs, is an important step toward ensuring you receive the highest quality of care. In certain situations you may be asked to select an available IN-NETWORK PCP after you enroll. While we are requesting you select a PCP it is not required. If you do choose a PCP, you may change your selected PCP, including an OUT-OF-NETWORK PCP, at any time by visiting **BlueCrossNC.com**. Female MEMBERS, age 13 and older, may also select an obstetrician-gynecologist as their PCP. If you change PCPs, be sure to have your medical records transferred, especially immunization records, to provide your new PROVIDER with your medical history. You should participate actively in all decisions related to your health care and discuss all treatment options with your health care PROVIDER regardless of cost or benefit coverage. PCPs are trained to deal with a broad range of health care issues and can help you determine when you need a SPECIALIST. PROVIDERS from all primary care areas, including family practice, internal medicine and pediatrics may participate as PCPs.

Please visit the CORPORATION'S website at **BlueCrossNC.com** and click on Find a Doctor or call Customer Service to confirm that the PROVIDER is in the network before receiving care.

If your PCP or SPECIALIST leaves the CORPORATION'S 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 the CORPORATION, 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 the CORPORATION, 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 Customer Service at the number listed in "Who to Contact?"

COVERED SERVICES

This section provides a more complete description of your benefits, along with some exceptions or services that are not covered by the PLAN. Keep in mind as you read this section. The PLAN covers only those services that are MEDICALLY NECESSARY. Also check the "Summary of Benefits" for any benefit maximums and limitations that may apply to your benefits. The COVERED SERVICES listed below are grouped in similar categories to make it easier for you to find what you are looking for.

Table of Contents:	Key Words:
- Office Services - PREVENTIVE CARE - EMERGENCY and Ambulance Services - URGENT CARE - HOSPITAL (Inpatient) and Other Facility Care - Alternatives to HOSPITAL Stays - Family Planning - Specific Therapies and Tests - Other Services - Equipment and Supplies - Surgical Benefits - Mental Health/Substance Use Disorder Services	- OFFICE VISIT - Outpatient Clinic - PREVENTIVE CARE - IN-NETWORK - OUT-OF-NETWORK - REHABILITATIVE THERAPIES/HABILITATIVE SERVICES - ADAPTIVE BEHAVIOR TREATMENT

Office Services

The PLAN covers care you receive as part of an OFFICE VISIT, including:

- electronic visit
- evaluation and treatment of obesity
- house call
- telehealth services

Telehealth services from MDLIVE: Telehealth services from MDLIVE include evaluation, management and consultation services for behavioral health, dermatology, and nonemergency medical issues with a PROVIDER via an interactive audio/video telecommunications or audio-only system. See MDLIVE in “Who to Contact?” to access a doctor who can diagnose and recommend treatment. Telehealth services from MDLIVE will be subject to the copayment and/or coinsurance and any applicable deductible listed in the “Summary of Benefits”.

Telehealth services from a local PROVIDER: You can also check with your PROVIDER to see if telehealth services are available. Telehealth services are available IN-NETWORK and OUT-OF-NETWORK and are separate from your telehealth benefit with MDLIVE. Telehealth services include, but are not limited to, evaluation, management, and consultative services for medical, counseling, and care management issues with a PROVIDER via an interactive audio/video or other telecommunications system. It is important to understand that your benefit will vary depending upon the type of PROVIDER you see for these services.

The PLAN also covers infusion services received at an AMBULATORY INFUSION SUITE. Certain infusion services may require PRIOR REVIEW and CERTIFICATION or services will not be covered.

If the PLAN has a copayment for PCP OFFICE VISITS, a copayment will not apply if you only receive services such as allergy shots or other injections and are not charged for an OFFICE VISIT.

Some DOCTORS or OTHER PROVIDERS may practice in a HOSPITAL-based or outpatient CLINIC or provide HOSPITAL-based services in their offices. These services are covered as outpatient services and are listed as HOSPITAL-based or OUTPATIENT CLINIC Services. See "Summary of Benefits." The PROVIDER search on the CORPORATION'S website at **bluecrossnc.com** indicates which PROVIDERS will collect deductible and coinsurance, or you can call Customer Service at the number listed in "Who to Contact?" for this information.

Some PROVIDERS may get ancillary services, such as laboratory services, medical equipment and supplies or PROVIDER-ADMINISTERED SPECIALTY DRUGS, from third parties. In these cases, you may be billed directly by the ANCILLARY PROVIDER. Benefit payments for these services will be based on the type of ANCILLARY PROVIDER, its network status, and how the services are billed.

PREVENTIVE CARE

The PLAN covers PREVENTIVE CARE services that can help you stay safe and healthy.

PREVENTIVE CARE services may fall into three categories: (1) federally-mandated PREVENTIVE CARE services (required to be covered at no cost to you IN -NETWORK); (2) state-mandated PREVENTIVE CARE services (required to be offered both IN- and OUT-OF-NETWORK); and (3) non-mandated PREVENTIVE CARE services. In order to determine your benefit, it is important to understand what type of PREVENTIVE CARE service you are receiving, where you are receiving it and why you are receiving it.

Federally-Mandated PREVENTIVE CARE Services

Under federal law, you can receive certain covered PREVENTIVE CARE services from an IN-NETWORK PROVIDER in an office-based, outpatient, ambulatory surgical setting, or URGENT CARE center, at no cost to you. Please log on to the CORPORATION'S website at **www.bluecrossnc.com/preventive** or call Customer Service at the number in "Who to Contact?" for the most up-to-date information on PREVENTIVE CARE that is covered under federal law, including general preventive services and screenings, immunizations, well-baby/ well-child care, and women's PREVENTIVE CARE, and nutritional counseling visits. Nutritional counseling visits are separate from the obesity-related OFFICE VISITS noted in the “Summary of Benefits.” For coverage of prescription contraceptive drugs and devices, certain preventive over-the counter medications, and preventive medications, see the Schedule of Prescription Drug Benefits.

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

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

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

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

Situation	Example	Reason/Result
How your PREVENTIVE CARE service is filed	If a laboratory test includes a primary diagnosis that is not preventive.	Certain PREVENTIVE CARE services will not be paid in full because the primary diagnosis filed on the claim is something other than PREVENTIVE CARE. In this instance, the lab is subject to any applicable copayment, deductible or coinsurance.
Type of PREVENTIVE CARE service	If a routine exam includes an additional procedure, such as a urinalysis.	This urinalysis will not be paid in full because it is not identified as a federally-mandated PREVENTIVE CARE service. This service is subject to any applicable copayment, deductible or coinsurance.
Place of service (where you receive your PREVENTIVE CARE service)	A mammogram service is performed in a setting that is not considered an office, such as a HOSPITAL.	Certain PREVENTIVE CARE services will not be paid in full because they are not performed in an office-based, outpatient, ambulatory setting or URGENT CARE center. In this example, the mammogram service is subject to deductible and coinsurance.

The PLAN provides benefits for some tobacco cessation over-the-counter nicotine replacement therapy (NRT) products, including patches, lozenges or gum, and FDA-approved PRESCRIPTION cessation medications. Please log on to the CORPORATION'S website at **www.bluecrossnc.com/preventive** or call Customer Service at the number listed in "Who to Contact?" for the most up-to-date information on tobacco cessation benefits.

Most PREVENTIVE CARE services performed by OUT-OF-NETWORK PROVIDERS are not covered. However, the following list of services is mandated by the state of North Carolina and is available OUT-OF-NETWORK. If you see an OUT-OF-NETWORK PROVIDER for these services, your benefits will be subject to the OUT-OF-NETWORK benefit level.

State-Mandated PREVENTIVE CARE Services:

Bone Mass Measurement Services

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. Please note that bone mass measurement tests will be covered under your diagnostic benefit (not your PREVENTIVE CARE benefit) if the claim for these services indicates a primary diagnosis of something other than preventive or wellness. Your diagnostic benefit will be paid at the benefit level for the location where services are received.

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

- Estrogen-deficient and at clinical risk of osteoporosis or low bone mass
- Radiographic osteopenia anywhere in the skeleton
- Receiving long-term glucocorticoid (steroid) therapy
- Primary hyperparathyroidism
- Being monitored to assess the response or effect of commonly accepted osteoporosis drug therapies

- History of low-trauma fractures
- Other conditions, or receiving medical therapies known to cause osteoporosis or low bone mass.

Colorectal Screening

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

The PROVIDER search on the CORPORATION'S website at **BlueCrossNC.com** can help you find office-based PROVIDER'S or you can call Customer Service at the number listed in "Who to Contact?' for this information.

Hearing Screening for Newborns

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

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 papilloma virus detection, and shall follow the American Cancer Society guidelines or guidelines adopted by the North Carolina Advisory Committee on Cancer Coordination and Control.

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 BENEFIT PERIOD, along with a DOCTOR'S interpretation of the results. More frequent or earlier mammograms will be covered as recommended by a DOCTOR when a female MEMBER is considered at risk for breast cancer.

A female MEMBER is "at risk" if she:

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

Ovarian Cancer Screening

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

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

Prostate Screening

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

Non-Mandated PREVENTIVE CARE Services:

3-D Mammograms

Benefits are available IN-NETWORK and are covered at no cost to you, and are a non-essential health benefit for MEMBERS. This benefit is also available OUT-OF-NETWORK.

Routine Eye Exams

Benefits are available IN-NETWORK and are covered at no cost to you. This benefit is considered non-mandated PREVENTIVE CARE. This benefit is also available OUT-OF-NETWORK. See "Summary of Benefits" for additional information.

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

PREVENTIVE CARE Exclusions

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

EMERGENCY and Ambulance Services

EMERGENCY Services

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. If you are unsure if your condition is an EMERGENCY, you can call HealthLine Blue and a HealthLine Blue nurse can provide information and support that may save you an unnecessary trip to the emergency room.

Benefits for services in the emergency room

Situation	Benefit
You go to an IN-NETWORK HOSPITAL emergency room	Applicable ER copayment, deductible and/or coinsurance. PRIOR REVIEW and CERTIFICATION are not required.
You go to an OUT-OF-NETWORK HOSPITAL emergency room	Benefits paid at the IN-NETWORK level and based on the billed amount. You may be responsible for charges billed separately which are not eligible for additional reimbursement, and you may be required to pay the entire bill at the time of service and file a claim. PRIOR REVIEW and CERTIFICATION are not required.
You are held for observation	Outpatient benefits apply to all COVERED SERVICES received in the emergency room and during the observation.
You are admitted to the HOSPITAL from the ER following EMERGENCY SERVICES	Inpatient HOSPITAL benefits apply for all COVERED SERVICES received in the emergency room and during hospitalization. PRIOR REVIEW and CERTIFICATION are required for inpatient hospitalization and other selected services following EMERGENCY SERVICES (including screening and stabilization) in order to avoid a penalty. You may need to transfer to an IN-NETWORK HOSPITAL once your condition has been stabilized in order to continue receiving IN-NETWORK benefits.
You get follow-up care (such as OFFICE VISITS or therapy) after you leave the ER or are discharged	Use IN-NETWORK PROVIDERS to receive IN-NETWORK benefits. Follow-up care related to the EMERGENCY condition is not considered an EMERGENCY.

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.

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

The PLAN covers services in an air ambulance only when:

- ground transportation is not medically appropriate due to the severity of the illness or the pick-up point is inaccessible by land, and
- 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.

Ambulance Services Exclusions (Ground or Air)

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

URGENT CARE

The PLAN 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.

Please note: For OUT-OF-NETWORK benefits, you may be required to pay for charges over the ALLOWED AMOUNT, in addition to any copayment or coinsurance amounts.

HOSPITAL (Inpatient) and Other Facility Care

Benefits are provided for:

- Outpatient services received in a HOSPITAL, a HOSPITAL-based facility, NONHOSPITAL FACILITY or a HOSPITAL-based or OUTPATIENT CLINIC
- Inpatient services received in a HOSPITAL or NONHOSPITAL FACILITY. You are considered an inpatient if you are admitted to the HOSPITAL or NONHOSPITAL FACILITY as a registered bed patient for whom a room and board charge is made. Your IN-NETWORK PROVIDER is required to use the PPO network HOSPITAL where he/she practices, unless that HOSPITAL cannot provide the services you need. If you are admitted before the EFFECTIVE DATE, benefits will not be available for services received prior to the EFFECTIVE DATE. PRIOR REVIEW must be requested and CERTIFICATION must be obtained in advance from the CORPORATION for inpatient admissions, except for maternity deliveries and EMERGENCIES. See "Maternity Care" and "EMERGENCY and Ambulance Services." IN-NETWORK PROVIDERS in North Carolina are responsible for requesting PRIOR REVIEW and obtaining CERTIFICATION. **If PRIOR REVIEW is not requested and CERTIFICATION is not obtained for covered OUT-OF-NETWORK inpatient admissions, allowed charges will be reduced by 25%, then deductible and coinsurance will be applied.** Also, the CORPORATION requires notification for MEMBERS who have Medicare as their primary coverage and who are admitted to a Medicare-certified HOSPITAL or NONHOSPITAL FACILITY.
- Surgical services received in an AMBULATORY SURGICAL CENTER
- COVERED SERVICES received in a licensed and accredited specialty care facility, such as a SKILLED NURSING FACILITY, or an acute inpatient rehabilitation facility or long-term acute care facility. PRIOR REVIEW must be requested and CERTIFICATION must be obtained in advance from the CORPORATION or services will not be covered. However, CERTIFICATION is not required for MEMBERS who have Medicare as their primary coverage and who are admitted to a Medicare-certified SKILLED NURSING FACILITY.

Alternatives to HOSPITAL Stays (Home Health Care, HOSPICE, Private Duty Nursing)

Home Health Care

Home health care services are covered when ordered by your DOCTOR for a MEMBER who is HOMEBOUND due to illness or injury, or is actively receiving treatment for a cancer related problem, and you need part-time or intermittent skilled nursing care from a REGISTERED NURSE (RN) or LICENSED PRACTICAL NURSE (LPN), and/or other skilled care services like REHABILITATIVE THERAPIES and HABILITATIVE SERVICES. Usually, a HOME HEALTH AGENCY coordinates the services your DOCTOR orders for you. Services from a

home health aide may be eligible for coverage only when the care provided supports a skilled service being delivered in the home. Home health skilled nursing care requires PRIOR REVIEW and CERTIFICATION or services will not be covered.

HOSPICE Services

The PLAN 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.

