Benefit Booklet

For Employees of Asahi KASEI America, Inc.

for

Blue Options®

Enhanced PPO Copay Plan

BlueCross BlueShield of North Carolina

An Independent Licensee of the Blue Cross and Blue Shield Association

BENEFIT BOOKLET

This benefit booklet describes the Asahi Kasei Health and Welfare Plan (the PLAN). Blue Cross and Blue Shield of North Carolina provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Please read this benefit booklet carefully.

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

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

Amendment and/or Termination of the PLAN

The PLAN SPONSOR expects this PLAN to be continued indefinitely, but the PLAN SPONSOR reserves the right to terminate the PLAN at any time with respect to its EMPLOYEES by a written instrument signed by an officer of the PLAN SPONSOR. Such termination may be made without the consent of the MEMBERS, or any other persons. The PLAN SPONSOR also reserves the right to amend the PLAN, including reduction or elimination of benefits or COVERED SERVICES. Amendments shall be made only in accordance with the provisions of the PLAN. The PLAN ADMINISTRATOR will provide notice to MEMBERS within sixty days of the adoption of any amendment that results in a material reduction in COVERED SERVICES or benefits.

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

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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.

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GETTING STARTED WITH BLUE OPTIONS

IMPORTANT INFORMATION REGARDING THE PLAN:

In accordance with applicable federal law, the PLAN 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 PLAN 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 us 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.

This Booklet

This booklet tells you about:

- Your COVERED SERVICES and exclusions or services that are not covered
- How the PLAN works
- How we share expenses for COVERED SERVICES
- Who is eligible to be covered under the PLAN and when this coverage starts and ends
- Our 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. 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 **www.BlueCrossNC.com** for the PRIOR REVIEW list, which is updated when new services are added or when services are removed. You can also call Blue Cross NC 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. Blue Cross NC will not recognize any such assignment, and any attempted assignment is void if performed without Blue Cross NC's prior written consent. PROVIDERS are not considered beneficiaries under the PLAN and do not have standing to sue under ERISA. Blue Cross NC may pay a PROVIDER directly. For example, Blue Cross NC pays IN-NETWORK PROVIDERS directly under applicable contracts with those PROVIDERS. However, any PROVIDER'S right to be paid directly is through such contract with Blue Cross NC, and not through the PLAN. Under the PLAN, Blue Cross NC has the sole right to determine whether payment for services is made to the PROVIDER, to the SUBSCRIBER, or allocated among both. Blue Cross NC's decision to pay a PROVIDER directly in no way reflects or creates any rights of the PROVIDER under the PLAN, including but not limited to benefits, payments or procedures. 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 Blue Cross NC 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 **www.BlueCrossNC.com/providers/medical-policies-and-coverage/search-medical-policy**, or call Blue Cross NC 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, therapies, or PRESCRIPTION DRUGS in connection with programs designed to reduce medical costs, or to encourage

MEMBERS to seek appropriate, high quality, efficient care based on Blue Cross NC 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:"

Copayment	The fixed dollar amount you must pay for some COVERED SERVICES at the time you receive them. Copayments are not credited to the deductible; however, they are credited to the OUT-OF-POCKET LIMIT.
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	Your share of the cost of a covered health service, after you have met your BENEFIT PERIOD deductible. This is stated as a percentage of the ALLOWED AMOUNT. The coinsurance listed is your share of the cost of a COVERED SERVICE.
OUT-OF-POCKET LIMIT	The OUT-OF-POCKET LIMIT is the dollar amount you pay for COVERED SERVICES in a BENEFIT PERIOD before the PLAN pays 100% for COVERED SERVICES in a BENEFIT PERIOD. The OUT-OF-POCKET LIMIT includes your deductible, coinsurance, and copayments. It does not include charges over the ALLOWED AMOUNT, including any charges over the allowable cost difference between GENERIC and BRAND-NAME drugs, premiums, and charges for noncovered services.

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

Here is an **example** of what your costs could be for IN-NETWORK or OUT-OF-NETWORK services. The scenario is a total outpatient hospital bill of $5,000.

	IN-NETWORK	OUT-OF-NETWORK
A. Total Bill	$5,000	$5,000
B. ALLOWED AMOUNT	$4,250	$4,250

	IN-NETWORK	OUT-OF-NETWORK
C. Deductible Amount	$2,000	$4,000
D. ALLOWED AMOUNT Minus Deductible (B-C)	$2,250	$250
E. Your Coinsurance Amount (x% times D)	(20% x $2,250) = $450	(40% x $250) = $100
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)	$2,450	$4,850

Deductible and coinsurance amounts are for example only. See the "Summary of Benefits" for your benefits.

For Help in Reading this Benefit Booklet

Blue Cross NC provides consumer assistance tools and services for individuals living with disabilities (including accessible websites and the provision of auxiliary aids and services at no cost to the individual) in accordance with the Americans with Disabilities Act and section 504 of the Rehabilitation Act. Blue Cross NC also provides language services at no cost to the individual, including oral interpretation and written translations. To access these services and more, call Blue Cross NC Customer Service at the number listed in "Who to Contact?".

WHO TO CONTACT?

Toll-Free Phone Numbers, Website and Addresses

Blue Cross NC Website: **www.BlueCrossNC.com**	Find IN-NETWORK PROVIDERS (including pharmacies), and get information about top-performing facilities, PRESCRIPTION DRUG information, and news about Blue Cross NC.
Blue Connect Website: **www.BlueConnectNC.com**	Use our secure MEMBER 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.
Blue Cross NC Customer Service: 1-877-275-9787 TTY/TDD: 711	For questions about your benefits, claims, new ID CARD requests or to voice a complaint.
PRESCRIPTION DRUG Information: 1-877-275-9787 and **www.BlueCrossNC.com/umdrug**	You may visit Blue Cross NC's website or call Blue Cross NC Customer Service to access a list of IN-NETWORK pharmacies (including the Specialty Network); a list of PRESCRIPTION DRUGS that are subject to PRIOR REVIEW, quantity or benefit limitations; or a copy of the FORMULARY. You may also visit **www.BlueCrossNC.com/umdrug** for more information.
PRIOR REVIEW and CERTIFICATION: To request, MEMBERS call: 1-877-275-9787 PROVIDERS call: 1-800-672-7897	Some services need PRIOR REVIEW and CERTIFICATION from Blue Cross NC. Up-to-date information about which services may need PRIOR REVIEW can be found online at **www.BlueConnectNC.com.**
Behavioral Health: 1-800-359-2422	For questions about your mental health and substance use disorder benefits and claims.
Out of North Carolina Care: 1-800-810-BLUE (2583)	For help in obtaining care outside of North Carolina or the U.S., call this number or visit **www.bcbs.com.**
Care Management Nurse Support: 1-800-218-5295	Care management (case management as well as disease management) encourages MEMBERS with complicated or chronic medical needs, their PROVIDERS, and Blue Cross NC to work together to meet the individual's health needs and promote quality outcomes. Talk to a Nurse Advocate about available resources to help you manage your health and well-being.

My Pregnancy: **www.BCBSNC.com/mypregnancy**	The maternity program will provide you with support for managing your pregnancy.
Teladoc Telehealth: (855) 549-2214 and **www.Teladoc.com**	Teladoc Telehealth provides 24/7 access to DOCTORS who can diagnose and treat for conditions related to primary care, acute care, mental health teletherapy, dermatology and nutritional counseling. Please contact your PLAN ADMINISTRATOR to see which of these benefits are available to you.
Medical Claims Filing: Blue Cross NC Claims Department PO Box 35 Durham, NC 27702-0035	Mail completed medical claims to this address.
PRESCRIPTION DRUG Claims Filing: Prime Therapeutics Mail Route: Commercial Blue Cross NC PO Box 25136 Lehigh Valley, PA 18002-5136	Mail completed PRESCRIPTION DRUG claims to this address.
COBRA Administrator Flores & Associates (800) 532-3327	For questions about your COBRA benefits or eligibility for COBRA, please contact the PLAN ADMINISTRATOR.

Please note: By sharing your phone number, you agree to calls or text messages from Blue Cross NC or its partners. Calls could include prerecorded, or robot voiced calls.

Value-Added Programs

Not all plans have these Value-Added programs. These programs are not covered benefits and are outside of the PLAN. To see if these programs are available, talk to your PLAN ADMINISTRATOR. Blue Cross NC does not accept claims or reimburse for these goods or services and MEMBERS are responsible for paying all bills. The PLAN ADMINISTRATOR and Blue Cross NC 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 Blue Cross NC offers Blue365™. It's a simple way to save on everything you need for a well-balanced lifestyle.

Get deals, discounts & more:

- Fitness: Gym memberships & fitness gear

WHO TO CONTACT? *(cont.)*

- Personal Care: Vision & hearing care
- Healthy Eating: Weight loss & nutrition programs
- Lifestyle: Travel & family activities
- Wellness: Mind/body wellness tools & resources
- Financial Health: Financial tools & programs

Join and save

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

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

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:

- 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 for those services
- 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.
- To receive IN-NETWORK benefits, you must receive care from a Blue Options IN-NETWORK PROVIDER. However, in an EMERGENCY, you may receive care from an IN-NETWORK or OUT-OF-NETWORK PROVIDER. Please see "EMERGENCY and Ambulance Services" in "COVERED SERVICES" for additional information on EMERGENCY care.

Please Note: The list of IN-NETWORK PROVIDERS may change from time to time, so please verify that the PROVIDER is still in the Blue Options network before receiving care. Find a PROVIDER on Blue Cross NC's website at **www.BlueCrossNC.com** or call Blue Cross NC Customer Service at the number listed on your ID CARD or in "Who to Contact?"

BENEFIT PERIOD—01/01/2026 through 12/31/2026

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

Benefits	IN-NETWORK	OUT-OF-NETWORK
Deductibles, OUT-OF-POCKET LIMITS and Benefit Maximums		
The following deductibles and maximums apply as indicated to the services listed below in the "Summary of Benefits."		
Deductible		
Individual-only Coverage		
Individual, per BENEFIT PERIOD	$100	$250
Family Coverage		
Family MEMBER, per BENEFIT PERIOD	$100	$250
Family, per BENEFIT PERIOD	$200	$500
The PLAN has an embedded deductible, which is determined by your type of coverage. The individual deductible applies if you select individual-only coverage, otherwise, the family MEMBER and family deductible apply. For family coverage, each covered family MEMBER has their own family member deductible, as well as a family deductible. No single family MEMBER can contribute more than the family MEMBER deductible. If a covered family MEMBER meets their family MEMBER deductible, benefits are payable by Blue Cross NC for just that MEMBER. Once the family deductible is met, it is met for all covered family MEMBERS. Amounts applied to your OUT-OF-NETWORK deductible are credited to your IN-NETWORK deductible. Amounts applied to your IN-NETWORK deductible are credited to your OUT-OF-NETWORK deductible.		
OUT-OF-POCKET LIMIT		
Individual-only Coverage		
Individual, per BENEFIT PERIOD	$500	$1,500
Family Coverage		
Family MEMBER, per BENEFIT PERIOD	$500	$1,500
Family, per BENEFIT PERIOD	$1,000	$3,000
The PLAN has an embedded OUT-OF-POCKET LIMIT, which is determined by your type of coverage. The individual OUT-OF-POCKET LIMIT applies only if you selected individual-only coverage, otherwise, the family MEMBER and family OUT-OF-POCKET LIMIT apply. No single family MEMBER can contribute more than their family MEMBER OUT-OF-POCKET LIMIT. If a		

Benefits	IN-NETWORK	OUT-OF-NETWORK
covered family MEMBER meets their family MEMBER OUT-OF-POCKET LIMIT, Blue Cross NC will pay 100% of COVERED SERVICES, up to the ALLOWED AMOUNT, for just that MEMBER. Once the family OUT-OF-POCKET LIMIT is met, Blue Cross NC will pay 100% of COVERED SERVICES, up to the ALLOWED AMOUNT, for all covered family MEMBERS. Charges applied to your OUT-OF-NETWORK OUT-OF-POCKET LIMIT are credited to your IN-NETWORK OUT-OF-POCKET LIMIT. Amounts applied to your IN-NETWORK OUT-OF-POCKET LIMIT are credited to your OUT-OF-NETWORK 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	Limited to $1,000	
INFERTILITY and SEXUAL DYSFUNCTION Services (in any place of service)	Three (3) ovulation induction cycles, with or without insemination. Limited to $15,000 lifetime maximum.	
Outpatient HOSPICE Services	Limited to $10,000	
Temporomandibular Joint (TMJ) Services	Limited to $2,500 for office, treatment, SURGERY, and appliances. Crowns, bridges and orthodontia are excluded.	
Vein Treatment	Endovenous or microfoam-sclerotherapy procedures—one (1) procedure per limb Liquid-sclerotherapy tributary vein treatment—three (3) procedures per limb	
Benefit 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. All day and visit limits are for IN- and OUT-OF-NETWORK benefits combined.		
Breast Pump and Supplies (Maximums are per pregnancy)	Limit of one (1) manual or electric pump. Limit of two (2) each for supplies including but not limited to, tubing, shields and bottles. See Family Planning Exclusions and **www.BlueCrossNC.com/preventive** for more information.	