Private Duty Nursing

The PLAN provides benefits for MEDICALLY NECESSARY private duty services of an RN or LPN when ordered by your DOCTOR for a MEMBER who may be receiving active acute care management when certain criteria is met. Private duty nursing provides more individual and continuous skilled care than can be provided in a skilled nursing visit through a HOME HEALTH AGENCY. It is to be used as a short-term solution for a MEMBER transitioning from an acute care setting to the home setting and is not meant to be for long-term permanent or custodial care. Also see "Care Management." Private duty nursing requires PRIOR REVIEW and CERTIFICATION or services will not be covered.

Private Duty Nursing Exclusion

- Services received as an inpatient at a HOSPITAL or NONHOSPITAL FACILITY.

Family Planning

Maternity Care

Maternity care benefits are available to all MEMBERS, and include prenatal care, admission to labor and delivery, management of labor including fetal monitoring, delivery and uncomplicated post-delivery care until six weeks postpartum. Together these make up the global maternity delivery fee. See the chart below for additional information. However, maternity benefits for DEPENDENT CHILDREN cover only treatment for COMPLICATIONS OF PREGNANCY. Also visit **www.bluecrossnc.com/preventive** for those federally-mandated PREVENTIVE CARE services that are available for DEPENDENT CHILDREN. See Special Programs for information on a maternity wellness program.

	Mother	Newborn	Payment
Prenatal care	Care related to the pregnancy before birth		A copayment may apply for the OFFICE VISIT to diagnose pregnancy. Otherwise, coinsurance and any applicable deductible apply for the remainder of maternity care. Deductible and coinsurance for OUT-OF-NETWORK care.
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	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.	Deductible and coinsurance apply. If adding the baby changes your policy from EMPLOYEE to family coverage, the family BENEFIT PERIOD deductible applies.

	received within 72 hours of discharge.		
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.	

For information on CERTIFICATION, contact Customer Service at the number listed in "Who to Contact?" See "Federal Notices" for more information about maternity benefits.

Elective Termination of Pregnancy (Abortion)

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

COMPLICATIONS OF PREGNANCY

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

INFERTILITY Services

Benefits are provided for certain services related to the diagnosis, treatment and correction of any underlying causes of INFERTILITY for all MEMBERS except DEPENDENT CHILDREN.

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

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

SEXUAL DYSFUNCTION Services

The PLAN provides benefits for certain services related to the diagnosis, treatment and correction of any underlying causes of SEXUAL DYSFUNCTION for all MEMBERS.

Sterilization

This benefit is available for all MEMBERS. Sterilization includes female tubal occlusion and male vasectomy. Certain sterilization procedures for female MEMBERS are covered under the PREVENTIVE CARE benefit. See **www.bluecrossnc.com/preventive** or call Customer Service for information about procedures that are covered according to federal regulations and any limitations that may apply.

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. Certain FDA-approved contraceptive methods for female MEMBERS are covered under your PREVENTIVE CARE benefit. See the CORPORATION'S website **www.bluecrossnc.com/preventive** or call Customer Service for information about procedures that are covered according to federal regulations and any limitations that may apply.

Family Planning Exclusions

- Assisted reproductive technologies as defined by the Centers for Disease Control and Prevention, including, but not limited to, in-vitro fertilization (IVF), with fresh or frozen embryos, ovum or embryo placement, intracytoplasmic sperm injection (ICSI), zygote intra-fallopian transfer (ZIFT), specialized sperm retrieval techniques, and gamete intrafallopian transfer (GIFT) and associated services
- Oocyte and sperm donation
- Cryopreservation of oocytes, sperm or embryos
- Services performed by a doula
- Expenses INCURRED by any MEMBER who receives compensation from a third party in exchange for a medical procedure, such as surrogacy-related medical expenses
- Expenses INCURRED by a surrogate parent not covered as a MEMBER under the plan
- Care or treatment of the following:
  - maternity for DEPENDENT CHILDREN, except as specifically covered by the PLAN
  - elective termination of pregnancy (abortion) for DEPENDENT CHILDREN
  - reversal of sterilization
  - INFERTILITY for DEPENDENT CHILDREN
- Elective termination of pregnancy (abortion) after 16 weeks of pregnancy
- Treatment for INFERTILITY or reduced fertility that results from a prior sterilization procedure or a normal physiological change such as menopause.

Specific Therapies and Tests

The following therapies are covered when provided for an illness, disease or injury when ordered by a DOCTOR or OTHER PROFESSIONAL PROVIDER.

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 a licensed, registered, or certified health care professional acting within the scope of their practice. PRIOR REVIEW and CERTIFICATION are required for certain home infusion therapy services or services will not be covered.

REHABILITATIVE THERAPIES and HABILITATIVE SERVICES

The following therapies are covered:

- Occupational therapy and/or physical therapy performed in 15-minute increments, up to a one-hour session per day
- Chiropractic services and osteopathic manipulation performed in 15-minute increments, up to a one-hour session
- Speech therapy.

Benefits are limited to a combined IN- and OUT-OF-NETWORK BENEFIT PERIOD visit maximum for each of these three categories of therapies: (1) occupational and/or physical therapy, or any combination of these

therapies; (2) chiropractic services; and (3) speech therapy. REHABILITATIVE and HABILITATIVE THERAPIES received while an inpatient are not included in the BENEFIT PERIOD MAXIMUM.

ADAPTIVE BEHAVIOR TREATMENT

This benefit is a non-essential health benefit. Benefits are provided for ADAPTIVE BEHAVIOR TREATMENT for MEMBERS up to age 19. Charges for ADAPTIVE BEHAVIOR TREATMENT from an inpatient or outpatient facility do not apply to the dollar limit. Coverage includes assessments and treatment, which must be MEDICALLY NECESSARY, and ordered by a licensed physician or licensed psychologist. ADAPTIVE BEHAVIOR TREATMENT must be provided or supervised by the following professionals who are licensed and certified to provide this treatment:

- Licensed psychologist or psychological associate
- Licensed psychiatrist or developmental pediatrician
- Licensed speech and language pathologist
- Licensed occupational therapist
- Licensed clinical social worker
- Licensed clinical mental health counselor
- Licensed marriage and family therapist

Call Behavioral Health at the number listed in "Who to Contact?" Visit the CORPORATION'S website at **BlueCrossNC.com** or call Customer Service at the number listed in "Who to Contact?" for a list of PROVIDERS.

OTHER THERAPIES

The PLAN covers:

- Cardiac rehabilitation therapy
- Pulmonary and respiratory therapy
- Dialysis treatment
- Radiation therapy
- Chemotherapy, including intravenous chemotherapy. Chemotherapy benefits are based on where services are received. For chemotherapy received in conjunction with bone marrow or peripheral blood stem cell transplants, follow transplant guidelines described in "Transplants."

Diagnostic Services

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

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

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

Diagnostic Services Exclusions

- Lab tests that are not ordered by your DOCTOR or OTHER PROVIDER.
- Diagnostic tests used to confirm a known diagnosis or condition
- Tests used only for administrative purposes to measure process or quality improvement
- Tests that are duplicative or that are inclusive to other COVERED SERVICES

- Testing when a therapeutic or diagnostic course would not be determined by the outcome of the testing.

Other Services

Autism Spectrum Disorder Services

The PLAN provides coverage for the screening, diagnosis, and treatment of autism spectrum disorder as defined in the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association ("DSM-V") or any later edition. Coverage includes any MEDICALLY NECESSARY assessments, evaluations or tests to determine whether a MEMBER has autism spectrum disorder. If a MEMBER is diagnosed with autism spectrum disorder, coverage includes the following treatment or equipment related to the care of autism spectrum disorder, which must be MEDICALLY NECESSARY and ordered by a licensed physician or licensed psychologist:

- ADAPTIVE BEHAVIOR TREATMENT (see “Specific Therapies and Tests” for additional information)
- Pharmacy care
- Psychiatric care
- Psychological care
- Therapeutic care (services provided by the following licensed professionals: speech therapist, occupational therapist, physical therapist, clinical social worker, clinical mental health counselor or marriage and family therapist)

Autism Spectrum Disorder Exclusion

- Services provided in a school setting, which includes: (i) services that are part of an individualized family service plan, an individualized education program, or an individualized service plan, or (ii) services performed by school personnel that are not part of an intensive behavioral plan prescribed by a licensed professional, including, but not limited to, school staff assistants, and shadow professionals.

Blood

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

Blood Exclusion

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

Certain Drugs Covered under Your Medical Benefit

The PLAN covers certain PROVIDER-ADMINISTERED SPECIALTY DRUGS that must be dispensed under a PROVIDER’S supervision in an office, outpatient setting, or through home infusion. PROVIDER-ADMINISTERED SPECIALTY DRUGS ordered or prescribed for a MEMBER by a PROVIDER must be adjudicated by the PLAN and are covered under your medical benefit rather than your prescription drug benefit. Coverage of some of these drugs may be limited to certain PROVIDER settings (such as office, outpatient, AMBULATORY SURGERY CENTER, or provided by a HOME HEALTH AGENCY). For a list of drugs covered under your medical benefit that are covered only at certain PROVIDER settings, visit the CORPORATION'S website at **BlueCrossNC.com.** PRIOR REVIEW and CERTIFICATION may be required for certain drugs covered under your medical benefit or services will not be covered

Clinical Trials

The PLAN provides benefits for participation in clinical trials phases I, II, III, and IV. Coverage is also provided for CMS Investigational Device Exemption (IDE) Category B device trials. Coverage is provided only for MEDICALLY NECESSARY costs of health care services associated with the trials, and only to the extent such costs have not been or are not funded by other resources. The MEMBER must meet all protocol requirements and provide informed consent in order to participate. The trial must involve the treatment of

cancer or a life-threatening medical condition with services that are medically indicated and preferable for that MEMBER compared to non-investigational alternatives. In addition, the trial must:

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

Clinical Trials Exclusions

- Early feasibility/safety/pilot states of device trials
- CMS IDE Category A device trials
- 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 sound teeth, jaw, cheeks, lips, tongue, roof and floor of the mouth
- CONGENITAL deformity, including cleft lip and cleft palate
- Removal of:
  - oral tumors which are not related to teeth or associated dental procedures
  - oral cysts which are not related to teeth or associated dental procedures
  - exostoses for reasons other than for preparation for dentures.

The PLAN provides benefits for dental implants and related procedures, such as bone grafting associated with the above three conditions. The PLAN also provides benefits for extractions, root canal therapy, crowns, bridges, and dentures necessary for treatment of accidental injury or for reconstruction for the conditions listed above. In addition, benefits may be provided for dentures and orthodontic braces if used to treat CONGENITAL deformity including cleft lip and cleft palate.

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

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

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

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
- COSMETIC procedures, except as specifically covered by the PLAN

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

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

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. PRIOR REVIEW must be requested and CERTIFICATION obtained for certain surgical procedures or services will not be covered, unless treatment is for an EMERGENCY. 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 the CORPORATION before you receive surgical treatment for TMJ.

Diabetes-Related Services

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

Equipment and Supplies

DURABLE MEDICAL EQUIPMENT

Benefits are provided for DURABLE MEDICAL EQUIPMENT and supplies required for operation of equipment when prescribed by a PROVIDER. 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 and accessories that serve no medical purpose or that are primarily for comfort or convenience and are upgrades beyond the stated medical purpose
- Repair or replacement of equipment due to abuse or desire for new equipment.

Hearing Aids

The PLAN provides coverage for MEDICALLY NECESSARY hearing aids, including implantable bone-anchored hearing aids (BAHA), and related services that are ordered by a DOCTOR or a licensed audiologist. Benefits are provided for one hearing aid per hearing-impaired ear, and replacement hearing aids when alterations to an existing hearing aid are not adequate to meet the MEMBER'S needs. Benefits are also provided for the evaluation, fitting, and adjustments of hearing aids or replacement of hearing aids, and

for supplies, including ear molds. Certain hearing aids and related services may require PRIOR REVIEW and CERTIFICATION or services will not be covered.

Lymphedema-Related Services

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

Lymphedema-Related Services Exclusion

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

MEDICAL SUPPLIES

Coverage is provided for MEDICAL SUPPLIES. To obtain MEDICAL SUPPLIES and equipment, please find a PROVIDER on the CORPORATION'S website at **BlueCrossNC.com** or call Customer Service.

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 Exclusions

- Pre-molded foot orthotics
- Over-the-counter supportive devices
- Appliances and accessories that serve no medical purpose or that are primarily for comfort or convenience or are upgrades beyond the stated medical purpose
- Repair or replacement of equipment due to abuse or desire for new equipment.

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. Certain PROSTHETIC APPLIANCES require PRIOR REVIEW and CERTIFICATION or services will not be covered. Therapeutic contact lenses may be covered when used as a corneal bandage for a medical condition. Benefits include a onetime replacement of eyeglass or contact lenses due to a prescription change after cataract SURGERY.

PROSTHETIC APPLIANCES Exclusions

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

Surgical Benefits

Surgical services 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. Certain surgical procedures, including gender confirmation SURGERY and associated hormone therapy, bariatric surgery, and those surgical procedures that are potentially COSMETIC, require PRIOR REVIEW and CERTIFICATION or services will not be covered.

Surgical benefits include, but are not limited to:

- diagnostic SURGERY such as biopsies, and reconstructive SURGERY performed to correct CONGENITAL defects that result in functional impairment of newborn, adoptive, and FOSTER CHILDREN
- surgical treatment of morbid obesity (bariatric surgery). Bariatric surgery must be performed at a Blue Distinction Center for Bariatric Surgery®, unless you live more than 50 miles from a Blue Distinction

Center for Bariatric Surgery®. Bariatric surgery requires PRIOR REVIEW and CERTIFICATION or services will not be covered. Side effects and complications arising from bariatric surgery performed at a non-Blue Distinction Center for Bariatric Surgery® will not be covered except for EMERGENCY SERVICES. For a list of Blue Distinction Centers for Bariatric Surgery® call Customer Service at the number listed in "Who to Contact?"

- surgical, endovenous or microfoam-sclerotherapy procedures used to support the normal function of your major (truncal) veins. Coverage is also provided for liquid-sclerotherapy tributary vein treatment associated with a covered truncal vein procedure.
- mastectomy SURGERY, including:
  - reconstruction of the breast on which the mastectomy has been performed
  - SURGERY and reconstruction of the nondiseased breast to produce a symmetrical appearance, without regard to the lapse of time between the mastectomy and the reconstructive SURGERY
  - prostheses and physical complications of all stages of the mastectomy, including lymphedemas. (See "Federal Notices" for more information about mastectomy benefits.)
- joint replacement SURGERY.

If you have more than one surgical procedure performed on the same date of service, those procedures may not be eligible for separate reimbursement. For information about coverage of multiple surgical procedures, please refer to the CORPORATION'S reimbursement policies, which are on the CORPORATION'S website at **BlueCrossNC.com**, or call Customer Service at the number listed in "Who to Contact?"

Anesthesia

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

Transplants

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. The PLAN provides benefits for transplants, including HOSPITAL and professional services for covered transplant procedures. The PLAN provides care management for transplant services and will help you find a HOSPITAL or Blue Distinction Center for Transplants that provides the transplant services required. Travel and lodging expenses and charges related to a search for a donor may be reimbursed based on the CORPORATION'S guidelines that are available upon request from a transplant coordinator.

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

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

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

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

Transplants Exclusions

- The purchase price of the organ or tissue if any organ or tissue is sold rather than donated to the recipient MEMBER

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

Blue Distinction® Centers

You may want to go to a Blue Distinction Center (BDC) to receive your surgical procedure. BDCs are HOSPITALS and health care facilities with proven track records for delivering outstanding quality of care, service, and patient safety in the following specialties:

- bariatric surgery
- cardiac care
- knee or hip replacement
- maternity care
- transplants
- substance use disorder treatment and recovery
- spine surgery.

The list of specialties may change from time to time. If you receive care at a BDC, your out-of-pocket expenses may be less. Please visit **www.bluecrossnc.com/bdc** for more information, including the most up-to-date list of specialties, and to find a BDC near you.

Mental Health and Substance Use Disorder Services

The PLAN provides benefits for the treatment of MENTAL ILLNESS and substance use disorder by a HOSPITAL, RESIDENTIAL TREATMENT FACILITY, DOCTOR or OTHER PROVIDER without a referral, and includes, but is not limited to:

- OFFICE VISIT services
- Outpatient services (includes partial-day/night hospitalization services (minimum of four hours per day and 20 hours per week), and intensive therapy services (less than four hours per day and minimum of nine hours per week))
- Inpatient and RESIDENTIAL TREATMENT FACILITY services (includes room and board and detoxification to treat substance use disorder).

How to Access Mental Health and Substance Use Disorder Services

PRIOR REVIEW is not required for any OFFICE VISIT services or in EMERGENCY situations; however, in EMERGENCY situations, please notify the CORPORATION of your inpatient admission as soon as reasonably possible.

PRIOR REVIEW and CERTIFICATION are required for inpatient (including RESIDENTIAL TREATMENT FACILITY services) and certain outpatient services. Failure to request PRIOR REVIEW and receive CERTIFICATION may result in allowed charges being reduced by 25% or a full denial of benefits. See PRIOR REVIEW and CERTIFICATION number listed in "Who to Contact?" Information about which services require PRIOR REVIEW as well as a list of IN-NETWORK PROVIDERS can be found online at **www.bluecrossnc.com/providers/medical-policies-and-coverage/prior-plan-review** or you can call Customer Service or the mental health phone number on the back of your ID CARD.

Mental Health and Substance Use Disorder Services Exclusions

- Counseling with relatives about a patient.

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 EMPLOYEE, EMPLOYER or carrier is liable or responsible for the specific medical charge (1) according to a final adjudication of the claim under a state's workers' compensation laws, or (2) by an order of a state Industrial Commission or other applicable regulatory agency approving a settlement agreement
- Benefits that are provided by any governmental unit except as required by law
- Services that are ordered by a court that are otherwise excluded from benefits under this PLAN
- Any condition suffered as a result of any act of war or while on active or reserve military duty
- A dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust or similar person or group
- Services received prior to the MEMBER'S EFFECTIVE DATE of coverage
- Services received in excess of any BENEFIT PERIOD MAXIMUM or LIFETIME MAXIMUM
- A benefit, drug, service or supply that is not specifically listed as covered in this benefit booklet
- Any benefit, drug, service, supply, test or charge that is duplicative or inclusive to other COVERED SERVICES.

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

A

Acupuncture and acupressure

Administrative charges including, but not limited to: charges billed by a PROVIDER, including charges for failure to keep a scheduled visit, completion of claim forms, obtaining medical records, late payments, telephone charges, shipping and handling and taxes

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

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

B

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

C

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

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

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

COSMETIC services: the removal of excess skin from any area of the body (except panniculectomy), skin tag excisions, cryotherapy, dermabrasion and/or chemical exfoliation for acne and acne scarring, injection of

dermal fillers, removal of wrinkles (facelift), services for hair transplants, skin tone enhancements, electrolysis, liposuction/lipectomy from head, neck, trunk/buttocks, 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 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 the CORPORATION without regard to the place of service or the PROVIDER prescribing or providing the services.

D

Dental appliances, except when MEDICALLY NECESSARY for the treatment of temporomandibular joint disease or obstructive sleep apnea

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 described in "Dental Treatment Covered Under Your Medical Benefit"

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
- Drugs associated with assisted reproductive technology
- 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 I, II, III and IV clinical trials, or drugs approved by the FDA for treatment of cancer, if prescribed for the treatment of any type of cancer for which the drug has been proven as effective and accepted in any one of the following:
  - The National Comprehensive Cancer Network Drugs & Biologics Compendium
  - The Thomson Micromedex® DRUGDEX®
  - The Elsevier Gold Standard's Clinical Pharmacology
  - Any other authoritative compendia as recognized periodically by the United States Secretary of Health and Human Services.

E

Ear piercing

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

The following **equipment**:

- Devices and equipment used for environmental accommodation requiring vehicle and/or building modifications such as, but not limited to, chair lifts, stair lifts, home elevators, and ramps

- Air conditioners, furnaces, humidifiers, dehumidifiers, vacuum cleaners, electronic air filters and similar equipment
- Physical fitness equipment, hot tubs, Jacuzzis, heated spas, or pools
- Standing frames
- Automatic external defibrillators
- 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, except for the treatment of conditions related to diabetes

G

Genetic testing, except for high risk patients when the identification of a genetic abnormality correlates with the likelihood of a disease or condition, and when the therapeutic or diagnostic course would be determined by the outcome of the testing

H

Routine **hearing** examinations and **hearing aids**, including implantable bone-anchored hearing aids (BAHA) or examinations for the fitting of hearing aids for MEMBERS, except as specifically covered by the PLAN

Certain **home health care** services, including, but not limited to: 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.

Hypnosis except when used for control of acute or chronic pain

I

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

Inpatient confinements that are primarily intended as a change of environment

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

M

Services or supplies deemed not **MEDICALLY NECESSARY** or not ordered by a PROVIDER

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, and services deemed not MEDICALLY NECESSARY, or elective termination of pregnancy if not specifically covered by the PLAN.

O

The following **obesity** services:

- Bariatric surgery services performed at a non-Blue Distinction Center for Bariatric Surgery®, except specifically as covered by the PLAN
- Any cost associated with membership in a weight management program or health club

- Prescription drugs indicated for short-term or long-term treatment of clinical obesity
- Any treatment or regimen, medical or surgical, for the purpose of reducing or controlling the weight of the MEMBER or for treatment of obesity, except for surgical treatment of morbid obesity, or as specifically covered by the PLAN

P

Body **piercing**

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

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

R

The following **residential care** services:

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

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

T

The following types of **Temporomandibular Joint (TMJ) Services**:

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

The following types of **therapy**:

- Music therapy, recreational or activity therapy, and all types of animal therapy. Remedial reading and all forms of special education and supplies or equipment used similarly, except as specifically covered by the PLAN
- Massage therapy
- Cognitive rehabilitation
- Group classes for pulmonary rehabilitation

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

V

The following **vision** services:

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

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

WHEN COVERAGE BEGINS AND ENDS

This section provides information on who is eligible and how to qualify for coverage under the PLAN:

Table of Contents:	Key Words:
- Enrolling in the PLAN - Adding or Removing a DEPENDENT - Qualified Medical Child Support Order - Types of Coverage - Reporting Changes - Continuing Coverage - Continuation under Federal Law - Certificate of CREDITABLE COVERAGE - Termination of MEMBER coverage - Guaranteed Renewability - Plan Amendment or Termination	- EMPLOYEE - DEPENDENTS - PLAN ADMINISTRATOR

EMPLOYEES shall be added to coverage no later than 90 days after their first day of employment (check with your EMPLOYER about any specific probationary period). To be covered under the PLAN, you must be an active full-time W-2 EMPLOYEE who works 20 or more hours per week and is otherwise eligible for coverage. 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.

Your EMPLOYER may allow eligibility to extend to other persons, such as retirees. The Group's Retirement Program requires attainment of age 55 and 10 years of service with present institution or attainment of age 65 without regards to years of service. Eligibility under the Group's Retirement Program will be determined at least 30 days prior to the EMPLOYEE'S termination of employment and continuation of coverage must be elected within 30 days of the date of the EMPLOYEE'S termination of employment. Eligible Retirees continued for coverage, as SUBSCRIBERS will be considered in the determination of enrollment percentages. Each EMPLOYEE of the Group covered as a SUBSCRIBER under the PLAN who retires from service, and who is qualified to receive benefits due to normal retirement as specified under the Group's Retirement Program will be eligible to continue as a SUBSCRIBER until any of the following:

- SUBSCRIBER ceases to be eligible as a retired employee as specified under the Group's Retirement Program
- SUBSCRIBER fails to pay any applicable fees to the Group on or before the due date
- Termination of the PLAN
- SUBSCRIBER becomes eligible for benefits under Medicaid (Title XIX of the Social Security Act).

Coverage will be continued under the type coverage (Individual, Parent/Child, Parent/Children, Employee/ Spouse, Family) as was in effect immediately preceding retirement date and benefits will be the same as for all other SUBSCRIBERS. Coverage will be available only to those eligible DEPENDENTS of the SUBSCRIBER covered on the day immediately preceding the date of retirement.

Retirees and their spouses continued for coverage who are eligible for benefits under Title XVIII (Medicare) of the Social Security Act may remain covered. Benefits provided under this PLAN will not be paid to the extent that services are covered by or the MEMBER is eligible for COVERED SERVICES under Title XVIII (Medicare) of the Social Security Act.

The surviving spouse and any eligible DEPENDENTS of a deceased retired SUBSCRIBER will be eligible to continue coverage in the PLAN provided 1) such spouse and DEPENDENTS were covered by the PLAN at the time of the SUBSCRIBER'S death, and 2) such deceased retired SUBSCRIBER had completed 10 years or more of credible service with the Group. Benefits will be the same as for all other SUBSCRIBERS. Surviving spouses over age 65 will be considered a "retiree" for purposes of coordinating benefits between the PLAN and Medicare.

Coverage for such surviving spouse and eligible DEPENDENTS will continue until any of the following:

- The surviving spouse becomes eligible for coverage under another group health insurance program
- The surviving spouse remarries
- Termination of the PLAN
- DEPENDENT ceases to be eligible as a MEMBER

- The surviving spouse fails to pay any applicable fees to the Group on or before the due date.

Surviving spouses continued for coverage who are eligible for benefits under Title XVIII (Medicare) of the Social Security Act may remain covered hereunder.

Benefits provided under this PLAN will not be paid to the extent that services are covered by or the MEMBER is eligible for COVERED SERVICES under Title XVIII (Medicare) of the Social Security Act.

Eligible surviving spouses must elect to continue coverage within 30 days of the date of the retired SUBSCRIBER'S death. Eligible surviving spouses continued for coverage as SUBSCRIBERS will be considered in the determination of enrollment percentages and contribution of the full monthly fee (Individual, Parent/Child, Parent/Children, Family) will be made by eligible surviving spouses.

Coverage will be continued under the type coverage (Individual, Parent/Child, Parent/Children, Employee/Spouse, Family) as was in effect immediately preceding retirement date and benefits will be the same as for all other SUBSCRIBERS. Coverage will be available only to those eligible DEPENDENTS of the Subscriber covered on the day immediately preceding the date of retirement. However, newly eligible children (newborns, adoptive children, or FOSTER CHILDREN), and children added as a result of a court or administrative order such as a Qualified Medical Child Support Order (QMCSO) are eligible for coverage after the date of the SUBSCRIBER'S retirement. 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.

For DEPENDENTS to be covered under the PLAN, you must be covered and your DEPENDENT must be one of the following:

- Your spouse, under an existing marriage that is legally recognized under any state law
- Your same sex domestic partner, if allowed by your EMPLOYER'S human resources policy, so long as you and your same sex domestic partner have attested to the GROUP ADMINISTRATOR in writing to the following:
    1. That you are both mentally competent
    2. That you are both at least the age of consent for marriage in the state of North Carolina
    3. That you are not related by blood to a degree of closeness that would prohibit legal marriage in North Carolina
    4. That neither of you are married to anyone else
    5. That you 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 live together and intend to do so permanently
    7. That you do not currently have another domestic partner covered under this PLAN
    8. That you have not had a domestic partner covered under this PLAN at any time within the past 12 months before adding this domestic partner unless the previous domestic partnership was terminated by death.

    The conditions listed in 2-8 above must remain true and correct for your same sex domestic partner to remain an eligible DEPENDENT under the terms of this coverage. If you are unsure whether your EMPLOYER'S policy allows for coverage of domestic partners, please contact your EMPLOYER'S human resources department.

- Your, your spouse's, or your same sex domestic partner's (if allowed by your EMPLOYER'S human resources policy), DEPENDENT CHILDREN through the end of the month of their 26th birthday. Your EMPLOYER may require proof that your child meets the definition of DEPENDENT CHILD as outlined in "Glossary."
- A DEPENDENT CHILD with respect to whom permanent guardianship has been granted to you or your spouse in accordance with North Carolina law. They may be covered under the PLAN through the end of the month of their 26th birthday. A court order granting the permanent guardianship will be required as proof of guardianship.
- A DEPENDENT CHILD who in accordance with North Carolina law, is and continues to be intellectually or physically disabled 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 end of eligibility for

DEPENDENT CHILDREN. Proof of the disability, which could include a medical certification by the child's DOCTOR, must be provided to the PLAN within 31 days of the DEPENDENT CHILD'S reaching the limiting age, and may be verified annually by the CORPORATION.

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 coverage or make changes to your coverage during your EMPLOYER'S annual enrollment period, which is held once a year. Your EMPLOYER does not impose any WAITING PERIOD for PRE-EXISTING CONDITIONS (a condition, disease, illness or injury for which medical advice, diagnosis, care or treatment was received or recommended within the 6-month period prior to your enrollment date). If you do not apply for coverage within 30 days of when you or your DEPENDENTS first become eligible, you will have to wait for a future annual enrollment period. Newly eligible children (newborns, adoptive children, or FOSTER CHILDREN), and children added as a result of a court or administrative order such as a Qualified Medical Child Support Order (QMCSO) are not restricted to the annual enrollment period. See also "Adding or Removing a DEPENDENT."