Benefits	IN-NETWORK	OUT-OF-NETWORK
Dialysis Treatment	Three (3) hemodialysis treatments per week, more hemodialysis treatments are available if MEDICALLY NECESSARY	
REHABILITATIVE THERAPY and HABILITATIVE SERVICES (applies to home, office and outpatient setting)	25 visits per benefit period for chiropractic services 30 visits per benefit period for speech therapy Visit limits do not apply to MENTAL ILLNESS diagnoses. Visit limits for physical/occupational/speech therapy do not apply with an autism diagnosis.	
SEXUAL DYSFUNCTION DRUGS	4 pills per 30 days	
SKILLED NURSING FACILITY	120 days per benefit period	
PREVENTIVE CARE		
Available in an office-based, outpatient, ambulatory surgical setting, or URGENT CARE centers. This benefit is only for services that indicate a primary diagnosis of preventive or wellness. See "PREVENTIVE CARE" in "COVERED SERVICES." Please visit Blue Cross NC's website at **www.BlueCrossNC.com/preventive** for the most up-to-date information on PREVENTIVE CARE covered under federal law.		
Screenings	No Charge*	No Charge
*Includes: gynecological exams, cervical cancer screening, ovarian cancer screening, screening mammograms, colorectal screening, bone mass measurement, prostate-specific antigen tests, and newborn hearing screening.		
Other PREVENTIVE CARE (federally mandated)	No Charge	No Charge
For a list of PREVENTIVE CARE services that are covered under federal law, see Blue Cross NC's website at www.BlueCrossNC.com/preventive or call Blue Cross NC Customer Service at the number in "Who to Contact?" Please note that the following services are also covered at No Charge IN-NETWORK: nutritional counseling visits, regardless of diagnosis. However, benefits are not available OUT-OF-NETWORK.		
PROVIDER'S Office See Outpatient for OUTPATIENT CLINIC or HOSPITAL-based services.		
OFFICE VISIT Services		
PRIMARY CARE PROVIDER	$20 copayment	30% after deductible

Benefits	IN-NETWORK	OUT-OF-NETWORK
SPECIALIST	$20 copayment	30% after deductible
Includes: all OFFICE VISITS for medical, INFERTILITY and SEXUAL DYSFUNCTION services, pre-natal/post-delivery care (not included in the global maternity delivery fee), office SURGERY, x-rays and lab tests. Also included are infusion services received at an AMBULATORY INFUSION SUITE. If you see your PCP for mental health or substance use disorder related services, your PCP OFFICE VISIT benefit will apply.		
Telehealth Services		
Teladoc Telehealth		
Acute Care	$5 copayment	Not Applicable
Dermatology	$5 copayment	Not Applicable
Mental Health Care	$5 copayment	Not Applicable
Telehealth services are also available from a local IN-NETWORK or OUT-OF-NETWORK PROVIDER, see "Office Services" in "COVERED SERVICES."		
THERAPY SERVICES		
Therapy Services		
REHABILITATIVE THERAPY and HABILITATIVE SERVICES	$20 copayment	30% after deductible
Chiropractic Services	$20 copayment	30% after deductible
Speech Therapy	$20 copayment	30% after deductible
OTHER THERAPIES	0% after deductible	30% after deductible
Includes chemotherapy, dialysis, radiation, inhalation, IV therapy, shock and cardiac rehabilitation provided in the office. See Outpatient for OTHER THERAPIES provided in an outpatient setting.		
EMERGENCY and Ambulance Services		
EMERGENCY Room Visit (with or without Observation)	$150 copayment	$150 copayment
EMERGENCY Room Visit (with Inpatient Admission)	10% after deductible	10% after deductible
If you are sent to the emergency room from an URGENT CARE center, you may be responsible for both the emergency room copayment and the URGENT CARE copayment.		
Ambulance Services	10% after deductible	10% after deductible
See "COVERED SERVICES" for more information regarding coverage of EMERGENCY and air ambulance services.		

URGENT CARE Centers		
URGENT CARE Centers **Includes Behavioral Health URGENT CARE Centers**	$20 copayment	30% after deductible
AMBULATORY SURGICAL CENTER		
Ambulatory Surgical Services	10% after deductible	30% after deductible
Outpatient		
Physician Services	10% after deductible	30% after deductible
HOSPITAL and HOSPITAL-based and OUTPATIENT CLINIC Services	10% after deductible	30% after deductible
Outpatient Diagnostic Services		
Outpatient lab tests, when performed alone		
Physician Services	10%	30% after deductible
HOSPITAL and HOSPITAL-based Services	10%	30% after deductible
Outpatient lab tests, when performed with another service		
Physician Services	10%	30% after deductible
HOSPITAL and HOSPITAL-based Services	10% after deductible	30% after deductible
Outpatient x-rays, ultrasounds, and other diagnostic tests, such as EEGs, EKGs and pulmonary function tests		
Physician Services	10% after deductible	30% after deductible
HOSPITAL and HOSPITAL-based Services	10% after deductible	30% after deductible
Outpatient CT Scans, MRIs, MRAs, PET scans		
Physician Services	10% after deductible	30% after deductible
HOSPITAL and HOSPITAL-based Services	10% after deductible	30% after deductible
Outpatient diagnostic mammography		
Physician Services	10%	30% after deductible

Benefits	IN-NETWORK	OUT-OF-NETWORK
HOSPITAL and HOSPITAL-based Services	10%	30% after deductible
See PREVENTIVE CARE for coverage of screening mammograms.		
Outpatient diagnostic colonoscopy		
Physician Services	10% after deductible	30% after deductible
HOSPITAL and HOSPITAL-based Services	10% after deductible	30% after deductible
The first colonoscopy of the year is covered at No Charge regardless of diagnosis.		
Inpatient		
Physician Services	10% after deductible	30% after deductible
HOSPITAL and HOSPITAL-based Services	10% after deductible	30% after deductible
Includes inpatient HOSPITAL services, including, but not limited to medical, INFERTILITY, therapies, maternity delivery, and surgeries. 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. If you receive care at a Blue Distinction Center (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.		
Transplant Services		
If performed at a Blue Distinction Center (BDC)		
Physician Services, HOSPITAL and HOSPITAL-based Services	0% after deductible	Not Applicable*
All other places of service		
Physician Services, HOSPITAL and HOSPITAL-based Services	10% after deductible	30% after deductible
***All Blue Distinction Centers are IN-NETWORK facilities.**		
SKILLED NURSING FACILITY		
SKILLED NURSING FACILITY	10% after deductible	30% after deductible
Other Services		
Home Health care	No Charge	No Charge

Benefits	IN-NETWORK	OUT-OF-NETWORK
HOSPICE Services	No Charge	No Charge
Private Duty Nursing	50% after deductible	50% after deductible
Cochlear Implants	10% after deductible	30% after deductible
DURABLE MEDICAL EQUIPMENT	10% after deductible	10% after deductible
Equipment obtained in an office setting	0% after deductible	0% after deductible
MEDICAL SUPPLIES, orthotic devices, PROSTHETIC APPLIANCES	10% after deductible	10% after deductible
Hearing Aids and related services	10% after deductible	30% after deductible
CT Scans, MRIs, MRAs and PET scans in any location, including a physician's office	0% after deductible	30% after deductible
Mental Health and Substance Use Disorder Services		
Mental Health Office Services	$20 copayment	30% after deductible
Mental Health Inpatient Services		
Physician Services	10% after deductible	30% after deductible
HOSPITAL and HOSPITAL-based, including Facility-Based Crisis Services, and RESIDENTIAL TREATMENT FACILITY Services	10% after deductible	30% after deductible
Mental Health Outpatient Services		
Physician Services	10% after deductible	30% after deductible
HOSPITAL and HOSPITAL-based Services	10% after deductible	10% after deductible
Substance Use Disorder Office Services	$20 copayment	30% after deductible
Substance Use Disorder Inpatient Services		
Physician Services	10% after deductible	30% after deductible

Benefits	IN-NETWORK	OUT-OF-NETWORK
HOSPITAL and HOSPITAL-based, including Facility-Based Crisis Services, Medically Monitored Inpatient Withdrawal Management Services, and RESIDENTIAL TREATMENT FACILITY Services	10% after deductible	30% after deductible
Substance Use Disorder Outpatient Services		
Physician Services	10% after deductible	30% after deductible
HOSPITAL and HOSPITAL-based Services	10% after deductible	10% after deductible
CERTIFICATION Requirements		
Certain services require PRIOR REVIEW and CERTIFICATION by the PLAN in order to receive benefits. See "COVERED SERVICES" and "PRIOR REVIEW (Pre-Service)" in "UTILIZATION MANAGEMENT" for additional information. Blue Cross NC delegates PRIOR REVIEW and CERTIFICATION for particular benefits to other companies not associated with Blue Cross NC. Please see **www.BlueCrossNC.com** 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 **www.BlueCrossNC.com.**		