You may also apply for coverage and/or add DEPENDENTS within a 30-day period following any of the triggering/qualifying life events ("QLEs") listed below unless otherwise noted. A QLE for one individual within a family qualifies as an event for the MEMBER and all family members, regardless of current enrollment. Coverage is effective no later than the first day of the first month following a completed request for enrollment. The following are considered QLEs:

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

For coverage to be effective on the date the DEPENDENT becomes eligible, your form must be completed within 30 days after the DEPENDENT becomes eligible.

If you are adding a newborn child, a child legally placed for adoption, a child placed by court or administrative order, 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 to the CORPORATION within 30 days after the child becomes eligible, but it is important to provide notification as soon as possible.

You may remove DEPENDENTS from your coverage by contacting the PLAN ADMINISTRATOR and completing the proper form. DEPENDENTS must be removed from coverage when they are no longer eligible, such as when a child is no longer eligible due to age, or when a spouse is no longer eligible due to divorce or death. Failure to timely notify the CORPORATION and the 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 participant whose child(ren) is (are) to be covered, the type of coverage, the child(ren) to be covered and the applicable period of the QMCSO. A copy of the QMCSO procedures may be obtained free of charge from the CORPORATION and 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 same sex domestic partner, if allowed by your EMPLOYER'S human resources policy
- Employee-children coverage - The PLAN covers you and your DEPENDENT CHILDREN
- Family coverage - The PLAN covers you, your spouse or same sex domestic partner, if allowed by your EMPLOYER'S human resources policy, 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 CORPORATION and the PLAN ADMINISTRATOR and fill out the proper form. It will help assure better service if the CORPORATION 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. DEPENDENTS of an active full-time EMPLOYEE who elect Medicare only will continue their eligibility under the PLAN until the time the active EMPLOYEE terminates employment or DEPENDENTS become eligible for Medicare or Medicaid. All other eligibility provisions apply to these DEPENDENTS.

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 for advice about continuation of coverage under the PLAN.

Continuation under Federal Law

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

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

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

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

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

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

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

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

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

- Divorce
- Ineligibility of a DEPENDENT CHILD.

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

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

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

If you are covered by the PLAN and called to the uniformed services, as defined in the Uniformed Services Employment and Reemployment Rights Act (USERRA), consult the CORPORATION. The CORPORATION 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 CORPORATION 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. You may request a Certificate of CREDITABLE COVERAGE from Customer Service while you are still covered under the PLAN and up to 24 months following your

termination. You may call Customer Service at 1-877-275-9787 (toll-free), Monday through Friday except holidays or visit the CORPORATION'S web site at **BlueCrossNC.com**.

Termination of MEMBER Coverage

The CORPORATION 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.

Cessation of active work shall be deemed termination of employment, except if an EMPLOYEE is not working because of an EMPLOYER'S approved leave of absence, temporary layoff, injury, illness, disability as a result of injury or illness, maternity or personal reasons. Coverage will be continued during that time until discontinued by the EMPLOYER according to the Employer's Personnel Practice. Coverage shall be limited to the lesser of the Employer's Personnel Practice or 12 months.

Termination for Cause

A MEMBER'S coverage may be terminated upon 31 days prior written notice for the following reasons:

- The MEMBER fails to pay or to have paid on his or her behalf or to make arrangements to pay any copayments, deductible or coinsurance for services covered under the PLAN
- No IN-NETWORK PROVIDER is able to establish or maintain a satisfactory DOCTOR-patient relationship with a MEMBER, as determined by the PLAN
- A MEMBER exhibits disruptive, abusive, or fraudulent behavior toward an IN-NETWORK PROVIDER.

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

A MEMBER'S coverage under the PLAN will be terminated immediately for the following reasons:

- Fraud or intentional misrepresentation of a material fact by the EMPLOYEE or DEPENDENT. However, if such termination is made retroactively, including back to the EFFECTIVE DATE of your policy (called a rescission), you will be given 30 days advance written notice of this rescission and may submit an appeal; see “Need to Appeal a Decision?” If your policy is rescinded, any premiums paid will be returned unless the CORPORATION 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 the CORPORATION'S 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 the PLAN, or uses another person's ID CARD.

Guaranteed Renewability

Coverage is renewable at the option of the EMPLOYER, except that coverage may be terminated by the PLAN SPONSOR, as specified by law, for any of the following reasons:

- Nonpayment of premium fees by the EMPLOYER
- Fraud or intentional misrepresentation of a material fact by the EMPLOYER or, with respect to coverage of individual MEMBERS, the MEMBERS or their representatives
- The EMPLOYER fails to comply with contribution or participation rules required under the terms of coverage
- The PLAN SPONSOR ceases to offer coverage in the small employer market or the large employer market or to both, provided that notice is given to the EMPLOYER and the North Carolina Department of Insurance 180 days prior to cancellation; or
- The PLAN SPONSOR ceases to offer a specific type of health insurance product in the market, provided that notice is given 90 days prior to cancellation and;
    - If the EMPLOYER is a small employer, the EMPLOYER is given the option to enroll in any small employer product offered by the PLAN SPONSOR; or
    - If the EMPLOYER is not a small employer, the EMPLOYER is given the option to enroll to enroll in a product chosen by the PLAN SPONSOR.
- EMPLOYER loses eligibility for participation in the PLAN.

Plan Amendment or Termination

North Carolina Bankers Association Health Benefit Trust reserves the full, absolute and discretionary right to amend, modify, suspend, withdraw, discontinue or terminate the PLAN in whole or in part at any time for any and all participants of the PLAN by formal action taken by the Trustees, or by the execution of a written amendment by the PLAN SPONSOR. If the PLAN is amended, modified, suspended, withdrawn, discontinued or terminated, covered EMPLOYEES and covered DEPENDENTS will be entitled to benefits for claims incurred prior to the date of such action.

Such changes may include, but are not limited to, the right to (1) change or eliminate benefits, (2) increase or decrease participant contributions, (3) increase or decrease deductibles, and (4) change the class(es) of employees or DEPENDENTS covered by the PLAN.

UTILIZATION MANAGEMENT

This section provides information on how certain services are reviewed to determine if they are MEDICALLY NECESSARY.

Table of Contents:	Key Words:
- Rights and Responsibilities - PRIOR REVIEW - Concurrent/Retrospective Review - Care Management - Continuity of Care - Delegated UTILIZATION MANAGEMENT	- ADVERSE BENEFIT DETERMINATION - MEDICALLY NECESSARY - CERTIFICATION - PRIOR REVIEW

To make sure you can have high quality, cost-effective health care, the CORPORATION has a UTILIZATION MANAGEMENT (UM) program. The UM program requires certain health care services to be reviewed and approved by the CORPORATION in order to receive benefits. As part of this process, the CORPORATION looks at whether health care services are MEDICALLY NECESSARY, given in the proper setting and for a reasonable length of time. The CORPORATION 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
- You were not eligible for these services under the PLAN due to cancellation of coverage (including your voluntary termination of coverage)
- Nonpayment of premiums.

Rights and Responsibilities Under the UM Program

Your MEMBER Rights

Under the UM program, you have the right to:

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

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

The CORPORATION'S Responsibilities

As part of all UM decisions, the CORPORATION will:

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

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

PRIOR REVIEW (Pre-Service)

Certain services require PRIOR REVIEW as noted in "COVERED SERVICES." These types of reviews are called pre-service reviews.

If PRIOR REVIEW is required by the CORPORATION, you or your PROVIDER must request PRIOR REVIEW regardless of whether the PLAN is your primary or secondary coverage (see "Coordination of Benefits (Overlapping Coverage)"). Approval of a pre-service review for services to be provided by an OUT-OF-NETWORK PROVIDER does not guarantee payment of the OUT-OF-NETWORK PROVIDER billed charges. The CORPORATION pays the ALLOWED AMOUNT for COVERED SERVICES rendered by an OUT-OF-NETWORK PROVIDER. If neither you nor your PROVIDER requests PRIOR REVIEW and receives CERTIFICATION,

this may result in an ADVERSE BENEFIT DETERMINATION. The list of services that need PRIOR REVIEW may change from time to time. General categories of services with this requirement are noted in "COVERED SERVICES." For a detailed list of these services and the most up-to-date information visit the CORPORATION'S website at **BlueCrossNC.com** or call Customer Service at the number listed in "Who to Contact?"

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

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

Urgent PRIOR REVIEW

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

If the CORPORATION needs additional information to process your urgent review, the CORPORATION will let you and your PROVIDER know of the information needed as soon as possible but no later than 24 hours following the receipt of your request. You will then be given a reasonable amount of time, but not less than 48 hours, to provide the requested information. The CORPORATION will make a decision on your request within a reasonable time but no later than 48 hours after receipt of requested information or within 48 hours after the time period given to the PROVIDER to submit necessary clinical information, whichever comes first. An urgent review may be requested by calling Customer Service at the number given in "Who to Contact?"

Concurrent Reviews

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

If a request for an extension of treatment is non-urgent, a decision will be made and communicated to the requesting PROVIDER within three business days after receipt of all necessary clinical information, but no later than 15 calendar days after the CORPORATION receives the request.

In the event of an ADVERSE BENEFIT DETERMINATION, the CORPORATION will let you, your HOSPITAL'S or other facility's UM department and/or your PROVIDER know within three business days after receipt of all necessary clinical information, but no later than 15 calendar days after the CORPORATION receives the request. Written confirmation of the decision will also be sent to your home by U.S. mail. For concurrent reviews, the CORPORATION will remain responsible for COVERED SERVICES you are receiving until you or your representatives have been notified of the ADVERSE BENEFIT DETERMINATION.

Urgent Concurrent Review

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

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

If the CORPORATION needs more information to process your urgent concurrent review, the CORPORATION will let the requesting HOSPITAL or other facility know of the information needed as soon as possible but no later than 24 hours after receiving the request. The requesting HOSPITAL or other facility will then be given a reasonable amount of time, but not less than 24 hours, to provide the requested information. The CORPORATION will make a decision within 72 hours after receipt of the request.

Retrospective Reviews (Post-Service)

The CORPORATION also reviews the coverage of health care services after you receive them (retrospective/post-service reviews). Retrospective review may include a review to see if services received in an EMERGENCY setting qualify as an EMERGENCY. All decisions will be based on MEDICAL NECESSITY and whether the service received was a benefit under this PLAN.

The CORPORATION will make all retrospective review decisions and let you and your PROVIDER know of its decision within a reasonable time but no later than 30 calendar days from the date the CORPORATION received the request for coverage.

If more information is needed before the end of the initial 30-day period, the CORPORATION will let you know of the information needed. You will then have 90 days to provide the requested information.

As soon as the CORPORATION gets the requested information, or at the end of the 90 days, whichever is earlier, the CORPORATION will make a decision within 15 calendar days. Regardless if additional information is needed, in the event of a NONCERTIFICATION, the CORPORATION will let you and your PROVIDER know in writing within five business days after making the NONCERTIFICATION.

Services that were approved in advance by the CORPORATION will not be subject to denial for MEDICAL NECESSITY once the claim is received, unless the CERTIFICATION was based on a material misrepresentation about your health condition or you were not eligible for these services under the PLAN due to termination of coverage or nonpayment of premiums. All other services may be subject to retrospective review and could be denied for MEDICAL NECESSITY or for a benefit limitation or exclusion.

Care Management

MEMBERS with complicated and/or chronic medical needs may be eligible for care management services. Care management (case management as well as disease 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 the CORPORATION or by a representative of the CORPORATION. The PLAN is not obligated to give the same benefits or services to a MEMBER at a later date or to any other MEMBER. Information about these services can be found by calling Customer Service. You may also want to talk to your PCP or SPECIALIST.

In addition to the CORPORATION'S care management programs for MEMBERS with complicated and/or chronic medical needs, MEMBERS may receive a reduced or waived out-of-pocket costs in connection with programs and/or promotions .These are designed to encourage MEMBERS to seek appropriate, high quality, efficient care based on the CORPORATION'S criteria.

Continuity of Care

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

An ongoing special condition means:

- an acute illness, a condition that is serious enough to require medical care or treatment to avoid a reasonable possibility of death or permanent harm;
- a chronic illness or condition, a disease or condition that is life-threatening, degenerative, or disabling, and requires medical care or treatment over a prolonged period of time;

- pregnancy during the second and third trimesters;
- terminal illness, an individual has a medical prognosis that the MEMBER'S life expectancy is six months or less.

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

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

Continuity of care requests must be submitted to the CORPORATION within 45 days of the PROVIDER termination date or within 45 days of EFFECTIVE DATE for MEMBERS new to the PLAN. Continuity of care requests will be reviewed by a medical professional based on the information given about specific medical conditions. If your continuity of care request is denied, you may request a review through our appeals process (see “Need to Appeal a Decision?”). 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 given when the PROVIDER'S contract was terminated for reasons relating to quality of care or fraud. Such a decision may not be reviewed on appeal. Please call Customer Service at the number listed in "Who to Contact?" for more information.

Delegated UTILIZATION MANAGEMENT

The CORPORATION delegates certain UM services for particular benefits to other companies not associated with the CORPORATION. Please see **https://www.bluecrossnc.com/providers/medical-policies-and-coverage/search-medical-policy** for a detailed list of these companies and benefits. While some benefits have been identified under "COVERED SERVICES, " the list of benefits and/or companies may change from time to time; for the most up-to-date information visit **https://www.bluecrossnc.com/providers/medical-policies-and-coverage/search-medical-policy**.

NEED TO APPEAL A DECISION?

This section tells you more about how the appeal process works and what steps you need to take to file an appeal.

Table of Contents:	Key Words:
- First and Second Level Appeals - Expedited Appeals - External Review - Delegated Appeals	- ADVERSE BENEFIT DETERMINATION - GRIEVANCE - MEDICALLY NECESSARY

In addition to the UTILIZATION MANAGEMENT (UM) program, the PLAN offers a voluntary appeals process for MEMBERS. An appeal is another review of your case.

If you want to appeal an ADVERSE BENEFIT DETERMINATION or have a GRIEVANCE, you can request that the CORPORATION review the decision or GRIEVANCE. The process may be requested by the MEMBER or an authorized representative acting on the MEMBER'S behalf with the MEMBER'S written consent. In the event you name an authorized representative, "you" under this section means "you or your authorized representative." Your representative will also receive all notices and benefit determinations from the appeal. You may also ask for, at no charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits. Additionally, you will be provided with, at no charge, any new or additional evidence that is relied upon or generated by the PLAN or the CORPORATION in connection with the claim being appealed. Mental health and substance abuse appeals have been delegated to a third party vendor. Please see the end of this section for contact information. References to the CORPORATION throughout this section refer to the CORPORATION or its designee.

Steps to Follow in the Appeals Process

For each step in this process, there are set time frames for filing an appeal and for letting you or your PROVIDER know of the decision. The type of ADVERSE BENEFIT DETERMINATION or GRIEVANCE will determine the steps that you will need to follow in the appeals process. For appeals about an ADVERSE BENEFIT DETERMINATION, the review must be requested in writing, within 180 days of an ADVERSE BENEFIT DETERMINATION or by the date listed on your Explanation of Benefits. To request a form to submit a request for a review, visit the CORPORATION'S website at **BlueConnectNC.com** or call Customer Service at the number listed in “Who to Contact?”

Any request for review should include:

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

All information related to a request for a review through the CORPORATION'S appeals process should be sent to:
Blue Cross NC
Appeals Department
PO Box 30055
Durham, NC 27702

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

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

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

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

If a claims denial is based on medical judgment, including determinations about whether a certain treatment, drug or other item is EXPERIMENTAL, INVESTIGATIONAL, or not MEDICALLY NECESSARY or appropriate, the CORPORATION shall seek

advice from a health care professional with an appropriate level of training and expertise in the field of medicine involved (as determined by the CORPORATION). The health care professionals have not reviewed your case or information before.

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

Timeline for Appeals

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

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

First Level Appeal

The CORPORATION will provide you with the name, address and phone number of the appeals coordinator within three business days after receipt of a review request. The CORPORATION 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. The CORPORATION asks that you send all of the written material you feel is necessary to make a decision. The CORPORATION will use the material provided in the request for review, along with other available information, to reach a decision.

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

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

Quality of Care Complaints

For quality of care complaints, an acknowledgement will be sent by the CORPORATION within ten business days. We will defer the complaint to our quality assurance committee for review and consideration or any appropriate action against the PROVIDER. State law does not allow for a second-level grievance review for grievances concerning quality of care.

Second Level Appeal

Second Level Appeal Timeline

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

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

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

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

Notice of Decision

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

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

Expedited Appeals (Available only for NONCERTIFICATIONS)

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

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

four days after receiving the request for the expedited appeal. Information initially given by telephone must also be given in writing.

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

External Review (Available only for NONCERTIFICATIONS)

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

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

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

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

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

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

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

Standard External Review

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

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

Expedited External Review

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

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

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

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

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

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

(Mail)
North Carolina Department of Insurance
Health Insurance Smart NC

1201 Mail Service Center
Raleigh, NC 27699-1201

(In person)
North Carolina Department of Insurance

For the physical address for Health Insurance Smart NC,
325 N. Salisbury Street
Raleigh, NC 27603
https://www.ncdoi.gov/consumers/health-insurance

Tel (toll free in NC): (855) 408-1212 Monday-Friday, 8:00 a.m. - 5:00 p.m. EST

(Web): https://www.ncdoi.gov/consumers/health-insurance/health-claim-denied/request-externalreview for external review information and request form

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

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

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

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

(i) the name and contact information for the IRO assigned to your case;

(ii) a copy of the information about your case that the CORPORATION has provided to the NCDOI; and

(iii) a notification that you may submit additional written information and supporting documentation relevant to the initial ADVERSE BENEFIT DETERMINATION to the assigned IRO within seven days after the receipt of the notice.

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

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

Blue Cross NC
Appeals Department
PO Box 30055
Durham, NC 27702-3055

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

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

If you are no longer covered by the PLAN at the time the CORPORATION 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 noncertified when first requested.

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

Delegated Appeals

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

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

Second level appeal, if eligible, is provided by the CORPORATION.

Prescription Drug Appeals

The CORPORATION does not administer your prescription drug benefits. Responsibility for first level and second level appeals for retail, mail order and specialty pharmacy services is handled by Express Scripts, Inc. Please note the address for sending written appeals about your prescription drugs:

Express Scripts
PO Box 66587
St. Louis, MO 63166-6587
Attention – Benefit Coverage Review

ADDITIONAL TERMS OF YOUR COVERAGE

This section provides information on:

Table of Contents:	Key Words:
- Benefits to Which MEMBERS are Entitled - Disclosure of Protected Health Information (PHI) - Administrative Discretion - North Carolina PROVIDER Reimbursement - Services Received Outside of North Carolina - Right of Recovery Provision - Notice of Claim - Notice of Benefit Determination	- COVERED SERVICES - PROVIDERS
- Limitation of Actions - Evaluating New Technology - Coordination of Benefits (Overlapping Coverage) - Important Information for MEMBERS eligible for Medicare	

Benefits to Which MEMBERS *Are* Entitled

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

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

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

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

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

Disclosure of Protected Health Information (PHI)

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

Administrative Discretion

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

North Carolina PROVIDER Reimbursement

The CORPORATION 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. The CORPORATION'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 the CORPORATION and the PROVIDER. Under certain circumstances, a contracting PROVIDER may receive payments from the CORPORATION greater than the charges for services provided to an eligible MEMBER, or the CORPORATION may pay less than charges for services, due to negotiated contracts. The MEMBER is not entitled to receive any portion of the payments made under the terms of contracts with PROVIDERS. The MEMBER'S liability when defined as a percent of charge shall be calculated based on the lesser of the ALLOWED AMOUNT or the PROVIDER'S billed charge for COVERED SERVICES provided to a MEMBER.

Some OUT-OF-NETWORK PROVIDERS have other agreements with the CORPORATION that affect their reimbursement for COVERED SERVICES provided to 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 the CORPORATION.

Services Received Outside of North Carolina

The CORPORATION has a variety of relationships with other Blue Cross and/or Blue Shield licensees, generally referred to as " Inter-Plan Arrangements." As a MEMBER of the PLAN, you have access to PROVIDERS outside the state of North Carolina.

Your ID CARD tells PROVIDERS that you are a MEMBER of the PLAN. While the CORPORATION maintains its contractual obligation to provide benefits to MEMBERS for COVERED SERVICES, the Blue Cross and/or Blue Shield licensee in the state where you receive services (“Host Blue”) is responsible for contracting with and generally handling all interactions with its participating PROVIDERS.

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

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

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 the CORPORATION uses for your claim because they will not be applied retroactively to claims already paid.

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

As an alternative to the BlueCard Program and depending on your geographic location, your claim may be processed through a Negotiated National Account Arrangement with a Host Blue. In these situations, the amount you pay for COVERED SERVICES will be calculated based on the lower of the participating PROVIDER’S billed covered charges or the negotiated price made available to the CORPORATION 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.

Value-Based Programs: BlueCard® Program

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

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

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

Blue Cross Blue Shield Global Core:

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

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

- Inpatient Services

In most cases, if you contact the service center for assistance, HOSPITALS will not require you to pay for covered inpatient services, except for any applicable copay, deductible or coinsurance amounts. In such cases, the HOSPITAL will submit your claims to the service center to begin claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for COVERED SERVICES. You must contact the CORPORATION to obtain precertification for non-emergency inpatient services.

- Outpatient Services

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

Submitting a Blue Cross Blue Shield Global Core Claim

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

Right of Recovery Provision

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

As used throughout this provision, the term "responsible party" means any party possibly responsible for making any payment to a MEMBER due to a MEMBER'S injuries or illness or any insurance coverage including, but not limited to,

uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers' compensation coverage, no-fault automobile insurance coverage, or any first party insurance coverage.

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

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

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

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

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

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

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

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

The MEMBER acknowledges that the CORPORATION 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 the CORPORATION'S efforts to recover benefits paid by the PLAN. It is the duty of the MEMBER to notify the CORPORATION in writing of the MEMBER'S intent to pursue a claim against any potentially responsible party, within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of the intention to pursue or investigate a claim to recover damages or obtain compensation due to injuries or illness sustained by the MEMBER. The MEMBER and their agents agree to provide the PLAN or its representatives notice of any recovery the MEMBER or the MEMBER'S

agents obtain prior to receipt of such recovery funds or within 5 days if no notice was given prior to receipt. Further, the MEMBER and the MEMBER'S agents shall provide notice prior to any disbursement of settlement or any other recovery funds obtained. The MEMBER shall provide all information requested by the CORPORATION or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the CORPORATION may reasonably request and all documents related to or filed in personal injury litigation.

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

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

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

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

The MEMBER agrees that any legal action or proceeding with respect to this provision may be brought in any court of competent jurisdiction in North Carolina as the CORPORATION may elect.

Notice of Claim

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

Notice of Benefit Determination

The CORPORATION will provide an explanation of benefits determination to the MEMBER or the MEMBER'S authorized representative within 30 days of the CORPORATION'S receipt of a notice of claim if the MEMBER has financial liability on the claim other than a copayment or other services where payment was made at the point of service. The CORPORATION may take an extension of up to 15 more days to complete the benefits determination if additional information is needed. If the CORPORATION takes an extension, the CORPORATION 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 the CORPORATION receives the requested information, or at the end of the 90 days, whichever is earlier, the CORPORATION will make a decision within 15 days.

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

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

Limitation of Actions

You must complete all of the required steps under the PLAN'S administrative claims and appeals procedures. Since the PLAN is subject to ERISA, this means that you must timely file an initial claim (if applicable) and timely file a first level appeal of any ADVERSE BENEFIT DETERMINATION before bringing suit under ERISA.

Any lawsuit that you file must be filed within the earlier of (1) within one year after receiving a final **ADVERSE BENEFIT DETERMINATION** regarding your first level appeal or (2) three years from the date the charge giving rise to the claim is **INCURRED** (or, if there are no such charges, the date your claim arose). Failure to follow the PLAN'S administrative claims and appeals procedures in a timely manner will cause you to lose your right to sue regarding an **ADVERSE BENEFIT DETERMINATION** and/or to recover benefits. Generally, this means that any claim, action or suit filed in court or in another tribunal will be dismissed.

Evaluating New Technology

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

Coordination of Benefits (Overlapping Coverage)

If a MEMBER is also enrolled in another group health plan, the PLAN may take into account benefits paid by the other plan. Coordination of benefits (COB) means that if a MEMBER is covered by more than one group insurance plan, benefits under one group insurance plan are determined before the benefits are determined under the second group insurance plan. The group insurance plan that determines benefits first is called the primary group insurance plan. The other group insurance plan is called the secondary group insurance plan.

Important Information for MEMBERS Eligible for Medicare

If you are eligible for or enrolled in Medicare, the PLAN will determine Medicare primacy in accordance with the Medicare Secondary Payer rules and will coordinate benefits based on your Medicare eligibility. Information regarding how Medicare works with other insurance benefits like those offered by the PLAN can be found on **www.medicare.gov**. If you or your DEPENDENTS are covered under the PLAN, and are eligible for Medicare, **the PLAN may take into account the benefits that you or your DEPENDENTS are eligible for under Medicare, regardless of whether you have actually enrolled for such coverage**. In other words, even if you have not enrolled in Medicare, the PLAN may reduce a claim based on the benefits you are eligible for under Medicare, and then pay the remaining claim amount under the terms of the PLAN and in accordance with the Medicare Secondary Payer rules. As a result, if you are eligible for Medicare and Medicare would pay benefits primary to the PLAN, your out-of-pocket costs may be higher if you do not enroll in Medicare. The Medicare Secondary Payer rules that determine when Medicare pays benefits primary to other insurance benefits like those offered by the PLAN are complex and will not result in higher out-of-pocket costs in every instance. Therefore, if you become eligible for Medicare and are unsure about how the PLAN will coordinate benefits with Medicare, please contact your PLAN ADMINISTRATOR for more information.

Benefits paid by the secondary group insurance plan may be reduced to avoid paying benefits between the two plans that are greater than the cost of the health care service. Most group health insurance plans include a COB provision. COB is explained in more detail in the Administrative Services Agreement between your EMPLOYER and the CORPORATION; however, the rules used to determine which plan is primary and secondary are listed in the following chart. The "participant" is the person who is signing up for group health insurance coverage.

When a person is covered by 2 group health plans, and	Then	Primary	Secondary
One plan does not have a COB provision	The plan without the provision is	√	
	The plan with the provision is		√
The person is the participant under one plan and a DEPENDENT under the other	The plan covering the person as the participant is	√	
	The plan covering the person as a DEPENDENT is		√
The person is covered as a DEPENDENT CHILD under both plans, and the parents are either: 1) married or living together; or 2) divorced/separated or not living together and a court decree* states that they have joint custody without specifying which parent is responsible for the DEPENDENT CHILD'S health care coverage; or 3) divorced/separated or not living together and a court decree* states that both parents have responsibility for the DEPENDENT CHILD'S health care coverage	The plan of the parent whose birthday occurs earlier in the calendar year (known as the birthday rule) is	√	
	The plan of the parent whose birthday is later in the calendar year is		√
	Note: When the parents have the same birthday, the plan that covered the parent longer is	√	
The person is covered as a DEPENDENT CHILD under both plans and parents are divorced/separated or not living together with no court decree* for coverage	The custodial parent's plan is	√	
	The plan of the spouse of the custodial parent is		√
	Or, if the custodial parent covers the child through their spouse's plan, the plan of the spouse is	√	
	The non-custodial parent's plan is		√
	Note: The custodial parent is considered to be the parent awarded custody of a child by a court decree; or in the absence of a court decree, the parent with whom the child resides more than one half of the calendar year.*		
The person is covered as a DEPENDENT CHILD under both plans and parents are divorced/separated or not living together, and coverage is stipulated in a court decree*	The plan of the parent primarily responsible for health coverage under the court decree is	√	
	The plan of the other parent is		√
	Note: If there is a court decree that requires a parent to assume financial responsibility for the child's health care coverage, and the CORPORATION or the PLAN ADMINISTRATOR has actual knowledge of those terms of the court decree, benefits under that parent's health benefit plan are	√	

When a person is covered by 2 group health plans, and	Then	Primary	Secondary
The person is covered as a laid-off or retired EMPLOYEE or that EMPLOYEE'S DEPENDENT on one of the plans, including coverage under COBRA	The plan that covers a person other than as a laid-off or retired EMPLOYEE or as that EMPLOYEE'S DEPENDENT is	√	
	The plan that covers a person as a laid-off or retired EMPLOYEE or the DEPENDENT of a laid-off or retired EMPLOYEE is		√
	Note: This rule does not apply if it results in a conflict with any of the other rules for determining order of benefits.		
The person is the participant in two active group health plans and none of the rules above apply	The plan that has been in effect longer is	√	
	The plan that has been in effect the shorter amount of time is		√

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

Please note that payment by the CORPORATION 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. However, if neither the primary nor secondary plan covers a particular service, the MEMBER will be responsible for payment for that service.

The CORPORATION may request information about the other plan from the MEMBER. A prompt reply will help the CORPORATION process payments quickly. There will be no payment until primary coverage is determined. It is important to remember that even when benefits are coordinated with other group health plans, benefits for COVERED SERVICES are still subject to program requirements, such as PRIOR REVIEW and CERTIFICATION procedures.