PRESCRIPTION DRUGS		
Benefits	**IN-NETWORK**	**OUT-OF-NETWORK**
Note: You may pay a different amount than listed below if you choose a BRAND-NAME PRESCRIPTION DRUG instead of a GENERIC PRESCRIPTION DRUG. If your PROVIDER requires you to take, or you decide you want the BRAND-NAME drug on the higher tier instead of the GENERIC equivalent on the lower tier, you will pay the BRAND-NAME copayment or coinsurance plus the cost difference between the BRAND-NAME ALLOWED AMOUNT and the GENERIC ALLOWED AMOUNT. Your provider must submit a Request for Waiver of Brand Drug for approval. Applicable copayment or coinsurance amount would still apply. You may not be required to pay the difference between the BRAND-NAME ALLOWED AMOUNT and the GENERIC ALLOWED AMOUNT for certain BRAND-NAME PRESCRIPTION DRUGS if these criteria are met: 1) the BRAND-NAME PRESCRIPTION DRUG is on the Narrow Therapeutic Index (NTI). See **General Pharmacy FAQs (ncbop.org)** for a current list of these drugs; or 2) your PROVIDER required the use of a BRAND-NAME PRESCRIPTION DRUG to treat your condition. Your PROVIDER must submit a Request for Waiver of Brand Drug for approval. Find more information at **www.BlueCrossNC.com/umdrug**. Applicable copayment or coinsurance amounts would still apply.		
TIER 1 DRUGS	$10 copayment	$10 copayment
TIER 2 DRUGS	$10 copayment	$10 copayment
TIER 3 DRUGS	$20 copayment	$20 copayment
TIER 4 and TIER 5 DRUGS	$40 copayment	$40 copayment
Spacers and Peak Flow Meters	25%	25%
One (1) copayment for up to a 30-day supply. 31-60-day supply is two (2) copayments, and 61-90-day supply is three (3) copayments. See Net Results FORMULARY at **http://www.bcbsnc.com/netresults5tierC** for information on coverage of diabetic supplies. Also see "PRESCRIPTION DRUG Benefits" in "COVERED SERVICES." Also see Net Results FORMULARY at **http://www.bcbsnc.com/netresults5tierC**. Please note: During a government issued public health EMERGENCY, the MEMBER expense may change for certain PRESCRIPTION DRUGS, reducing the out-of-pocket cost to the MEMBER. Find more information at **www.bluecrossnc.com/understanding-insurance/how-drug-benefits-work/copayment-tier-definitions.**		
Mail Order PRESCRIPTION DRUGS		
TIER 1 DRUGS	$20 copayment	**Benefits Not Available**
TIER 2 DRUGS	$20 copayment	**Benefits Not Available**
TIER 3 DRUGS	$40 copayment	**Benefits Not Available**
TIER 4 and TIER 5 DRUGS	$80 copayment	**Benefits Not Available**

Preventive over-the-counter medications and PRESCRIPTION contraceptive drugs and devices as listed at www.BlueCrossNC.com/preventive*	No Charge	No Charge**

*Please visit the website at **www.BlueCrossNC.com/preventive** or call Blue Cross NC Customer Service for guidelines on which preventive over-the-counter medications are covered and individuals who may qualify, as well as more information and any limitations that apply for contraceptives. PRESCRIPTION contraceptive drugs and devices that are not covered at the PREVENTIVE CARE benefit level will be covered according to your regular PRESCRIPTION DRUG benefits. Also see "PREVENTIVE CARE" in "COVERED SERVICES."

**No Charge indicates no obligation for MEMBERS to pay any portion of the ALLOWED AMOUNT. For OUT-OF-NETWORK benefits, you may be required to pay for charges over the ALLOWED AMOUNT, the difference between the ALLOWED AMOUNT and the billed charge.

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 Blue Options plan, you enjoy quality health care from a network of health care PROVIDERS and easy access to SPECIALISTS. You do not have to get a referral to see your DOCTOR. You also have the freedom to choose health care PROVIDERS who do not participate in the Blue Options network – the main difference will be the cost to you. To get the most from your health care benefits, visit an IN-NETWORK PROVIDER.

Benefits are available for services from an IN- or OUT-OF-NETWORK PROVIDER that is recognized by Blue Cross NC as eligible. For a list of eligible PROVIDERS, please visit Blue Cross NC's website at **www.BlueCrossNC.com** or call Blue Cross NC Customer Service at the number listed in "Who to Contact?" Here's a look at how it works:

	IN-NETWORK	**OUT-OF-NETWORK**
Type of PROVIDER	IN-NETWORK PROVIDERS are health care professionals and facilities that have contracted with Blue Cross NC, or a PROVIDER participating in the BlueCard® program. ANCILLARY PROVIDERS outside North Carolina are considered IN-NETWORK only if they contract directly with the Blue Cross or Blue Shield plan in the state where services are provided, even if they participate in the BlueCard® program. See "Glossary" for a description of ANCILLARY	OUT-OF-NETWORK PROVIDERS are not designated as Blue Options PROVIDERS by Blue Cross NC. Also see "OUT-OF-NETWORK Benefit Exceptions."

	IN-NETWORK	OUT-OF-NETWORK
	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 Blue Cross NC's website at **www.BlueCrossNC.com**, or call Blue Cross NC Customer Service at the number listed in "Who to Contact?"	
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, and non-covered expenses. For EMERGENCY SERVICES, see "OUT-OF-NETWORK Benefit Exceptions" and "EMERGENCY and Ambulance Services."
Referrals	Blue Cross NC does not require you to obtain any referrals.	
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.	
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	All IN-NETWORK PROVIDERS in North Carolina and some	OUT-OF-NETWORK PROVIDERS are not obligated by contract to

	IN-NETWORK	OUT-OF-NETWORK
	outside of North Carolina are responsible for requesting PRIOR REVIEW when necessary. See "COVERED SERVICES" and "PRIOR REVIEW (Pre-Service)" in "UTILIZATION MANAGEMENT" for additional information about those services which require PRIOR REVIEW and CERTIFICATION. See "Who to Contact?" for information on who to call for PRIOR REVIEW and to obtain CERTIFICATION. PRIOR REVIEW is not required for EMERGENCY SERVICES or for an inpatient HOSPITAL stay for 48 hours after a vaginal delivery or 96 hours after a Cesarean section.	request PRIOR REVIEW by Blue Cross NC. **You are responsible for ensuring that you or your OUT-OF-NETWORK PROVIDER requests PRIOR REVIEW by Blue Cross NC.** Failure to request PRIOR REVIEW and obtain CERTIFICATION will result in a penalty. However, PRIOR REVIEW is not required for EMERGENCY SERVICES 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 Blue Cross NC. However, you will have to file a claim if you do not show your ID CARD when you obtain a PRESCRIPTION from an IN-NETWORK pharmacy, or the IN-NETWORK pharmacy's records do not show as eligible for coverage. In order to recover the full cost of the PRESCRIPTION minus any applicable copayment or coinsurance you owe, return to the IN-NETWORK pharmacy within 14 days of receiving your PRESCRIPTION so that it can be reprocessed with your correct eligibility information	You may have to pay the OUT-OF-NETWORK PROVIDER in full and submit your own claim to Blue Cross NC. Mail claims in time to be received within 18 months of the date the service was provided. Claims not received within 18 months from the service date will not be covered, except in the absence of legal capacity of the MEMBER. For EMERGENCY SERVICES, see "OUT-OF-NETWORK Benefit Exceptions" and "EMERGENCY and Ambulance Services."

	IN-NETWORK	OUT-OF-NETWORK
	and the pharmacy will make a refund to you if necessary. If you are unable to return to the pharmacy within 14 days, mail claims in time to be received within 18 months of the date of the service in order to receive IN-NETWORK benefits. Claims not received within 18 months from the service date will not be covered, except in the absence of legal capacity of the MEMBER.	

OUT-OF-NETWORK Benefit Exceptions

You will only be responsible for your IN-NETWORK share of the cost and PROVIDERS may not bill you more than your IN-NETWORK share of the cost in the following situations:

- When EMERGENCY SERVICES are provided by an OUT-OF-NETWORK PROVIDER or an OUT-OF-NETWORK EMERGENCY facility*
- When you receive EMERGENCY MEDICALLY NECESSARY ground or air transport ambulance services from an OUT-OF-NETWORK PROVIDER*
- When you receive MEDICALLY NECESSARY air transport ambulance services from an OUT-OF-NETWORK PROVIDER*
- When non-EMERGENCY SERVICES are provided by an OUT-OF-NETWORK PROVIDER at an IN-NETWORK health care facility*
- When non-EMERGENCY SERVICES are provided by an OUT-OF-NETWORK PROVIDER in situations where IN-NETWORK PROVIDERS are not reasonably available as determined by Blue Cross NC's access to care standards
- In Continuity of Care situations

*These situations may not qualify for an OUT-OF-NETWORK PROVIDER benefit exception if the MEMBER gives consent. Please see **www.cms.gov/nosurprises** for notice regarding surprise billing describing your rights and how consent may impact these situations.

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 Blue Cross NC's access to care standards, visit Blue Cross NC's website at **www.BlueCrossNC.com/accesstocare**. 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 Blue Cross NC before receiving care from an OUT-OF-NETWORK PROVIDER.

Bundled Care and Payments Program

Blue Cross NC 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 **www.BlueCrossNC.com/bundle** for more information and to see the list of PROVIDERS participating in this program. You will also want to verify that these PROVIDERS are in the Blue Options network by visiting **www.BlueCrossNC.com** or calling Blue Cross NC's 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 IDENTIFICATION CARD

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

> For ID CARD requests, please visit Blue Cross NC's website at **www.BlueCrossNC.com** or call Blue Cross NC Customer Service at the number listed in "Who to Contact?"

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

Blue Cross NC 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 towards 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 **www.BlueCrossNC.com**.

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 to determine when you need a SPECIALIST. PROVIDERS from medical specialties such as family practice, internal medicine, and pediatrics, may participate as PCPs.

Please visit Blue Cross NC's website at **www.BlueCrossNC.com** and click on Find a Doctor for information on PROVIDERS, including but not limited to: name, address, telephone number; professional qualifications, specialties, and medical school attended, residency completion, and board certified status or call Blue Cross NC Customer Service to confirm that the PROVIDER is in the network before receiving care.

If your PCP or SPECIALIST leaves the Blue Cross NC 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 Blue Cross NC, 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 Blue Cross NC, 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 Blue Cross NC 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 Blue Options covers only those services that are MEDICALLY NECESSARY and cost effective when compared to alternative services or supplies. Also check the "Summary of Benefits" for any benefit maximums and limitations that may apply to your benefits. We have grouped these COVERED SERVICES listed below 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 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 • PRESCRIPTION DRUG Benefits	• OFFICE VISIT • OUTPATIENT CLINIC • PREVENTIVE CARE • IN-NETWORK • OUT-OF-NETWORK • REHABILITATIVE THERAPY/HABILITATIVE SERVICES • ADAPTIVE BEHAVIOR TREATMENT • GENERIC and BRAND-NAME PRESCRIPTION DRUGS

Office Services

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

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

Telehealth services from Teladoc: Telehealth services from Teladoc include evaluation, management and consultation services for acute care, mental health teletherapy, and dermatology with a PROVIDER via an interactive audio/video or audio-only telecommunications system. See Teladoc Telehealth in "Who to Contact?" for additional information.

Telehealth services from a local PROVIDER: You can also check with your local PROVIDER to see if telehealth services are available. Telehealth services are available from IN-NETWORK and OUT-OF-NETWORK PROVIDERS and are separate from your telehealth benefit with Teladoc. 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 telecommunication 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 HOSPITAL-based or OUTPATIENT CLINICS or provide HOSPITAL-based services in their offices. These services are covered as outpatient services and are listed as HOSPITAL-based or OUTPATIENT CLINIC. See "Summary of Benefits."

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.

> Please check with your PROVIDER before your visit to determine if your PROVIDER will collect deductible and coinsurance, or you can call Blue Cross NC Customer Service at the number listed in "Who to Contact?" for this information.

PREVENTIVE CARE

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

Under federal law, you can receive certain covered PREVENTIVE CARE services from an IN-NETWORK PROVIDER in an office-based, outpatient, or ambulatory surgical setting, or URGENT CARE center, at no cost to you. Please note, this benefit is only for services that indicate a primary diagnosis of preventive or wellness and which are identified by recent federal regulations as being eligible. Services, such as diagnostic lab tests, that may be delivered with a PREVENTIVE CARE service are not considered PREVENTIVE CARE. These services and services that do not include a primary diagnosis of preventive or wellness will be subject to your IN-NETWORK benefit level for the location where services are received. In addition, if a particular PREVENTIVE CARE service does not have a federal recommendation or guideline concerning the frequency, method, treatment or setting in which it must be provided, the PLAN may use reasonable medical management procedures to determine any coverage limitations or restrictions that may apply. IN-NETWORK routine wellness exams are covered once per BENEFIT PERIOD. MEMBERS do not need to wait 365 days between visits.

Please visit Blue Cross NC's website at **www.BlueCrossNC.com/preventive** or call Blue Cross NC 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 any limitations that may apply. Certain over-the-counter medications may also be available. These over-the-counter

medications are covered only as indicated and when a PROVIDER'S PRESCRIPTION is presented at a pharmacy.

PREVENTIVE CARE COVERED SERVICES include:

Routine Physical Examinations and Screenings

Routine physical examinations and related diagnostic services and screenings are covered for MEMBERS as recommended with an A or B rating by the United States Preventive Services Task Force (USPSTF).

Well-Baby and Well-Child Care

These services are covered for each MEMBER including periodic assessments as recommended by the Health Resources and Services Administration (HRSA).

Well-Woman Care

These services are covered for each female MEMBER, including periodic assessments, screenings, counseling, or support services, as recommended by the Health Resources and Services Administration (HRSA).

Contraceptive Methods

Contraceptive methods and procedures requiring a PRESCRIPTION and approved by the U.S. Food and Drug Administration are covered for each female MEMBER with reproductive capacity. This includes intrauterine devices, diaphragms and caps, injectable or transdermal contraceptives, NuvaRing®, implanted hormonal contraceptives, certain EMERGENCY contraceptives and GENERIC oral contraceptives.

Immunizations

Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) are covered.

Nutritional Counseling

The PLAN provides benefits for nutritional counseling visits to an IN- or OUT-OF-NETWORK PROVIDER. The nutritional counseling visits may include counseling specific to achieving or maintaining a healthy weight. If you see an IN-NETWORK PROVIDER in an office-based setting, any applicable copayment, or coinsurance or deductible is waived for these visits. If you go to an OUT-OF-NETWORK PROVIDER, deductible and coinsurance will apply. Additional visits may be covered for those MEMBERS diagnosed with diabetes; however, any applicable copayment, coinsurance or deductible will apply. Nutritional counseling visits are separate from the obesity-related OFFICE VISITS noted in "Summary of Benefits."

Tobacco Cessation

This 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 Blue Cross NC's website at **www.BlueCrossNC.com/preventive** or call Blue Cross NC Customer Service at the number listed in "Who to Contact?" for the most up-to-date information on tobacco cessation benefits.

Bone Mass Measurement Services

The PLAN covers one scientifically proven and approved bone mass measurement for the diagnosis and evaluation of osteoporosis or low bone mass during any 23-month period for certain qualified individuals only. Additional follow-up bone mass measurement tests will be covered if MEDICALLY NECESSARY. 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 subject to 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 asymptomatic MEMBER who is at least 45 years of age, or is less than 45 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.

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 a DOCTOR'S interpretation of the lab results. Coverage for cervical cancer screening includes Pap smear screening, liquid-based cytology, and human papillomavirus detection, and shall follow the American Cancer Society guidelines or guidelines adopted by the North Carolina Advisory Committee on Cancer Coordination and Control.

Newborn Hearing Screening

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

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

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.

PREVENTIVE CARE Exclusions

- Immunizations required for occupational hazard or international travel, unless specifically covered by the PLAN
- Fitting for contact lenses, glasses or other hardware
- Male contraceptives

EMERGENCY and Ambulance Services

EMERGENCY SERVICES

The PLAN provides benefits for EMERGENCY SERVICES.

An EMERGENCY is the sudden and unexpected onset of a medical condition, including a mental health or substance use disorder 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 MEMBER the health of the pregnant MEMBER or their unborn child, in serious jeopardy
- Serious physical impairment to bodily functions
- Serious dysfunction of any bodily organ or part
- Death.

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

What to Do in an EMERGENCY

In an EMERGENCY, you should seek care immediately from an emergency room or other similar facility. If necessary and available, call 911 or use other community EMERGENCY resources to obtain assistance in handling life-threatening EMERGENCIES. PRIOR REVIEW is not required for EMERGENCY SERVICES.

What are my benefits when I receive EMERGENCY SERVICES?

Situation	Benefit
• You receive IN-NETWORK or OUT-OF-NETWORK ground or air ambulance services prior to admission to an EMERGENCY department (ED).	• Ambulance benefits apply. • PRIOR REVIEW and CERTIFICATION are required for non-EMERGENCY air ambulance services.

Situation	Benefit
	• PROVIDERS may not bill you for more than your IN-NETWORK share of the cost for these services*
• You go to an IN-NETWORK or OUT-OF-NETWORK HOSPITAL ED. • You go to an IN-NETWORK or OUT-OF-NETWORK ED and then are held for observation or admitted inpatient to the HOSPITAL for additional EMERGENCY SERVICES. • You receive IN-NETWORK or OUT-OF-NETWORK EMERGENCY ground or air ambulance services after admission to an ED.	• EMERGENCY benefits apply for all COVERED SERVICES in the event of an EMERGENCY until you are considered stable by your PROVIDER. • PRIOR REVIEW and CERTIFICATION are not required for EMERGENCY SERVICES. • PROVIDERS may not bill you for more than your IN-NETWORK share of the cost for these services.*
• You get non-EMERGENCY follow-up care (such as OFFICE VISITS or therapy) after you are considered stable by your PROVIDER and you leave the EMERGENCY room 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.

*If you have questions or feel that you have been billed more than your IN-NETWORK share of the cost, in addition to the rights under "Need to Appeal a Decision?", please see **www.cms.gov/nosurprises** for additional options and a full statement of your rights under federal law regarding surprise billing.

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, acute inpatient rehabilitation facility, or a long-term acute care facility when such a facility is the closest one that can provide COVERED SERVICES appropriate to your condition. Benefits may also be provided for ambulance services from a HOSPITAL or SKILLED NURSING FACILITY to a MEMBER'S home when MEDICALLY NECESSARY.

The PLAN covers services in an air ambulance only when:

- Ground transportation is not medically appropriate due to the severity of the illness or the pick-up point is inaccessible by land, or
- Great distances, limited time frames, or other obstacles are involved in getting the patient to the nearest HOSPITAL that can provide COVERED SERVICES appropriate to your condition.

Non-EMERGENCY air ambulance services require PRIOR REVIEW and CERTIFICATION, or services will not be covered.

Ambulance Service 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 also provides benefits for URGENT CARE services. When you need URGENT CARE, call your PCP, a SPECIALIST or go to an URGENT CARE PROVIDER.
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:

- Inpatient services received in a HOSPITAL or NONHOSPITAL FACILITY. You are considered an inpatient if you are admitted to the HOSPITAL or NONHOSPITAL FACILITY as a registered bed patient for whom a room and board charge is made. Your IN-NETWORK PROVIDER is required to use the Blue Options network HOSPITAL where he/she practices, unless that HOSPITAL cannot provide the services you need. If you are admitted before the EFFECTIVE DATE, benefits will not be available for services received prior to the EFFECTIVE DATE. Take home drugs are covered as part of your PRESCRIPTION DRUG benefit.

  PRIOR REVIEW must be requested and CERTIFICATION must be obtained in advance from Blue Cross NC for inpatient admissions, except for maternity deliveries and EMERGENCIES. See "Maternity Care," if applicable, and "EMERGENCY and Ambulance Services". If PRIOR REVIEW is not requested and CERTIFICATION is not obtained for covered OUT-OF-NETWORK inpatient admissions, allowed charges will be reduced by $250, then deductible and coinsurance will be applied. Also, Blue Cross NC requires notification for MEMBERS who have Medicare as their primary coverage and who are admitted to a Medicare-certified HOSPITAL or NONHOSPITAL FACILITY.
- Outpatient services received in a HOSPITAL, a HOSPITAL-based facility, NONHOSPITAL FACILITY or a HOSPITAL-based or OUTPATIENT CLINIC

- 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. SKILLED NURSING FACILITY services are limited to a day maximum per BENEFIT PERIOD. See "Summary of Benefits."

PRIOR REVIEW must be requested and CERTIFICATION must be obtained in advance from Blue Cross NC 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

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 needs part-time or intermittent skilled nursing care from a REGISTERED NURSE (RN) or LICENSED PRACTICAL NURSE (LPN) and/or other skilled care 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

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

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 services 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, intermittent, and temporary solution for a MEMBER transitioning from an acute care setting to the home setting. The MEMBER must be homebound, or have a technology need immediately post discharge, causing an increased amount of frequency of nursing interventions to stabilize the MEMBER and provide the household caregiver with training. It is not meant to be for

long-term permanent or custodial care or intended to be provided on a permanent ongoing basis. Long-term permanent care is defined as lasting more than 30 days. Also see "Care Management."

Private duty nursing requires PRIOR REVIEW and CERTIFICATION or services will not be covered.

Private Duty Nursing Exclusion

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

Family Planning

Maternity Care

Maternity care benefits, including prenatal care, admission to labor and delivery, management of labor including fetal monitoring, delivery, and uncomplicated post-delivery care until six weeks postpartum, are available to all female MEMBERS and are covered. Together these make up the global maternity delivery fee. See the chart below for additional information.

Also visit **www.BlueCrossNC.com/preventive** for the most up-to-date federally-mandated PREVENTIVE CARE services, including those available for DEPENDENT CHILDREN. Coverage for breastfeeding counseling and certain breast pumps for pregnant or postpartum MEMBERS are covered under your PREVENTIVE CARE benefit. See **www.BlueCrossNC.com/preventive** for limits that may apply and also see "Summary of Benefits" for limits on breast pumps and breast pump supplies.

If a MEMBER changes PROVIDERS during pregnancy, terminates coverage during pregnancy, or the pregnancy does not result in delivery, one or more copayments may be charged for prenatal services depending upon how the services are billed by the PROVIDER.

	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.

Labor & delivery services	No PRIOR REVIEW required for inpatient HOSPITAL stay for 48 hours after a vaginal delivery or 96 hours after a cesarean section. Mothers choosing a shorter stay are eligible for a home health visit for post-delivery follow-up care if received within 72 hours of discharge.	No PRIOR REVIEW required for inpatient well-baby care for 48 hours after a vaginal delivery or 96 hours after a cesarean section. Benefits include newborn hearing screening ordered by a DOCTOR to determine the presence of permanent hearing loss. (Please see PREVENTIVE CARE in "Summary of Benefits.")	For the first 48/96 hours, only one BENEFIT PERIOD deductible is required for both mother and baby.
Post-delivery services	All care for the mother after the baby's birth that is related to the pregnancy. In order to avoid a penalty, PRIOR REVIEW and CERTIFICATION are required for inpatient stays extending beyond 48/96 hours.	After the first 48/96 hours, whether inpatient (sick baby) or outpatient (well baby), the newborn must be enrolled for coverage as a DEPENDENT CHILD, according to the rules in "When Coverage Begins and Ends." For inpatient services following the first 48/96 hours, PRIOR REVIEW and CERTIFICATION are required in order to avoid a penalty.	If the newborn must remain in the HOSPITAL beyond the mother's prescribed length of stay for any reason, the newborn is considered a sick baby and these charges are subject to the BENEFIT PERIOD deductible if the newborn is added and covered under the policy

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

Termination of Pregnancy (Abortion)

Benefits for abortion are available as allowed by state law for all MEMBERS.