The following federal notices describe benefits that are included as part of your ESSENTIAL HEALTH BENEFITS. See "COVERED SERVICES" for more details.

Important Notice of Special Enrollment

If you are declining enrollment for yourself or your DEPENDENTS (including your spouse) because of other health insurance (including Medicaid or Children's Health Insurance Program (CHIP)) or group health plan coverage, you may be able to enroll yourself and the DEPENDENTS in the PLAN if you or your DEPENDENTS lose eligibility for that other coverage (or if the employer stops contributing towards your or your DEPENDENTS' other coverage). However, you must request enrollment within 30 days after your or your DEPENDENTS' other coverage ends (other than Medicaid or CHIP) or if the employer stops contributing towards your or your DEPENDENTS' other coverage and within 60 days after the loss of Medicaid or CHIP eligibility.

In addition, if you have a new DEPENDENT as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your DEPENDENTS. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption or foster care, except when adding a DEPENDENT CHILD will not change your coverage type or premiums that are owed.

For questions or to obtain more information, contact Customer Service at:

Blue Cross NC Customer Service
Blue Cross and Blue Shield of North Carolina
PO Box 2291
Durham, NC 27702

1-877-275-9787 (toll-free)

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.

Mastectomy Benefits

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

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

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

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

Programs Outside Your Regular Benefits

The PLAN ADMINISTRATOR and the CORPORATION may agree to offer or provide programs that are outside your regular benefits. These offers or programs may be changed from time to time. Following are examples of programs that may be included outside your regular benefits:

- Discounts or promotional offers on goods and services from other companies including certain types of PROVIDERS
- Service programs for MEMBERS identified with complex health care needs, including a dedicated administrative contact, consolidated claims data information, and supportive gift items
- Health and wellness programs
- Clinical Opportunities Notification Program involves the analysis of claims and subsequent notification to PROVIDERS suggesting consideration of certain patient-specific treatment options along with medical literature addressing these treatment options
- Rewards or drawings for gifts based on activities related to online tools found on the CORPORATION'S website
- Rewards or drawings for gifts based on participation in initiatives and/or programs to reduce health care costs
- Periodic drawings for gifts, which may include club memberships and trips to special events, based on submitting information
- Charitable donations made on your behalf by the CORPORATION.

The PLAN or the CORPORATION may not provide some or all of these items directly, but may instead arrange these for your convenience. These discounts or promotional offers are outside the PLAN benefits. Neither the PLAN nor the CORPORATION 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 the CORPORATION is liable for third party providers' negligent provision of the gifts. The PLAN or the CORPORATION may stop or change these programs at any time.

Maternity Wellness Program

When you participate in the maternity wellness program, the PLAN will reimburse $100 of your maternity care expenses. MEMBERS are reimbursed upon completion of a pregnancy survey taken on the MyPregnancy App. To download the app, go to your app store and search for **My Pregnancy Blue Cross NC**. Use your Blue Cross NC subscriber ID to register. Access the Pregnancy Survey under Tools, then Surveys within the My Pregnancy app.

Health and Wellness Programs

The PLAN offers health and wellness programs at no additional cost to MEMBERS. These confidential programs can help MEMBERS improve their health and manage specific health care needs.

Programs provide educational materials, tools and other resources. These programs also offer benefits to MEMBERS with certain conditions. Programs include:

Nurse Support – provides support to MEMBERS with high-risk health conditions to better manage the daily challenges of those conditions. MEMBERS work one-on-one with a nurse by phone or digitally.

Maternity – provides support to MEMBERS 18 years of age and older who are currently pregnant and through six weeks after delivery. This program offers a free mobile application called My Pregnancy to track the pregnancy, learn helpful tips on staying healthy, store appointment information, and more. Women also have access to nurses by telephone for extra support.

Wellness – provides wellness programs on-line to help MEMBERS improve their health. This program includes a health assessment, virtual coaching programs, a personal health record, and a variety of tools, trackers, and newsletter articles.

Nurse Line – provides a toll-free number called Health Line Blue, that MEMBERS can call for help in making health care decisions. Highly trained registered nurses are available 24/7 to give MEMBERS with chronic and acute illnesses, injuries, and other health care issues advice on the best solution at the lowest cost.

Program information, including how to get started, are located on the website at **BlueCrossNC.com**. Programs are available at the discretion of your EMPLOYER.

Health Information Services

If you have certain health conditions, the CORPORATION or a representative of the CORPORATION 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.

These definitions will help you understand the PLAN. Please note that some of these terms may not apply to the PLAN.

ADAPTIVE BEHAVIOR TREATMENT
Behavioral and developmental interventions that systematically manage instructional and environmental factors or the consequences of behavior that have been shown to be clinically effective through research published in peer reviewed scientific journals and based upon randomized, quasi-experimental, or single subject designs. All services performed must be within the PROVIDER'S scope of license or certification to be eligible for reimbursement.

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

ALLOWED AMOUNT
The maximum amount that the CORPORATION determines is reasonable for COVERED SERVICES provided to a MEMBER. The allowed amount includes any CORPORATION payment to the PROVIDER, plus any deductible, coinsurance or copayment. For PROVIDERS that have entered into an agreement with the CORPORATION, the allowed amount is the negotiated amount that the PROVIDER has agreed to accept as payment in full. Except as otherwise specified in "EMERGENCY and Ambulance Services," for PROVIDERS that have not entered into an agreement with the CORPORATION, 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 the CORPORATION or through the BlueCard system that is applied to comparable PROVIDERS for similar services under a similar health benefit plan. Where the CORPORATION has not established an OUT-OF-NETWORK fee schedule amount for the billed service, the allowed amount will be the lesser of the PROVIDER'S billed charge or an amount established by the CORPORATION or through the BlueCard system using a methodology that is applied to comparable PROVIDERS who may have entered into an agreement with the CORPORATION for similar services under a similar health benefit plan. Other than as described above, the CORPORATION will not pay the OUT-OF-NETWORK PROVIDER'S billed charge unless doing so is required in order to comply with North Carolina Statutes. Calculation of the allowed amount is based on several factors including the CORPORATION'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 INFUSION SUITE
An Ambulatory Infusion Suite is a free-standing facility that solely provides infusion services under the supervision of a nurse or medical director.

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

ANCILLARY PROVIDER
Independent clinical laboratories, durable/home medical equipment and supply providers, or specialty pharmacies. Ancillary providers are considered IN-NETWORK if they contract directly with the Blue Cross or Blue Shield plan in the state where services are received, based on the following criteria:
a) For independent clinical laboratories, services are received in the state where the specimen is drawn
b) For durable/home equipment and supply PROVIDERS, services are received in the state where the equipment or supply is shipped (receiving address) or if purchased at a retail store the vendor must be contracted with the plan in the state where the retail store is located
c) For specialty pharmacies, services are received in the state where the ordering physician is located.

BENEFIT PERIOD
The period of time, as stated in the "Summary of Benefits" 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 dollar amount for COVERED SERVICES 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 the CORPORATION that an admission, availability of care, continued stay, or other services, supplies or drugs have been reviewed and, based on the information provided, satisfy the CORPORATION'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.

CORPORATION
Blue Cross NC.

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 the PLAN'S 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 the CORPORATION 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
A child until the end of the month of their 26th birthday, who is either: 1) the EMPLOYEE'S biological child, stepchild, legally adopted child (or child placed with the EMPLOYEE and/or spouse or same sex domestic partner for adoption),

FOSTER CHILD, or 2) a child for whom legal guardianship has been awarded to the EMPLOYEE and/or spouse, or same sex domestic partner, or 3) a child for whom the EMPLOYEE and/or spouse or same sex domestic partner has been court-ordered to provide coverage, or 4) a child with respect to whom permanent guardianship has been granted to you or your spouse in accordance with North Carolina law. They may be covered under the PLAN through the end of the month of their 26th birthday. A court order granting the permanent guardianship will be required as proof of guardianship. The spouse or children of a DEPENDENT CHILD are not considered DEPENDENTS.

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

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

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

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

EMERGENCY
A medical condition manifesting itself by acute symptoms of sufficient severity, including, but not limited to, severe pain, or by acute symptoms developing from a chronic medical condition that would lead a prudent layperson, possessing an average knowledge of health and medicine, to reasonably expect the absence of immediate medical attention to result in any of the following:
a) placing the health of an individual or with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy,
b) serious impairment to bodily functions,
c) serious dysfunction of any bodily organ or part.
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
An employer participating in the North Carolina Bankers Association Health Benefit Trust whose EMPLOYEES are eligible to participate in the PLAN.

ERISA
The Employee Retirement Income Security Act of 1974.

ESSENTIAL HEALTH BENEFITS
The core set of services as defined by federal law that includes the following ten categories: (1) ambulatory patient services, (2) EMERGENCY SERVICES, (3) hospitalization, (4) maternity and newborn care, (5) mental health and substance use disorder services, including behavioral health treatment, (6) PRESCRIPTION DRUGS, (7) REHABILITATIVE THERAPY and

HABILITATIVE SERVICES and devices, (8) laboratory services, (9) preventive and wellness services and chronic disease management, and (10) pediatric services, including oral and vision care. The PLAN may cover essential health benefits, in which case no annual or lifetime dollar limits can apply to these services.

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 court or administrative order 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.

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

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

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

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

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 the CORPORATION.

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

IDENTIFICATION CARD (ID CARD)
The card issued to MEMBERS upon enrollment which provides EMPLOYER/MEMBER identification numbers, names of the MEMBERS, and key benefit information, phone numbers and addresses.

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

INFERTILITY

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

IN-NETWORK
Designated as participating in the PPO network. The CORPORATION'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 PPO PROVIDER by the CORPORATION or a PROVIDER participating in the BlueCard Program. ANCILLARY PROVIDERS outside North Carolina are considered IN-NETWORK only if they contract directly with the Blue Cross or Blue Shield plan in the state where services are received, even if they participate in the BlueCard program.

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

a) Services or supplies requiring federal or other governmental body approval, such as drugs and devices that do not have unrestricted market approval from the U.S. Food and Drug Administration (FDA) or final approval from any other governmental regulatory body for use in treatment of a specified condition. Any approval that is granted as an interim step in the regulatory process is not a substitute for final or unrestricted market approval.
b) There is insufficient or inconclusive scientific evidence in peer-reviewed medical literature to permit the CORPORATION'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 the CORPORATION 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 the CORPORATION but are not determinative or conclusive.

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

LIFETIME MAXIMUM
The benefit maximum of certain COVERED SERVICES, such as INFERTILITY services, and orthotic devices for POSITIONAL PLAGIOCEPHALY, 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.

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, the CORPORATION 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, SUBSCRIBER 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, in accordance with North Carolina law, a mental condition, other than intellectual disability alone, that so impairs the DEPENDENT CHILD'S capacity to exercise age adequate self-control or judgment in the conduct of his/her activities and social relationships so that he/she is in need of treatment; and a mental disorder defined in the current edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, Washington, DC (DSM-IV). Those mental disorders coded in the DSM-V as autism spectrum disorder, substance-related disorders, SEXUAL DYSFUNCTION not due to organic disease, and those coded as "V" codes are not included in the definition of mental illness.

NONCERTIFICATION
An ADVERSE BENEFIT DETERMINATION by the CORPORATION that a service covered under the PLAN has been reviewed and does not meet the CORPORATION'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 the CORPORATION. All services performed must be within the scope of license or certification to be eligible for reimbursement.

OFFICE VISIT
Services provided in a PROVIDER'S office, including, but not limited to the following:

- Medical care
- SURGERY
- Diagnostic Services
- REHABILITATIVE THERAPY and HABILITATIVE SERVICES
- MEDICAL SUPPLIES
- Mental health and substance use disorder services (evaluation and diagnosis, group therapy, individual and family counseling).

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 the CORPORATION. Examples may include physician assistants (PAs), nurse practitioners (NPs), or certified registered nurse anesthetists (CRNAs). All services performed must be within the scope of license or certification to be eligible for reimbursement.

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

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

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

OUT-OF-NETWORK
Not designated as participating in the PPO network, and not certified in advance by the CORPORATION 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 PPO PROVIDER by the CORPORATION.

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.

PEAK FLOW METERS
Devices prescribed to patients with asthma, chronic obstructive pulmonary disease (COPD), and other respiratory diseases for monitoring the severity of their disease and their response to therapy at home.

PLAN
The North Carolina Bankers Association Health Benefit Trust.

PLAN ADMINISTRATOR
Community Bank Services, Inc. For purposes of ERISA, the plan administrator has the discretionary authority and responsibility to manage and direct the operation of the PLAN.

PLAN SPONSOR
North Carolina Bankers Association.

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

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

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

PRIMARY CARE PROVIDER (PCP)
An IN-NETWORK PROVIDER who has been designated by the CORPORATION as a PCP.

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

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

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

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

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

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

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

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

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

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

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

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

SPACERS
An inhaler spacer is a device that attaches to a metered dose inhaler (MDI) and holds the medication until it is breathed in.

SPECIALIST
A DOCTOR who is recognized by the CORPORATION as specializing in an area of medical practice.

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

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

SUBSCRIBER

The person who is eligible for coverage under the PLAN due to employment and who is enrolled for coverage.

SURGERY
The performance of generally accepted operative and cutting procedures including specialized instrumentations, endoscopic examinations and other invasive procedures, such as:
a) The correction of fractures and dislocations
b) Usual and related pre-operative and post-operative care
c) Other procedures as reasonable and approved by the CORPORATION.