COMPLICATIONS OF PREGNANCY

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

INFERTILITY Services

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

Blue Cross NC medical policies are guides considered by Blue Cross NC when making coverage determinations. For more information about medical policies on INFERTILITY, visit Blue Cross NC's website at **www.BlueCrossNC.com** and search on "INFERTILITY", or call Blue Cross NC Customer Service at the number listed in "Who to Contact?"

The PLAN also provides benefits for assisted reproductive technologies as defined by the Centers for Disease Control and Prevention, including, but not limited to, in-vitro fertilization (IVF) with fresh or frozen embryos, ovum or embryo placement, intracytoplasmic sperm injection (ICSI), zygote intrafallopian transfer (ZIFT), specialized sperm retrieval techniques, and gamete intrafallopian transfer (GIFT) and associated services. See "Summary of Benefits" for any maximum amounts. These are considered non-essential health benefits.

SEXUAL DYSFUNCTION Services

The PLAN provides benefits for certain services related to the diagnosis, treatment and correction of any underlying causes of SEXUAL DYSFUNCTION for all MEMBERS. Benefits may vary depending on where services are received.

Sterilization

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

See "PRESCRIPTION DRUG Benefits" for coverage of oral contraceptives.

Family Planning Exclusions

- Hospital-grade breast pumps
- 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 such 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:
  - reversal of sterilization
  - INFERTILITY for DEPENDENT CHILDREN
- 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

Therapy services 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 healthcare 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 THERAPY and HABILITATIVE SERVICES

The following therapies are covered:

- Occupational therapy, physical therapy and/or chiropractic services and osteopathic manipulation up to a one-hour session per day
- Speech therapy

Any visit limits apply in all places of service except inpatient (e.g., outpatient, office and home) regardless of the type of PROVIDER (chiropractors, other DOCTORS, physical therapists). REHABILITATIVE THERAPY and HABILITATIVE SERVICES received while an inpatient are not included in the BENEFIT PERIOD MAXIMUM.

Benefits may vary depending on where services are received.

See “Summary of Benefits” for additional information and any visit maximums.

OTHER COVERED 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”. Also see "PRESCRIPTION DRUG Benefits" regarding related covered PRESCRIPTION DRUGS.

Diagnostic Services

Diagnostic procedures such as laboratory tests, 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. Blue Cross NC may delegate UTILIZATION MANAGEMENT of sleep studies, radiology services and laboratory tests to another company not associated with Blue Cross NC. 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 PLAN.

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

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
- Definitive prescription medication and illicit drug panel testing of more than seven drug classes.

Other Services

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 SURGICAL CENTER or provided by a HOME HEALTH AGENCY). For a list of drugs covered under your medical benefit that are covered only at certain PROVIDER settings, visit Blue Cross NC's website at **www.BlueCrossNC.com.** PRIOR REVIEW and CERTIFICATION may be required for certain drugs covered under your medical benefit or services will not be covered.

Gene and Cellular Therapy

The PLAN provides coverage for certain gene and cellular therapies. Gene and cellular therapies must be dispensed by a pharmacy participating in the Specialty Network in order to receive IN-NETWORK benefits. For a list of specific gene and cellular therapy product restrictions, visit Blue Cross NC's website at **www.BlueCrossNC.com**.

PRIOR REVIEW and CERTIFICATION may be required for gene and cellular therapies 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 stages 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 preparation of dentures.

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

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

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

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 and CERTIFICATION are required for certain surgical procedures or these 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 Blue Cross NC before receiving 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.

See "Summary of Benefits," depending on where services are received.

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. See "Summary of Benefits" for BENEFIT PERIOD MAXIMUMS.

Certain hearing aids and related services may require PRIOR REVIEW and CERTIFICATION or services will not be covered.

Cochlear Implants

The PLAN provides coverage for MEDICALLY NECESSARY cochlear implants and necessary related services that are ordered by a DOCTOR for each MEMBER. Benefits are also provided for the evaluation, fitting, and adjustments of cochlear implants, and for supplies, including replacement parts.

Cochlear Implants 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. Your benefits are based on where supplies are received, either as part of your MEDICAL SUPPLIES benefit or your PRESCRIPTION DRUG benefit. Select diabetic supplies and spacers for metered dose inhalers and peak flow meters are also covered under your PRESCRIPTION DRUG benefit.

To obtain MEDICAL SUPPLIES and equipment, please find a PROVIDER on Blue Cross NC's website at **www.BlueCrossNC.com** or call Blue Cross NC 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. Therapeutic contact lenses may be covered when used as a corneal bandage for a medical condition. Benefits include a one-time replacement of eyeglass or contact lenses due to a PRESCRIPTION change after cataract SURGERY.

Certain PROSTHETIC APPLIANCES require PRIOR REVIEW and CERTIFICATION or services will not be covered.

Prosthetic appliances Exclusions

- 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 SPECIFIED SEX-TRAIT MODIFICATION PROCEDURES, 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 children, and FOSTER CHILDREN
- 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 non-diseased breast to produce a symmetrical appearance, without regard to the lapse of time between the mastectomy and the reconstructive SURGERY
  - Prostheses and physical complications of all stages of the mastectomy, including lymphedemas.

  See “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 Blue Cross NC’s reimbursement policies, which are on Blue Cross NC's website at **www.BlueCrossNC.com,** or call Blue Cross NC 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

The PLAN provides benefits for transplants, including HOSPITAL and professional services for covered transplant procedures. The PLAN provides care management for transplant services and will help you find a HOSPITAL or Blue Distinction Centers for Transplants that provides the transplant services required. Travel and lodging expenses required for covered transplant procedures may be reimbursed up to a $10,000 maximum per transplant based on Blue Cross NC guidelines that are available upon request from a transplant coordinator or visit **www.bluecrossnc.com/members/health-plans/forms-resources**. Any reimbursed travel and lodging expenses are considered a non-essential health benefit. However, these expenses will only be reimbursed when related to IN-NETWORK transplant services.

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

For a list of covered transplants, call Blue Cross NC 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 Blue Cross NC for all transplant-related services in order to assure coverage of these services. Grafting procedures associated with reconstructive SURGERY are not considered transplants.

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

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

Some transplant services are INVESTIGATIONAL and are not covered for some or all conditions or illnesses. 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. Blue Distinction Centers 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 - MUST BE PERFORMED AT A BDC
- cardiac care
- knee or hip replacement
- maternity care
- transplants
- spine SURGERY
- substance use disorder treatment and recovery.

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. Depending on your plan, you may save $250 in an outpatient setting or $500 in an inpatient setting via a copayment reduction OR reduce your coinsurance by 10% simply by utilizing an outpatient or inpatient BDC. 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.

Sex-Trait Modification

The health benefit PLAN provides benefits for certain services related to SPECIFIED SEX-TRAIT MODIFICATION PROCEDURES. For additional information, including limitations and exclusions, please see **www.bluecrossnc.com/providers/policies-guidelines-codes/medical-policies**. PRIOR REVIEW and CERTIFICATION are required for certain services or services will not be covered. These benefits are considered non-essential health benefits.

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 (see "Glossary" for additional information)
- 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 related treatment).

Psychotherapy is additionally covered when provided in a school setting. Please note that partial hospitalization is not covered as part of an OFFICE VISIT.

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
- 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)

ADAPTIVE BEHAVIOR TREATMENT

Benefits are provided for ADAPTIVE BEHAVIOR TREATMENT for MEMBERS. Coverage includes assessments and treatment, which must be MEDICALLY NECESSARY, and ordered by a licensed physician or licensed psychologist. PRIOR REVIEW must be requested, and CERTIFICATION must be obtained in advance for ADAPTIVE BEHAVIOR TREATMENT or services will not be covered. ADAPTIVE BEHAVIOR TREATMENT must be provided or supervised by the following professionals who are licensed and/or board-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
- Licensed and/or board-certified behavior analyst*

*If received outside North Carolina, ADAPTIVE BEHAVIOR TREATMENT may be provided or supervised by a licensed and/or board-certified behavior analyst if such license and/or board certification exists in the state. PRIOR REVIEW and CERTIFICATION requirements still

apply, and the appropriate licensing and/or board certification requirements of the state in which the services are received must be met in order for these services to be covered.

Visit Blue Cross NC's website at **www.BlueCrossNC.com** or call Blue Cross NC Customer Service at the number listed in "Who to Contact?" for a list of PROVIDERS.

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, please notify Blue Cross NC of an EMERGENCY inpatient admission as soon as reasonably possible.

PRIOR REVIEW and CERTIFICATION are required for inpatient (including RESIDENTIAL TREATMENT FACILITY services) or certain outpatient services by Blue Cross NC, failure to request PRIOR REVIEW and receive CERTIFICATION may result in allowed charges being reduced by $250. 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/content/services/medical-policy/index.htm** or you can call Blue Cross NC Customer Service or the mental health phone number on the back of your ID CARD. See "PRIOR REVIEW (Pre-Service)" in "UTILIZATION MANAGEMENT" for additional information.

PRESCRIPTION DRUG Benefits

Your PRESCRIPTION DRUG benefits cover the following:

- PRESCRIPTION DRUGS, including self-administered injectable medications, and contraceptive drugs and devices
- Certain preventive over-the-counter drugs when listed as covered in the FORMULARY, or under the PREVENTIVE CARE benefit, and a PROVIDER'S PRESCRIPTION for that drug is presented at the pharmacy (see "Summary of Benefits")
- Immunizations for influenza, shingles, and pneumonia are covered at no cost to you when received at an IN-NETWORK pharmacy. The list of covered immunizations may change from time to time, call Blue Cross NC Customer Service for the most up-to-date list.
- Spacers for metered dose inhalers and peak flow meters
- PRESCRIPTION DRUGS related to treatment of SEXUAL DYSFUNCTION
- Insulin and diabetic supplies, such as: insulin needles, syringes, glucose testing strips, lancets and lancet devices. Benefits vary for MEDICAL SUPPLIES, depending on whether supplies are received at a MEDICAL SUPPLY PROVIDER or at a pharmacy. See "Summary of Benefits."
- All Weight Loss Drugs (GLP-1s and Traditional)

The following information will help you get the most value from your PRESCRIPTION DRUG coverage:

Situation	Value
Where you get your PRESCRIPTION filled	Your cost will be less if you use an IN-NETWORK pharmacy in North Carolina - or outside the state and show your ID CARD. If you fail to show your ID CARD or the IN-NETWORK pharmacy's records do not show you as eligible for coverage, you will have to pay the full cost of the PRESCRIPTION and file a claim. You may also get your PRESCRIPTION filled by an OUT-OF-NETWORK pharmacy; however, you may be asked to pay the full cost of the PRESCRIPTION DRUG and file a claim. You will be reimbursed the ALLOWED AMOUNT less any applicable deductible, coinsurance or copayment. Any charges over the ALLOWED AMOUNT are your responsibility. If you had an EMERGENCY condition and went to an OUT-OF-NETWORK pharmacy, call Blue Cross NC Customer Service at the number listed in "Who to Contact?" so that the claim will be processed at the IN-NETWORK level.
How the type of PRESCRIPTION DRUG may determine the amount you pay	Your PRESCRIPTION DRUG benefit has an open FORMULARY or list of PRESCRIPTION DRUGS, divided into categories or tiers. Blue Cross NC determines the tier placement of PRESCRIPTION DRUGS in the FORMULARY, and this determines the amount you pay. For more information on the exception process please visit **www.BlueCrossNC.com/umdrug**.
	Tier placement of PRESCRIPTION DRUGS in the FORMULARY may be determined by: the effectiveness and safety of the drug, the cost of the drug, and/or the classification of the drug by the U.S. Food and Drug Administration (FDA) or nationally-recognized drug databases (e.g., Medispan).
	The lowest cost PRESCRIPTION DRUGS, such as GENERICS, are generally located on the lowest tiers (TIER 1 and TIER 2). Higher cost PRESCRIPTION DRUGS, such as BRAND-NAME PRESCRIPTION DRUGS are generally located on the higher tiers. All tiers of the FORMULARY may contain GENERIC and BRAND-NAME PRESCRIPTION DRUGS. SPECIALTY DRUGS, if applicable, are located on the highest tiers of the PLAN, even though they may be classified as GENERIC, BRAND-NAME, BIOLOGIC, or BIOSIMILAR PRESCRIPTION DRUGS. Visit