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

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

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

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

MEMBER RIGHTS AND RESPONSIBILITIES

As a member of the North Carolina Bankers Association Health Benefit Trust, with a plan administered by the CORPORATION you have the right to:

- Receive, upon request, information about Blue Options including its services, DOCTORS, a benefit booklet, benefit summary and directory of IN-NETWORK PROVIDERS
- Receive courteous service from the CORPORATION
- Receive considerate and respectful care from your IN-NETWORK PROVIDERS
- Receive the reasons for the CORPORATION'S denial of a requested treatment or health care service, including (upon request) an explanation of the UTILIZATION MANAGEMENT criteria and treatment protocol used to reach the decision
- Receive (upon request) information on the procedure and medical criteria used by the CORPORATION to determine whether a procedure, treatment, facility, equipment, drug or device is INVESTIGATIONAL, EXPERIMENTAL or requires prior approval
- Receive accurate, reader-friendly information to help you make informed decisions about your health care
- Participate actively in all decisions related to your health care
- Discuss all treatment options candidly with your health care PROVIDER regardless of cost or benefit coverage
- Expect that measures will be taken to ensure the confidentiality of your health care information
- File a GRIEVANCE and expect a fair and efficient appeals process for resolving any differences you may have with the CORPORATION or the PLAN ADMINISTRATOR
- Be treated with respect and recognition of their dignity and right to privacy
- Voice complaints or appeals about the organization or the care it provides
- Make recommendations regarding the organization's members' rights and responsibilities policies

As a member of the North Carolina Bankers Association Health Benefit Trust, with a plan administered by he CORPORATION, you have the responsibility to:

- Present your ID CARD each time you receive services
- Give your DOCTOR permission to ask for medical records from other DOCTORS you have seen. You will be asked to sign a transfer of medical records authorization form
- Read your Blue Options benefit booklet and all other MEMBER materials
- Call Customer Service if you have a question or do not understand the material provided by the CORPORATION
- Follow the course of treatment prescribed by your DOCTOR. If you choose not to comply, tell your DOCTOR
- Provide complete information about any illness, accident or health care issues to the CORPORATION and providers
- Make and keep appointments for non-emergency medical care. If it is necessary to cancel an appointment, give the DOCTOR'S office adequate notice.
- Participate in understanding your health problems and the medical decisions regarding your health care
- Be considerate and courteous to Blue Options PROVIDERS, their staff and representatives of the PLAN and CORPORATION
- Notify the PLAN ADMINISTRATOR and the CORPORATION if you have any other group coverage
- Notify your PLAN ADMINISTRATOR of any changes regarding DEPENDENTS and marital status as soon as possible
- Protect your ID CARD from unauthorized use

NON-DISCRIMINATION AND ACCESSIBILITY NOTICE

Discrimination is Against the Law

- Blue Cross NC ("the CORPORATION") complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.
- The CORPORATION does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The corporation

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages
- If you need these services, contact Customer Service 1-888-206-4697, TTY and TDD, call 1-800-442-7028.
- If you believe that the CORPORATION has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

    Blue Cross NC, PO Box 2291, Durham, NC 27702, Attention: Civil Rights Coordinator- Privacy, Ethics & Corporate Policy Office, Telephone 919-765-1663, Fax 919-287-5613, TTY 1-888-291-1783 civilrightscoordinator@bcbsnc.com

- You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Civil Rights Coordinator- Privacy, Ethics & Corporate Policy Office is available to help you.
- You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
- This Notice and/or attachments may have important information about your application or coverage through the corporation. Look for key dates. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call Customer Service 1-877-275-9787.

BlueCross BlueShield of North Carolina

ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call 1-888-206-4697 (TTY: 1-800-442-7028).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-206-4697 (TTY: 1-800-442-7028).

注意：如果您講廣東話或普通話， 您可以免費獲得語言援助服務。請致電 1-888-206-4697 (TTY :1-800-442-7028）。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-206-4697 (TTY: 1-800-442-7028).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-206-4697 (TTY: 1- 800-442-7028)번으로 전화해 주십시오.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-206-4697 (ATS : 1-800-442-7028).

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-206-4697. المبرقة الكاتبة: 1-800-442-7028.

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-888-206-4697 (TTY: 1-800-442-7028).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-206-4697 (телетайп: 1-800-442-7028).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-206-4697 (TTY: 1-800-442-7028).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-888-206-4697 (TTY: 1-800-442-7028).

ចំណាំ៖ ប្រសិនបើលោកអ្នកនិយាយជាភាសាខ្មែរ សេវាកម្មជំនួយផ្នែកភាសាមានផ្តល់ជូនសម្រាប់លោកអ្នកដោយមិនគិតថ្លៃ។ សូមទំនាក់ទំនងតាមរយៈលេខ៖ 1-888-206-4697 (TTY: 1-800-442-7028)។

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-206-4697 (TTY: 1-800-442-7028).

ध्यान दें: यदि आप हिन्दी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-888-206-4697 (TTY: 1-800-442-7028) पर कॉल करें।

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-888-206-4697 (TTY: 1-800-442-7028).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-206-4697 （TTY: 1-800-442-7028）まで、お電話にてご連絡ください。

v. 10/16

SUMMARY PLAN DESCRIPTION OF HEALTH CARE BENEFITS

Summary Plan Description

The following information, together with the information contained in the benefit booklet furnished to EMPLOYEES by the PLAN ADMINISTRATOR, is intended to furnish 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 501 - North Carolina Bankers Association Health Benefit Trust

Name, Address and Telephone Number of PLAN SPONSOR
North Carolina Bankers Association
P.O. Box 19999
Raleigh, NC 27619-9916
919-781-7979

Other Employers Adopting the PLAN(S)
None

EMPLOYER Identification Number of PLAN SPONSOR
56-1268430

Identification of PLAN ADMINISTRATOR
Community Bank Services
PO Box 19999
Raleigh, NC 27619-9916

Benefits Provided by PLAN(S)
Medical Plan - The specific coverages provided by the PLAN are set forth in your benefit booklet.

Type of PLAN Administration
The general administration of the PLAN is provided by the PLAN SPONSOR under the Policy issued to the PLAN SPONSOR by Blue Cross and Blue Shield of North Carolina.

Contributions to the Cost of the PLAN(S)
The cost of the medical plan is paid by the EMPLOYER and the EMPLOYEES.

Financial Records
The financial records of the PLAN(S) are kept on a Plan Year basis. Each PLAN Year ends May 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.

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 PLAN 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 your 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.

NOTICE REGARDING HEALTH BENEFIT PREMIUMS/CONTRIBUTIONS

UNDER NORTH CAROLINA GENERAL STATUTE SECTION 58-50-40, NO PERSON, EMPLOYER, PRINCIPAL, AGENT, TRUSTEE, OR THIRD PARTY ADMINISTRATOR, WHO IS RESPONSIBLE FOR THE PAYMENT OF GROUP HEALTH OR LIFE INSURANCE OR GROUP HEALTH PLAN PREMIUMS, SHALL: (1) CAUSE THE CANCELLATION OR NONRENEWAL OF GROUP HEALTH OR LIFE INSURANCE, HOSPITAL, MEDICAL, OR DENTAL SERVICE CORPORATION PLAN, MULTIPLE EMPLOYER WELFARE ARRANGEMENT, OR GROUP HEALTH PLAN COVERAGES AND THE CONSEQUENTIAL LOSS OF THE COVERAGES OF THE PERSONS INSURED, BY WILLFULLY FAILING TO PAY THOSE PREMIUMS IN ACCORDANCE WITH THE TERMS OF THE INSURANCE OR PLAN CONTRACT, AND (2) WILLFULLY FAIL TO DELIVER, AT LEAST 45 DAYS BEFORE THE TERMINATION OF THOSE COVERAGES, TO ALL PERSONS COVERED BY THE GROUP POLICY A WRITTEN NOTICE OF THE PERSON'S INTENTION TO STOP PAYMENT OF PREMIUMS. THIS WRITTEN NOTICE MUST ALSO CONTAIN A NOTICE TO ALL PERSONS COVERED BY THE GROUP POLICY OF THEIR RIGHTS TO HEALTH INSURANCE CONVERSION POLICIES UNDER ARTICLE 53 OF CHAPTER 58 OF THE GENERAL STATUTES AND THEIR RIGHTS TO PURCHASE INDIVIDUAL POLICIES UNDER THE FEDERAL HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT AND UNDER ARTICLE 68 OF CHAPTER 58 OF THE GENERAL STATUTES. VIOLATION OF THIS LAW IS A FELONY. ANY PERSON VIOLATING THIS LAW IS ALSO SUBJECT TO A COURT ORDER REQUIRING THE PERSON TO COMPENSATE PERSONS INSURED FOR EXPENSES OR LOSSES INCURRED AS A RESULT OF THE TERMINATION OF THE INSURANCE.

NOTICE OF PRIVACY PRACTICES

The North Carolina Bankers Association Health Benefit Trust

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

Effective Date of this Notice: February 17, 2010

The North Carolina Bankers Association Health Benefit Trust (the "Plan") is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

- the Plan's uses and disclosures of Protected Health Information (PHI);
- your privacy rights with respect to your PHI;
- the Plan's duties with respect to your PHI;
- your right to file a complaint with the Plan and to the Secretary of the U.S. Department of Health and Human Services; and
- the person or office to contact for further information about the Plan's privacy practices.

The term "Protected Health Information" (PHI) includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form (oral, written, electronic). In other words, it is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We recognize that this Notice is long. However, the law requires us to include many specific things in this Notice.

Section 1. Notice of PHI Uses and Disclosures

The Plan may use and disclose PHI as permitted by federal and state privacy rules found in both statutes and regulations. The federal privacy rules are known as "HIPAA" (Health Insurance Portability and Accountability Act). HIPAA governs privacy matters relating to the privacy of health information concerning individuals in most instances. However, in some circumstances, North Carolina laws and regulations provide even greater privacy protections. For example, North Carolina law provides greater protection to certain information concerning mental health, substance abuse and/or chemical dependency, and HIV and AIDS matters. Where North Carolina law provides greater privacy protections, the Plan will comply with the stricter North Carolina laws.

Required PHI Uses and Disclosures

Upon your request, the Plan is required to give you access to certain PHI in order to inspect and copy it. Use and disclosure of your PHI may be required by the Secretary of the Department of and Human Services to investigate or determine the Plan's compliance with the privacy regulations.

Uses and disclosures to carry out treatment, payment and health care operations

The Plan will use PHI without your consent, authorization, or opportunity to agree or object to carry out treatment, payment and health care operations. The Plan also will disclose PHI to the North Carolina Bankers Association (the "Plan Sponsor") for purposes related to treatment, payment and health care operations. The Plan documents have been amended to protect your PHI as required by federal law.

The Plan may contract with individuals and entities known as business associates to perform various functions on behalf of the Plan. Business associates may create, maintain, use or disclose PHI in the performance of those functions. Before PHI will be disclosed to business associates, they will be required to agree in writing to comply with the privacy rules.

The Plan may also disclose PHI relating to a bank's employees to a bank which participates in the Plan to carry out treatment, payment and health care operations. However, before such a disclosure will be made, the bank will be required to certify that it is fully compliant with the HIPAA privacy regulations and has amended its plan documents to protect your PHI as required by federal law.

Treatment is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers.

For example, the Plan may disclose to a treating orthodontist the name of your treating dentist so that the orthodontist may ask for your dental X-rays from the treating dentist.

Payment includes but is not limited to actions to make coverage determinations and payment (including billing, claims management, subrogation, plan reimbursement, reviews for medical necessity and appropriateness of case and utilization review and preauthorizations).

For example, the Plan may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan.

Health care operations include but are not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities.

For example, the Plan may use information about your claims to refer you to a disease management program, project future benefit costs or audit the accuracy of its claims processing functions.

Uses and disclosures that require your written authorization
Your written authorization generally will be obtained before the Plan will use or disclose psychotherapy notes about you from your psychotherapist. Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session.

They do not include summary information about your mental health treatment. The Plan may use and disclose such notes when needed by the Plan to defend against litigation filed by you.

Uses and disclosures that require you be given an opportunity to agree or disagree prior to the use or release
Disclosure of your PHI to family members, other relatives and your close personal friends is allowed if

- the information is directly relevant to the family or friend's involvement with your care or payment for that care; and
- you have either agreed to the disclosure or have been given an opportunity to object and have not objected.

Uses and disclosures for which consent, authorization, or opportunity to object is not required
Use and disclosure of your PHI is allowed without your consent, authorization or request under the following circumstances:
(1) When required by law.
(2) When permitted for purposes of public health activities, including when necessary to report product defects, to permit product recalls and to conduct post-marketing surveillance. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.
(3) When authorized by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's PHI.
(4) The Plan may disclose your PHI to a public health oversight agency for oversight activities authorized by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).
(5) The Plan may disclose your PHI when required for judicial or administrative proceedings.

For example, your PHI may be disclosed in response to a subpoena or discovery request provided certain conditions are met. One of those conditions is that satisfactory assurances must be given to the Plan that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or were resolved in favor of disclosure by the court or tribunal.

(6) When required for law enforcement purposes (for example, to report certain types of wounds).

(7) For law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. Also, when disclosing information about an individual who is or is suspected to be a victim of a crime but only if the individual agrees to the disclosure or the covered entity is unable to obtain the individual's agreement because of emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to
obtain the individual's agreement and disclosure is in the best interest of the individual as determined by the exercise of the Plan's best judgment.

(8) When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.

(9) The Plan may use or disclose PHI for research, subject to conditions.

(10) When consistent with applicable law and standards of ethical conduct if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

(11) When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

Except as otherwise indicated in this notice, uses and disclosures will be made only with your written authorization subject to your right to revoke such authorization.

Section 2. Rights of Individuals

Right to Request Restrictions on PHI Uses and Disclosures
You may request the Plan to restrict uses and disclosures of your PHI to carry out treatment, payment or health care operations, or to restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the Plan is not required to agree to your request *in all cases.* The Plan must agree to any requested restriction, except as otherwise required by law, that concerns disclosures made to a health plan for purposes of carrying out payment of health care operations (and not for the purposes of carrying out treatment) and the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid by you, out of pocket in full.

You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI. Such requests should be made to the following officer: HIPAA Contact Person, Community Bank Services, 3601 Haworth Dr., Raleigh, North Carolina 27609, 1-800-662-7044.

Right to Inspect and Copy PHI
You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Plan maintains the PHI.

"Protected Health Information" (PHI) includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form.

"*Designated Record Set"*" includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the covered entity to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.

You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. Requests for access to PHI should be made to the following officer: HIPAA Contact Person, Community Bank Services, 3601 Haworth Dr., Raleigh, North Carolina 27609, 1-800-662-7044.

In some cases, you will have a right to obtain a copy of such information in an electronic format, and, if you choose, to direct transmittal of such copy directly to an entity or person designated by you.

If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

Right to Amend PHI
You have the right to request the Plan to amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set.

If the request is denied in whole or in part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

Requests for amendment of PHI in a designated record set should be made to the following officer: HIPAA Contact Person, Community Bank Services, 3601 Haworth Dr., Raleigh, North Carolina 27609, 1-800-662-7044. You or your personal representative will be required to complete a form to request amendment of the PHI in your designated record set.

The Right to Receive an Accounting of PHI Disclosures
At your request, the Plan will also provide you with an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request. However, such accounting need not include PHI disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own PHI; or (3) prior to the compliance date.

To the extent any electronic health records are maintained on you, you will have the right to request an accounting of disclosures of such electronic health records during the three-year period preceding the date of the request. Such accounting will not include (1) disclosures made to you; (2) disclosures made pursuant to your authorization; (3) disclosures made to friends or family in your presence or because of an emergency; (4) disclosures for national security purposes; and (5) disclosures incidental to otherwise permissible disclosures. Your right to this accounting will be available when required by law and no earlier that January 1, 2011.

If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

The Right to Receive a Paper Copy of This Notice Upon Request
To obtain a paper copy of this Notice contact the following officer: HIPAA Contact Person, Community Bank Services, 3601 Haworth Dr., Raleigh, North Carolina 27609, 1-800-662-7044.

A Note About Personal Representatives
You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- a power of attorney for health care purposes, notarized by a notary public;
- a court order of appointment of the person as the conservator or guardian of the individual; or
- an individual who is the parent of a minor child.

The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

Section 3. The Plan's Duties
The Plan is required by law to maintain the privacy of PHI and to provide individuals (participants and beneficiaries) with notice of its legal duties and privacy practices.

This notice is effective beginning April 14, 2003 and the Plan is required to comply with the terms of this notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan prior to that date.

If a privacy practice is changed, a revised version of this notice will be provided to all past and present participants and beneficiaries for whom the Plan still maintains PHI. The plan will mail the revised notice to each such person.

Any revised version of this notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, the individual's rights, the duties of the Plan or other privacy practices stated in this notice.

Minimum Necessary Standard
When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.
However, the minimum necessary standard will not apply in the following situations:

- disclosures to or requests by a health care provider for treatment;
- uses or disclosures made to the individual;
- disclosures made to the Secretary of the U.S. Department of Health and Human Services;
- uses or disclosures that are required by law; and
- uses or disclosures that are required for the Plan's compliance with legal regulations.

This notice does not apply to information that has been de-identified. De-identified information is information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual is not individually identifiable health information.

In addition, the Plan may use or disclose "summary health information" to the plan sponsor for obtaining premium bids or modifying, amending or terminating the group health plan, which summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan; and from which identifying information has been deleted in accordance with HIPAA.

Section 4. Your Right to File a Complaint With the Plan or the HHS Secretary
If you believe that your privacy rights have been violated, you may complain to the Plan in care of the following officers: HIPAA Privacy Officer or HIPAA Contact Person, Community Bank Services, 3601 Haworth Dr., Raleigh, North Carolina 27609, 1-800-662-7044, cbs@ncbankers.org.

You may file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, D.C. 20201.
The Plan will not retaliate against you for filing a complaint.

Section 5. How We Receive Information About You
During the normal operations of the Plan, the Plan may receive information about you from the following persons:

- you;
- your transactions with the Plan;
- insurance companies that provide you with current insurance or have provided coverage in the past;
- your employer (such as eligibility information you may have provided); and
- your health care providers.

Section 6. The Plan's Privacy Policies and Procedures
The Plan has established policies and procedures designed to protect the PHI it maintains about you. Those policies and procedures have been implemented to meet or exceed applicable laws. We have installed physical safeguards such as restricting access to PHI to personnel who have been trained on how to protect PHI, providing locked cabinets and doors, requiring computer passwords, and implementing specific rules concerning mail, telephone, fax, voicemail and electronic mail procedures. We require personnel who have access to PHI to sign confidentiality agreements. We require business associates to agree to privacy restrictions before we disclose PHI to them. We will only use your PHI for Plan purposes permitted under applicable law.

Section 7. Whom to Contact at the Plan for More Information
If you have any questions regarding this notice or the subjects addressed in it, you may contact the following officer: HIPAA Contact Person, Community Bank Services, 3601 Haworth Dr., Raleigh, North Carolina 27609, 1-800-662-7044, cbs@ncbankers.org.

Conclusion

PHI use and disclosure by the Plan is regulated by the federal law known as HIPAA and corresponding regulations. You may find the regulations at 45 *Code of Federal Regulations* Parts 160 and 164. This notice attempts to summarize the regulations. The regulations will supersede any discrepancy between the information in this notice and the regulations.

NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

Beginning in 2014, there is a new way to buy health insurance: the **Health Insurance Marketplace**. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace**The CORPORATION does not administer these prescription drug benefits referenced in the schedule below. These benefits are separate from this PLAN.**

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away.

The 2017 open enrollment period for health insurance coverage through the Marketplace will run from Nov. 1, 2016, through Jan. 31, 2017. Individuals must have enrolled or changed plans prior to Dec. 15, 2016, for coverage starting as early as Jan. 1, 2017. After Jan. 31, 2017, you can get coverage through the Marketplace for 2017 only if you qualify for a special enrollment period or are applying for Medicaid or the Children’s Health Insurance Program (CHIP).

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards.

If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5 percent (as adjusted each year after 2014) of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. (An employer-sponsored health plan meets the “minimum value standard” if the plan’s share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.)

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution—as well as your employee contribution to employer-offered coverage —is often excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact your Human Resources Department.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, as well as an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PHARMACY SCHEDULE OF BENEFITS AND INFORMATION

The CORPORATION does not administer these prescription drug benefits referenced in the schedule below. These benefits are separate from this plan.

SCHEDULE OF PRESCRIPTION DRUG BENEFITS
Prescription Drug Card Program
Administered by Express Scripts, Inc.
1-800-892-5143
HDHP Plans 3250 and 5250

	In-Network	Out-of-Network
Retail: Your coinsurance amount • Generic • Preferred Brand • Non-Preferred Brand	Up to a 30 day supply or 90 days for maintenance medications, after deductible is met • 0% (100% covered by the plan) • 0% (100% covered by the plan) • 0% (100% covered by the plan)	Up to a 30 day supply or 90 days for maintenance medications, after deductible is met Coinsurance + charge over IN-NETWORK ALLOWED AMOUNT
Mail Order: Your coinsurance amount	Up to a 90 day supply for maintenance – after deductible is met • 0% (100% covered by the plan)	Up to a 90 day supply – after deductible is met Coinsurance + charge over IN-NETWORK ALLOWED AMOUNT
Specialty: Your coinsurance amount • Generic • Preferred Brand • Non-Preferred Brand	Up to a 30 day supply– after deductible is met • 0% (100% covered by the plan)	Up to a 30 day supply– after deductible is met Coinsurance + charge over IN-NETWORK ALLOWED AMOUNT
Diabetic Supplies	• after deductible is met, 0%	• after deductible is met, 0%
Certain preventive medications and prescription contraceptive drugs and devices - Your coinsurance amount	• 0% (100% covered by the plan)	Coinsurance + charge over IN-NETWORK ALLOWED AMOUNT
Copayments and coinsurance for the Prescription Drug Card Program accumulate toward the total *out-of-pocket expense.*		

The *Plan's* Prescription Drug Card Program is administered by Express Scripts using the National Preferred formulary. The formulary is subject to change on an annual basis beginning January 1st of each year. Express Scripts has a national network of pharmacies which can identify *covered persons* and the *Plan's* coverage provisions. To find out which pharmacies participate or to inquire about specific coverage for prescription *drugs*, visit Express Scripts at www.express-scripts.com or call 1-800-892-5143.

PHARMACY SCHEDULE OF BENEFITS AND INFORMATION

Benefits are provided for the purchase of *drugs* through the *Plan's* Prescription Drug Card Program. The *covered person* must purchase the prescription *drugs* through the Prescription Drug Card Program, and use either a participating pharmacy, the mail order option or a specialty pharmacy.

Certain prescription medications may be subject to step therapy, quantity limitations, dosage optimization, prior authorization or specialty pharmacy. Contact Express Scripts for more information.

Please contact Express Scripts for the list of covered preventive drugs and contraceptive drugs and devices.

Important Note: This information is provided only as a guideline of services under the prescription drug card program through Express Scripts. Express Scripts will be able to assist the *covered person* in determining benefits, limitations and exclusions relative to the prescription drug card program.

Prescription Drugs Administered by Express Scripts

DEFINITIONS

Generic Drug means a Prescription Drug that has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a Generic Drug any Food and Drug Administration-approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Generics Mandatory – (DAW 1 & 2) – Whenever there is a generic alternative for the prescription drug, the member must choose the generic prescription, even if the Physician has prescribed a brand name drug. If the Covered Person chooses a brand name drug instead of a generic, the Covered Person must pay the difference in the cost between the generic and the brand name medication, plus the applicable brand name copayment amount.

Non-Participating Pharmacy means any retail or mail order pharmacy that is not contracted by the Pharmacy Benefits Administrator and is excluded from the network of pharmacies.

Participating Pharmacy means any retail or mail order pharmacy that is contracted by Pharmacy Benefits Administrator to be included in a network of pharmacies at a contracted amount.

Pharmacy means a licensed establishment where Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where the pharmacist practices.

Pharmacy Benefits Administrator is an organization that manages payment for Prescriptions and services under the Plan.

Preferred Brand means a list of carefully selected medications that can assist in maintaining quality care for patients while helping to reduce the cost of Prescription Drug benefits under the Plan.

Prescription Drug means any drug that under Federal Drug Administration (FDA) or state law requires a written Prescription by a Physician or dentist or any other health care provider licensed to write Prescriptions by state law. Drugs that are available without a Prescription are considered non-legend drugs.

Drugs and medicines prescribed by a licensed Physician and dispensed by a licensed pharmacist are covered by the Plan, except as otherwise provided by the Plan. Outpatient Prescription Drugs will be covered subject to the applicable Deductible, Co-pay amounts, benefit percentages, and any limitations as stated in the Schedule of Benefits.
A covered drug must be approved for use by the Food and Drug Administration for the purpose for which it is prescribed and dispensed by a licensed pharmacist or Physician.

Prior Authorization – Certain drugs require approval before the drug can be dispensed. A current list of drugs that require prior authorization can be obtained by contacting Express Scripts at the number listed on your identification card.

Specialty Pharmacy Program means a program that has been determined by the Pharmacy Benefits Administrator to require reimbursement only through the approved specialty pharmacy vendor(s) at the "specialty pharmacy program" level of benefits as indicated.

Supply Limits - Supply is limited to 30 days (or 90 days for maintenance medications) for PBM Network Prescriptions and Member Submit, or a 90-day supply for Mail Order Prescriptions.
Prescription drug refills are not allowed until 75% of the prescribed day supply is used.
The amount of certain medications are limited to promote safe, clinically appropriate drug usage. If you have exceeded a limit and your physician believes you need an additional supply of a medication, it will be reviewed for medical necessity. A current list of applicable limits can be obtained by contacting Express Scripts at the number listed on your identification card.

Note: FDA approval of a drug does not guarantee inclusion as a covered item under the Prescription Drug program. In addition, the level of coverage for some Prescriptions may vary depending on the medication's therapeutic classification. As a result, some medications (including, but not limited to, newly approved Prescriptions) may be subject to quantity limits or may require prior authorization before being dispensed.

For a specific up-to-date list of covered and/or excluded Prescription Drugs, contact Express Scripts.

EXCLUSIONS

The Plan will not cover the following drugs, even when prescribed by the covered person's physician. This list is **not** all-inclusive:

- Applicable exclusions listed under General Exclusions section of this SPD.
- Prescription products if a prior authorization was necessary but not received or denied.
- Prescription products that are available over-the-counter, except as specifically covered under preventive drugs.
- Prescription products that do not have Food and Drug Administration (FDA) approval for the purpose for which prescribed.
- All illegal drugs or supplies, even if prescribed by a duly licensed individual.
- Prescriptions that are in excess of the number of refills specified or dispensed more than one year after the order was written.
- Prescriptions which a Covered Person is entitled to receive without charge from any Workers' Compensation law, or any municipal, state or Federal program.
- Drugs which are not medically necessary for the treatment of an illness, injury or pregnancy.
- Prescriptions for cosmetic only indications, including but not limited to, photo –aged skin products (Renova), hair growth agents (Propecia, Vaniqua), injectable cosmetics (Botox), and depigmentation products used for skin conditions requiring a bleaching agent.
- Non-legend drugs, other than insulin.
- Experimental or investigational drugs.
- Therapeutic devices or appliances, support garments, and other non-medical substances.

The Covered Person has a right to purchase an excluded product at his or her own cost if the product is excluded under this Plan.
This Plan does not coordinate Prescription benefits.

For any Prescription Drug questions, please contact Express Scripts at the following:

Express Scripts
One Express Scripts Way
St Louis MO 63121
(800) 892-5143

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

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

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

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

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2020. Contact your State for more information on eligibility –

ALABAMA – Medicaid	COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711
ALASKA – Medicaid	**FLORIDA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ARKANSAS – Medicaid	**GEORGIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
CALIFORNIA – Medicaid	**INDIANA – Medicaid**
Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 1-800-541-5555	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864

IOWA – Medicaid and CHIP (Hawki)	MONTANA – Medicaid
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KANSAS – Medicaid	**NEBRASKA – Medicaid**
Website: http://www.kdheks.gov/hcf/default.htm Phone: 1-800-792-4884	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
KENTUCKY – Medicaid	**NEVADA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
LOUISIANA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
MAINE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/medical-assistance.jsp [Under ELIGIBILITY tab, see "what if I have other health insurance?"] Phone: 1-800-657-3739	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP	UTAH – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
OREGON – Medicaid	**VERMONT– Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
RHODE ISLAND – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA - Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2020, or for more information on special enrollment rights, contact either:

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

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this

collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

MEMBER'S AUTHORIZATION REQUEST FORM

You may give the North Carolina Bankers Association Health Benefit Trust (NCBAHBT) and its administrator 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 NCBAHBT and BCBSNC communicates with members or subscribers. For example, explanation of benefits (EOB) will continue to be sent statements to the subscriber**.

Member's Name _____Subscriber's Name (if different)_____Member's Date of Birth __/__/__

Subscriber ID Number _____ Group Number (from ID card, if applicable): _____

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

_____

(Name) (Address) (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) your address.

I authorize BCBSNC to disclose the following PHI to the person/entity listed above. Check all that apply:

☐ Any information requested ☐ Enrollment information ☐ Benefit information ☐ Premium payment information

☐ All claims information ☐ Explanation of Benefits (EOB) information

☐ All services from a specific health care provider (List provider's name): _____

☐ Other (Please list specific PHI): _____

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

I would like this authorization to expire on (enter date): _____/_____/____ **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 of my written notice of revocation.

I also understand that BCBSNC will not condition the provision of health plan benefits taken is not conditioned 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 Date

If signed by a personal representative, print your full name: _____

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

_____.

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

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 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: _____/_____/____.

RETURN THIS AUTHORIZATION TO: **Commercial Operations / IDC**
Blue Cross-and Blue Shield of North Carolina
P.O. Box 2291
Durham, NC 27702

North Carolina Bankers Association Plan 5250
HDHP 06/01/21

BlueOPTIONS℠

North Carolina Bankers Association Health Benefit Trust

Benefits Effective Date: June 1, 2021

Administered by: BlueCross BlueShield of North Carolina

An Independent Licensee of the Blue Cross and Blue Shield Association