Situation	Value
	Blue Cross NC's website at **www.BlueCrossNC.com/how-drug-benefits-work** for additional information on the tier classification of PRESCRIPTION DRUGS.
	The PRESCRIPTION DRUGS listed in the FORMULARY or their tier placement may change from time to time due to a change in the cost of the drug and/or in the classification of the drug by the U.S. Food and Drug Administration (FDA) or nationally-recognized drug databases (e.g., Medispan).
How your PRESCRIPTION is dispensed	In some cases, a PROVIDER may prescribe a total dosage of a drug that requires two different strengths of that drug to be dispensed. In these cases, you will be responsible for one copayment, that of the highest tier drug in the compound, based on each 30-day supply. Please note that some PRESCRIPTION DRUGS are only dispensed in 60- or 90-day quantities. For these drugs, you will pay either two or three copayments depending on the quantity you receive. If you need to receive an extended supply (greater than a 30-day supply and up to a 90-day supply), visit Blue Cross NC's website at **www.BlueCrossNC.com** for a listing of retail pharmacies or a mail-order service that can dispense an extended supply of your PRESCRIPTION. You cannot refill a PRESCRIPTION until: • three-fourths (75%) of the time period has passed that the PRESCRIPTION was intended to cover, or • up to nine-tenths (90%) of the time period has passed that the controlled PRESCRIPTION was intended to cover, or • the full time period has passed that the PRESCRIPTION was intended to cover if quantity limits apply, except during a government-declared state of emergency or disaster in the county in which you reside. During these circumstances, you must request a refill within 29 days after the date of the emergency or disaster (not the date of the declaration). A refill of a PRESCRIPTION with quantity limitations may take into account the proportionate dosage use prior to the disaster.
	Certain combinations of compound drugs may require PRIOR REVIEW and CERTIFICATION. For specific information about drug classes with limited or no plan coverage, please visit

Situation	Value
	www.BlueCrossNC.com/umdrug. Examples of these drug categories include (but are not limited to) SEXUAL DYSFUNCTION Drugs, and Non-FDA Approved Medications. Reference the "Drugs with Limited or No Plan Coverage" section for more details.
If you have multiple PRESCRIPTIONS and need to align your refill dates	If you have multiple PRESCRIPTIONS and need to align your refill dates you may need a PRESCRIPTION for less than a 30-day supply. If your DOCTOR or pharmacy agrees to give you a PRESCRIPTION for less than a 30-day supply for this purpose you will only pay a prorated daily cost-sharing amount (any dispensing fee will not be prorated). This benefit is only available for drugs covered under your PRESCRIPTION DRUG benefit, received at an IN-NETWORK pharmacy, and when PRIOR REVIEW requirements have been met. In addition, the drugs must: • be used for treatment and management of chronic conditions and are subject to refills; • NOT be a Schedule II or Schedule III controlled substance containing hydrocodone; • be able to be split over short-fill periods; and • not have quantity limits or dose optimization criteria that would be affected by aligning refill dates.
Use of Lower-Cost PRESCRIPTION DRUGS	When choosing a PRESCRIPTION DRUG, you and your DOCTOR should discuss whether a lower-cost PRESCRIPTION DRUG could provide the same results as a more expensive PRESCRIPTION DRUG. If you choose a BRAND-NAME PRESCRIPTION DRUG, your cost may be higher.
PRIOR REVIEW Requirements	PRIOR REVIEW and CERTIFICATION by Blue Cross NC is required for some PRESCRIPTION DRUGS or services will not be covered. Blue Cross NC may change the list of these PRESCRIPTION DRUGS from time to time. Blue Cross NC may change the authorization period for which a previously reviewed or certified drug was granted. Should this occur, you will be notified. Please visit Blue Cross NC's website at **www.BlueCrossNC.com** for more details.
SPECIALTY DRUGS	Blue Cross NC has a separate pharmacy PROVIDER for purchasing select SPECIALTY DRUGS. These SPECIALTY DRUGS (which include specialty GENERIC or BRAND-NAME PRESCRIPTION DRUGS, as well as BIOLOGIC or BIOSIMILAR PRESCRIPTION DRUGS)

Situation	Value
	must be dispensed by the specialty pharmacy PROVIDER in order to receive IN-NETWORK benefits. These drugs are limited to a one-month supply or less, except when an FDA approved dosing regimen exceeds this limitation. For a list of PRESCRIPTION DRUGS that are considered SPECIALTY DRUGS, visit Blue Cross NC's website at **www.BlueCrossNC.com**.
RESTRICTED-ACCESS DRUGS and Devices	Coverage will be provided for a RESTRICTED-ACCESS DRUG or device to a MEMBER without requiring PRIOR REVIEW or CERTIFICATION or use of a nonrestricted FORMULARY drug(s) if a MEMBER'S physician certifies in writing that the MEMBER has previously used an alternative nonrestricted-access drug(s) or device(s) and the alternative drug(s) or device(s) has been detrimental to the MEMBER'S health or has been ineffective in treating the same condition and, in the opinion of the prescribing physician, is likely to be detrimental to the MEMBER'S health or ineffective in treating the condition again.
Exception Requests	MEMBERS, their authorized representative, or their prescribing PROVIDER may request a standard exception request, an expedited exception request, or an external exception request in order to gain access to non-FORMULARY or RESTRICTED-ACCESS (STEP THERAPY) DRUGS OR DEVICES if determined to be MEDICALLY NECESSARY and appropriate by the MEMBER'S prescribing PROVIDER and to request and gain access to clinically appropriate drugs not otherwise covered under the health benefit plan. As part of an exception request, the MEMBER'S prescribing PROVIDER must provide supporting information of the request by including an oral or written statement that provides a justification supporting the need for the non-FORMULARY or RESTRICTED-ACCESS (STEP THERAPY) DRUGS OR DEVICES to treat the MEMBER'S condition. Exception requests will be granted if supporting information demonstrates any of the following: • the MEMBER has tried an alternate drug or drugs while covered by Blue Cross NC or their previous health benefit plan; • the FORMULARY or alternate drug or drugs has been ineffective in the treatment of the MEMBER'S disease or condition;

<table>
<tr><th>Situation</th><th>Value</th></tr>
<tr><td></td><td>

the FORMULARY or alternate drug or drugs causes or is reasonably expected by the prescribing PROVIDER to cause a harmful or adverse clinical reaction in the MEMBER;
either (i) the drug is prescribed in line with any applicable clinical protocol of Blue Cross NC or (ii) the drug has been approved as an exception to the clinical protocol consistent with Blue Cross NC's exception procedure;
the MEMBER'S prescribing PROVIDER certifies in writing that the MEMBER has previously used an alternative nonrestricted access drug or device and the alternative drug or device has been detrimental to the MEMBER'S health or has been ineffective in treating the same condition and, in the prescribing PROVIDER'S opinion, is likely to be detrimental to the MEMBER'S health or ineffective in treating the condition again.

PRESCRIPTION DRUG samples, coupons or other incentive programs will not be considered a trial and failure of a prescribed drug in place of trying the formulary-preferred or nonrestricted access PRESCRIPTION DRUG.
MEMBERS (or their authorized representatives) may visit www.BlueConnectNC.com for information about the ways to submit a request. Generally, MEMBERS may submit requests:

By fax (visit the website above for fax form and numbers)
By mail to Blue Cross and Blue Shield of North Carolina, Healthcare Management and Operations, Pharmacy Exception, P. O. Box 2291, Durham, NC 27702
By telephone at 1-800-672-7897

Once Blue Cross NC has all necessary and relevant information to make a decision, Blue Cross NC will provide a response to the MEMBER and their PROVIDER approving or denying their request (if approved, notice will provide duration of approval) within the following timeframes:
<table>
<tr><th>Type of Request</th><th>Blue Cross NC Response</th></tr>
<tr><td>Standard (non-urgent)</td><td>No later than 72 hours following the receipt of request</td></tr>
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<tr><th>Situation</th><th>Value</th></tr>
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<table>
<tr><td>Expedited*</td><td>No later than 24 hours following the receipt of request</td></tr>
<tr><td>External**</td><td>No later than 72 hours following the receipt of request (Original request was standard)

No later than 24 hours following the receipt of request (original request was expedited)</td></tr>
</table>
*An expedited request is permissible where a MEMBER is suffering from a health condition that may seriously jeopardize the MEMBER'S life, health, or ability to regain maximum function or when the MEMBER is getting a current course of treatment using a non-FORMULARY or RESTRICTED-ACCESS (STEP THERAPY) DRUGS or DEVICE.

**An external request will be reviewed by an independent review organization contracted by Blue Cross NC.</td></tr>
<tr><td>Quantity Limitations</td><td>The PLAN covers certain PRESCRIPTION DRUGS up to a set quantity based on criteria developed by Blue Cross NC to encourage the appropriate use of the drug. For these PRESCRIPTION DRUGS, PRIOR REVIEW and CERTIFICATION are required before excess quantities of these drugs will be covered. When excess quantities are approved, you may be required to pay an additional copayment, if applicable.</td></tr>
<tr><td>Benefit Limitations</td><td>Certain PRESCRIPTION DRUGS are subject to benefit limitations which may include, but not limited to:
• the amount dispensed per PRESCRIPTION, per day, or per defined time period;
• the amount dispensed per lifetime; per month's supply; or
• the amount dispensed per single copayment, if applicable.

Note: excess quantities are not covered. These benefit limitations can be found at www.BlueCrossNC.com/umdrug.</td></tr>
</table>

WHAT IS NOT COVERED?

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

- Any condition, disease, ailment, injury or diagnostic service to the extent that benefits are provided or persons are eligible for coverage under Title XVIII of the Social Security Act of 1965, including amendments, except as otherwise provided by federal law
- Conditions that federal, state or local law requires to be treated in a public facility
- Any condition, disease, illness or injury that occurs in the course of employment, if the 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
- Services prohibited by state law in the state in which they are performed
- Any condition suffered as a result of any act of war or while on active or reserve military duty
- A dental or medical department maintained by or on behalf of an EMPLOYER, a mutual benefit association, labor union, trust or similar person or group
- Services in excess of any BENEFIT PERIOD MAXIMUM or LIFETIME MAXIMUM
- A benefit, drug, service or supply that is not specifically listed as covered in this benefit booklet.
- 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 a claim form, 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 Blue Cross NC within 18 months of the date the charge was INCURRED, except in the absence of legal capacity of the MEMBER.

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 Blue Cross NC 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**:

- A PRESCRIPTION DRUG that is in excess of the stated quantity limits
- A PRESCRIPTION DRUG that is purchased to replace a lost, broken, or destroyed PRESCRIPTION DRUG except under certain circumstances during a state of emergency or disaster
- A PRESCRIPTION DRUG that is any portion or refill which exceeds the maximum supply for which benefits will be provided when dispensed under any one PRESCRIPTION
- Injections by a health care professional of injectable PRESCRIPTION DRUGS which can be self-administered, unless medical supervision is required
- Drugs associated with INFERTILITY
- PRESCRIPTION DRUGS with over-the-counter alternatives where select PRESCRIPTION DRUG BRAND and GENERIC drugs will be excluded. Examples include, but are not limited to:
  - Topical Antifungals: Combination Products
  - Ophthalmic Antiallergic Agents
  - Prenatal Vitamins
  - Ulcer Drugs, H2 Antagonists
  - Nasal Steroids
- EXPERIMENTAL drugs or any drug not approved by the U.S. Food and Drug Administration (FDA) for the applicable diagnosis or treatment. However, this exclusion does not apply to PRESCRIPTION DRUGS (1) specifically listed as a covered drug in the FORMULARY and a written PRESCRIPTION is provided; or (2) 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.

And any other drug that is:

- Purchased over-the-counter, unless specifically listed as a covered drug in the FORMULARY and a written PRESCRIPTION is provided
- Therapeutically equivalent to an over-the-counter drug

- A PRESCRIPTION DRUG that is compounded and does not contain at least one ingredient that is defined as a PRESCRIPTION DRUG (see "Glossary"). Compounds containing non-FDA approved bulk chemical ingredients are excluded from coverage
- A PRESCRIPTION DRUG that is contraindicated (should not be used) due to age, drug interaction, therapeutic duplications, dose greater than maximum recommended or other reasons as determined by FDA's approved product labeling
- A medical device, unless specifically listed as a covered medical device in the FORMULARY and a written PRESCRIPTION is provided
- A medication that has been repackaged — a pharmaceutical product that is removed from the original manufacturer container (Brand Originator) and repackaged by another manufacturer with a different NDC.
- Institutional packs or clinic packs — a pharmaceutical product that is labeled for Institutional Use Only (for HOSPITALS, institutions or clinics only) and which has a different NDC (National Drug Code) for clinical or institutional use.

E

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:**

- Air conditioners, furnaces, humidifiers, dehumidifiers, vacuum cleaners, electronic air filters and similar 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
- Physical fitness equipment, hot tubs, Jacuzzis, heated spas, or pools
- Automatic external defibrillators
- Personal computers
- Standing frames.

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 a palliative treatment, like shaving or paring of plantar warts, COSMETIC, or is not considered MEDICALLY NECESSARY.

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,** except as specifically covered by the PLAN in "Summary of Benefits" and "COVERED SERVICES".

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,** not cost effective when compared to alternative services or supplies, or not ordered by a PROVIDER.

Charges incurred due to injuries received in a **motor vehicle accident** involving any motor vehicle for which no-fault insurance is available, regardless of whether any such policy is designated as secondary to health coverage.

N

Side effects and complications of **noncovered services**, or services that would not be necessary if a **noncovered service** had not been received, except for EMERGENCY SERVICES in the case of an EMERGENCY. A noncovered service includes, but not limited to, any services, procedures or supplies associated with COSMETIC services, INVESTIGATIONAL services, services deemed not MEDICALLY NECESSARY.

O

The following **obesity** services:

- Any cost associated with membership in a weight management program or health club
- Any treatment or regimen, medical or surgical for the purpose of reducing or controlling the weight of a MEMBER or for treatment of **obesity**, except as specifically covered by the PLAN.

P

Partial hospitalization program is not covered for telehealth or virtual services.

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 Blue Cross NC 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 mental health and substance use disorder treatment) including a structured environment such as sober living whose use is simply to change the person's environment, 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

All services provided in a **school** setting except as specifically covered in a school setting by this health benefit plan.

Services or supplies that are:

- Not performed by or upon the direction of a DOCTOR or OTHER PROVIDER
- Available to a MEMBER without charge.

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 **tests**, which individuals can purchase online or in stores, are not covered because they are not considered a MEDICALLY NECESSARY service ordered by a healthcare professional:

- Over the counter (OTC)
- Direct to consumer (DTC)

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 or as specifically covered by the PLAN

V

The following **vision** services:

- Radial keratotomy and other refractive eye SURGERY, and related services to correct vision except for surgical correction of an eye injury. Also excluded are premium intraocular lenses or the services related to the insertion of premium lenses beyond what is required for insertion of conventional intraocular lenses, which are small, lightweight, clear disks that replace the distance-focusing power of the eye's natural crystalline lens.
- Routine eye examination services except as specifically covered by the PLAN
- 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 under 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 prenatal vitamins or PRESCRIPTION vitamin B-12 injections for anemias, neuropathies or dementias secondary to a vitamin B-12 deficiency, or certain over-the-counter medications that may be available under your PREVENTIVE CARE benefits for certain individuals.

W

Wigs, hairpieces and hair implants for any reason, except as specifically covered by the PLAN

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 • Type(s) of coverage • Reporting Changes • Continuing Coverage • Termination of MEMBER coverage	• EMPLOYEE • DEPENDENTS • PLAN ADMINISTRATOR

To be covered under the PLAN, you must be an active full-time EMPLOYEE who works 30 or more hours per week. However, your EMPLOYER may establish additional criteria you must meet before you are eligible for coverage. This may include satisfying a probationary period before your coverage begins. You may also be eligible for coverage under the PLAN if the PLAN ADMINISTRATOR allows eligibility to extend to other persons, such as retirees.

EMPLOYEES whose employment is subject to a collective bargaining agreement are not eligible, unless health benefits were the subject of good faith bargaining and the collective bargaining agreement specifically provides for coverage under the PLAN. Independent contractors, leased EMPLOYEES and temporary EMPLOYEES are not eligible.

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, or your spouse's DEPENDENT CHILDREN through the end of the month of their 26th birthday. Your EMPLOYER may require proof that your DEPENDENT CHILD meets the definition of DEPENDENT CHILD as outlined in the "Glossary."
- A DEPENDENT CHILD who, in accordance with North Carolina law, is and continues to be either 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. The disability must be medically certified by the child's DOCTOR and may be verified annually by the PLAN.

When Coverage Begins

Eligible EMPLOYEES may join the PLAN on the first of the month following the date of hire.

Your DEPENDENTS may join the PLAN on the later of the date you become eligible for EMPLOYEE coverage or the date your DEPENDENT becomes your DEPENDENT. You must enroll new DEPENDENTS within 30 days of the date they become your DEPENDENTS, or during a

SPECIAL ENROLLMENT PERIOD. Otherwise, you will need to wait until the next Annual Enrollment Period.

Enrolling in the PLAN

The PLAN no longer has a pre-existing condition rule or pre-existing condition exclusion period. However, it is still important that you consider enrolling yourself and your DEPENDENTS within 30 days of becoming eligible for coverage under the Plan. Once made, coverage elections are irrevocable until the next plan year unless you qualify for one of the SPECIAL ENROLLMENT PERIODS below or experience a Change In Family Status that is valid under Section 125 (See the Section 125 discussion in this booklet). Remember that adding yourself or your DEPENDENTS as the result of a Change in Family Status must be consistent with that change.

How to Enroll

To enroll you and your DEPENDENTS, you will need to complete an enrollment form or its electronic equivalent and return it to the PLAN ADMINISTRATOR during the first 30 days of eligibility, or, under the provisions for a SPECIAL ENROLLMENT PERIOD, or, under the provisions for a Change in Family Status under Section 125. Otherwise, you may enroll for a subsequent plan year by completing an enrollment form or its electronic equivalent and returning it to the PLAN ADMINISTRATOR during the Annual Enrollment Period.

SPECIAL ENROLLMENT PERIODS

SPECIAL ENROLLMENT PERIODS are 30 day periods during which an EMPLOYEE and/or DEPENDENT may enroll in the PLAN as a result of certain situations and events as described in this section. If you decline coverage at the time you are initially eligible because you and/or your DEPENDENTS have coverage under another health plan, and if you and/or your DEPENDENTS lose coverage under the other plan, you and/or your DEPENDENTS will be eligible to enroll in this PLAN within 30 days of losing coverage. You may be required to provide documentation showing your loss of coverage. If an eligible or covered EMPLOYEE marries, has a child, adopts a child, or has a child placed for adoption, you as well as eligible DEPENDENTS may join the PLAN within 30 days from the event.

See also "Adding or Removing a DEPENDENT."

Section 125

Because your medical EMPLOYEE contributions are paid with pre-tax dollars, under IRS regulations, you may not change your elections during a plan year, except within 30 days after a Change in Family Status or during a SPECIAL ENROLLMENT PERIOD. Any change in your election must be consistent with the Change in Family Status and must meet all other IRS requirements. Subject to additional IRS regulations that may be in effect from time to time, a “Change in Family Status” means:

- Your marriage;
- Your divorce, annulment or legal separation;

- Your death or the death of your spouse or child;
- A change in a dependent child's eligibility due to age;
- A change in employment status for you or your spouse that has an impact on benefits (including termination or commencement of employment, strike or lockout, commencement or return from an unpaid leave of absence);
- A reduction or loss of your dependent's coverage under this or another plan; A loss of coverage under Medicaid or the Children's Health Insurance Program (CHIP); or
- A Qualified Medical Child Support Order (QMCSO) that mandates coverage for an eligible DEPENDENT CHILD(REN); or
- You, your spouse, or your dependent child has a change in place of residence.

Other events may be designated as Changes in Family Status by the Internal Revenue Service in its regulations and will be so recognized by the PLAN.

You are responsible for notifying the PLAN ADMINISTRATOR of all Changes in Family Status within 30 days of any of these events (within 60 days for loss of Medicaid or CHIP coverage). CHIP is the national and state Children's Health Insurance Program.

Open Enrollment elections will take effect on January 1st of the following year. If you do not complete an election form before the end of the Election Period/Open Enrollment Period, your elections for the current year will remain in effect unless the PLAN ADMINISTRATOR conducts a positive Open Enrollment which means that everyone who wants coverage must submit a new enrollment form to be covered/enrolled in the PLAN.

Enrolling in the PLAN

It is very important to consider when you apply for coverage and/or add DEPENDENTS. Your EMPLOYER allows you to apply for or make changes to your coverage during the annual enrollment period, which is held once a year. 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 qualifying life events (hereafter referred to as "QLE") 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 the 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 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, any forms must be completed within 30 days after the DEPENDENT becomes eligible.

If you are adding a newborn child, or a child legally placed for adoption or a FOSTER CHILD, and adding the DEPENDENT CHILD would not change your coverage type or premiums, the change will be effective on the date the child becomes eligible (the date of birth for a newborn, or the date of placement for adoption for adoptive children, or the date of placement of a FOSTER CHILD in your home), as long as coverage was effective on that date. In these cases, notice is not required by the PLAN ADMINISTRATOR within 30 days after the child becomes eligible, but it is important to provide notification as soon as possible.

DEPENDENTS may be removed from coverage by contacting the PLAN ADMINISTRATOR and by completing the proper form. DEPENDENTS must be removed from coverage when they are no longer eligible, such as when a child is no longer eligible due to age, or when a spouse is no longer eligible due to divorce or death. Failure to timely notify your PLAN ADMINISTRATOR of

the need to remove a DEPENDENT could result in loss of eligibility for continuation of coverage.

Qualified Medical Child Support Order

A Qualified Medical Child Support Order (QMCSO) is any judgment, decree or order that is issued by an appropriate court or through an administrative process under state law that: (1) provides for coverage of the child of a MEMBER under the PLAN; and (2) is either issued according to state law or a law relating to medical child support described in Section 1908 of the Social Security Act. A QMCSO must be specific as to the 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 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
- EMPLOYEE-children coverage—The PLAN covers you and your DEPENDENT CHILDREN
- Family coverage—The PLAN covers you, your spouse and your DEPENDENT CHILDREN.

Reporting Changes

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

When Coverage Ends

Generally, your participation in the PLAN will end on the earliest of:

- If the person is over the age of 65 and still actively at work, this PLAN is primary to Medicare;
- The date of your termination;
- When you enlist in the armed forces of the United States or any other country, except as a reservist; or
- The end of the period for which you last pay a required premium.

Generally, your "DEPENDENTS" coverage will end on the earliest of:

- When your "DEPENDENT" no longer meets the definition of "DEPENDENT" under the PLAN; or
- The end of the period for which you last pay a required premium for "DEPENDENT" coverage.

If you or your DEPENDENTS lose coverage because of certain "Qualifying Events," you and your family may be eligible for "COBRA Continuation Coverage" beyond the limitations described above. COBRA Continuation Coverage is more fully described in another section of this Summary Plan Description.

Coverage under the PLAN may not be converted to an individual medical Plan.

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. Coverage available during a leave of absence varies depending on the type of leave you take and your EMPLOYER'S leave of absence policy. Contact your Human Resources department for more information.

Medicare

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

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

COBRA Continuation Coverage

What is COBRA?

COBRA refers to a federal law that ensures that employees and other "Qualified Beneficiaries" have the opportunity to continue health care coverage upon the occurrence of a "Qualifying Event" that would otherwise result in such person losing coverage under a group health plan. "COBRA Continuation Coverage" means your right, or your spouse's and DEPENDENTS' rights, to continue to be covered under the PLAN. For further information about your rights under ERISA, including COBRA, HIPAA, and other laws affecting group health plans, see the remainder of this Summary Plan Description, contact your PLAN ADMINISTRATOR, contact the nearest regional or district office of the U.S. Department of Labor's Employee Benefit Security Administration (EBSA) in your area or visit the EBSA website at www.DOL.gov/ebsa.

Qualified Beneficiaries

A "Qualified Beneficiary" is any person who, at the time of a Qualifying Event, is covered under the PLAN as (i) an EMPLOYEE of the EMPLOYER, covered under the PLAN as of such day

(such persons are called "Covered EMPLOYEES"), (ii) the spouse of the Covered EMPLOYEE, or (iii) DEPENDENT CHILD(REN) of the Covered EMPLOYEE.

In addition, a child born to or placed for adoption with a Covered EMPLOYEE during the period of COBRA Continuation Coverage is a Qualified Beneficiary. A Covered EMPLOYEE can be a Qualified Beneficiary only if the Qualifying Event consists of termination of employment (for any reason other than gross misconduct) or reduction of hours of employment.

Should a domestic Asahi Kasei America EMPLOYEE secure a position with any of Asahi Kasei America's global divisions/subsidiaries, reside in a foreign country and be paid through foreign payroll, the EMPLOYEE and his/her DEPENDENTS will be eligible for COBRA continuation coverage for up to 18 months as though the EMPLOYEE'S employment with Asahi Kasei America were terminated.

An individual who fails to elect COBRA Continuation Coverage within the election period described below shall not be considered a Qualified Beneficiary.

Qualifying Events

A "Qualifying Event" is any of the following which result in a loss of coverage under the PLAN:

- Termination (other than by reason of gross misconduct) of the Covered EMPLOYEE'S employment or reduction of hours of employment;
- Death of a Covered EMPLOYEE
- Divorce or legal separation of a Covered EMPLOYEE from the Covered EMPLOYEE'S spouse;
- A Covered EMPLOYEE'S becoming entitled to receive Medicare benefits under Title XVIII of the Social Security Act;
- A DEPENDENT child of a Covered EMPLOYEE ceasing to be a DEPENDENT under the terms of the plan;
- A proceeding under Title 11, United States Code (U.S.C.), with respect to the employer from whose employment
- the Covered EMPLOYEE retired at any time; or
- Your transfer to a foreign subsidiary of Asahi Kasei America International. Inc.

How to Elect COBRA Continuation Coverage

You and/or your DEPENDENTS will be offered COBRA Continuation Coverage within 14 days of the date that the COBRA administrator is notified of a Qualifying Event resulting in the termination of your or your DEPENDENT'S coverage.

When a Qualifying Event occurs, any Qualified Beneficiary entitled to COBRA Continuation Coverage shall have a period to elect COBRA Continuation Coverage which begins on the date the coverage terminates, is of at least 60 days duration, and which ends not earlier than 60 days after the later of (i) the date coverage terminates, or

(ii) the date a required notice is given of COBRA Continuation Coverage rights. Upon a Qualified Beneficiary's receipt of the notice described above, each Qualified Beneficiary will have an independent right to elect COBRA Continuation Coverage. Covered EMPLOYEES may make an election on behalf of their spouses and parents may make an election on behalf of their DEPENDENTS CHILD(REN).

Following election, applicable fees (premiums) must be paid to the COBRA administrator within 45 days.

Required Notices

The following notices are required upon occurrence of a Qualifying Event:

- In the case of termination, reduction of hours, death, entitlement to Medicare, or a proceeding under U.S.C. Title 11 (as more specifically described above), the PLAN ADMINISTRATOR shall furnish each Qualified Beneficiary with written notification of the termination of regular coverage and his right to elect COBRA Continuation Coverage.
- In the case of divorce or legal separation, or a dependent child ceasing to be a DEPENDENT CHILD under the PLAN
- (as more specifically described above), a Covered EMPLOYEE or a Qualified Beneficiary must notify the PLAN ADMINISTRATOR within 60 days of the Qualifying Event.
- Each Qualified Beneficiary who is determined, under Title II or XVI of the Social Security Act, to have been disabled at any time during the first 60 days of COBRA Continuation Coverage is responsible for notifying the PLAN ADMINISTRATOR of such determination within 60 days after the date of determination and for notifying the PLAN ADMINISTRATOR within 30 days of the date of any final determination under such title or titles that the Qualified Beneficiary is no longer disabled.

Coverage Period

In the case of termination or reduction in hours of a Covered EMPLOYEE, COBRA Continuation Coverage for Qualified Beneficiaries shall extend 18 months beyond the date regular coverage ceased due to the occurrence of a Qualifying Event, unless during such 18-month period a subsequent Qualifying Event occurs, in which case, another election to extend coverage for 18 months shall be available to the Qualified Beneficiary. In no event, however, shall COBRA Continuation Coverage extend more than 36 months beyond the date of the original Qualifying Event.

If a Qualified Beneficiary is determined, under Title II or XVI of the Social Security Act, to have been disabled at the time of the Covered EMPLOYEE'S termination or reduction in hours, or at anytime during the first 60 days of COBRA Continuation Coverage, COBRA Continuation Coverage shall extend for 29 months from the date of the Qualifying Event, but only if the EMPLOYER receives notice of this determination within 60 days of the date of the determination and before the end of 18 months following the Qualifying Event. The period of COBRA Continuation Coverage shall cease in the first month that begins more than 30 days

after the date of the final determination under the Social Security Act that the Qualified Beneficiary is no longer disabled.

In the case of death, divorce or legal separation of a Covered EMPLOYEE, entitlement to Medicare, or a dependent child of a Covered EMPLOYEE ceasing to be a DEPENDENTS CHILD under the PLAN, COBRA Continuation Coverage shall extend for 36 months from the original Qualifying Event.

Automatic Termination of COBRA Coverage

COBRA Continuation Coverage shall automatically cease if:

- The EMPLOYER no longer offers group health coverage to any of its EMPLOYEES;
- The required premium for COBRA Continuation Coverage is not paid within 30 days of the due date;
- After electing COBRA Continuation Coverage, a Qualified Beneficiary becomes entitled to receive benefits under Medicare.

If you are covered by the PLAN and called to the uniformed services, as defined in the Uniformed Services Employment and Re-employment Rights Act (USERRA), consult the PLAN ADMINISTRATOR. The PLAN administrator will advise you about the continuation of coverage under this PLAN as required under USERRA.

Also, read the section in this Summary Plan Description, "Uniformed Services Employment and Re-employment Rights Act of 1994".

Informing the PLAN ADMINISTRATOR

In order to protect all Qualified Beneficiaries under the PLAN, you should keep the PLAN administrator informed of any changes in address of such Qualified Beneficiaries. You should also keep a record of all notices you send to the PLAN administrator.

If you have any questions about your COBRA CONTINUATION COVERAGE rights, please contact the PLAN administrator.

DISABILITY

If you are disabled (see the PLAN'S definition of DISABILITY), you may continue medical coverage for you and your family through the duration of your paid short-term disability leave and any unpaid leave you qualify for by paying the contributions equal to the active EMPLOYEE contributions. During any periods of unpaid leave, you must make arrangements with the EMPLOYER to make these contributions by check or money order on a regular basis because payroll withholding will not be possible.

After you have exhausted all paid and unpaid leave, your employment will be terminated. You and your family may continue coverage under COBRA. While on COBRA Continuation Coverage you will be required to pay the contributions equal to active EMPLOYEE contributions for up to 18 months (up to 29 months, if COBRA Continuation Coverage is extended due to disability). See the COBRA Continuation Coverage section for additional information.

Death of Active EMPLOYEE

If you should die while an active EMPLOYEE, your eligible DEPENDENTS may continue coverage under COBRA. DEPENDENTS will be required to pay the contributions equal to active EMPLOYEE contributions for the first six (6) months of COBRA Continuation Coverage. See the COBRA Continuation Coverage section for additional information.

Uniformed Services Employment and Re-employment Rights Act of 1994

An EMPLOYEE on uniformed services leave is entitled to the same benefits made available to other EMPLOYEES with similar seniority, status and pay, if they were on furlough or leave of absence. If you are an EMPLOYEE and would otherwise lose coverage under this PLAN because of a uniformed services leave, you can continue coverage for yourself and your DEPENDENTS, for the lesser of the length of the leave or 24 months, even if covered by military health care programs. If the uniformed services leave is for less than 31 days, you will pay the same premium contribution as you did while you were an active EMPLOYEE. If the uniformed services leave is for 31 days or more, you may be required to pay 102% of the total premium. If you do not continue coverage during a period of uniformed services leave, you coverage will be reinstated upon re-employment.

FMLA Leave

The EMPLOYER will continue coverage for you and your dependents under the PLAN in accordance with the EMPLOYERS policy on Family and Medical Leaves of Absence as if you were in active employment if the following conditions are met:

- Applicable premiums are paid by you, and
- The EMPLOYER has approved your leave of absence in writing.
- Coverage will be continued for up to the greater of:
- The leave period required by the federal Family and Medical Leave Act of 1993 and any amendments (under some circumstances, your coverage may be continued up to 12 weeks, See Human Resources if you have questions about this); or
- The leave period required by applicable state law.

If you do not return to work at the end of your FMLA leave, you may elect COBRA Continuation Coverage for you and your DEPENDENTS.

Termination of MEMBER Coverage

Blue Cross NC will terminate coverage under the PLAN in accordance with eligibility information provided by the EMPLOYER. A MEMBER'S termination shall be effective at 11:59 p.m. on the date that eligibility ends.

Termination for Cause

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

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

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

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

- Fraud or intentional misrepresentation of a material fact by a MEMBER 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 Blue Cross NC 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 Blue Cross NC personnel or property
- A MEMBER permits the use of his or her or any other MEMBER'S ID CARD by any other person not enrolled under this PLAN, or uses another person's ID CARD.

UTILIZATION MANAGEMENT

This section provides information on how certain services are reviewed to determine if they are MEDICALLY NECESSARY, in the appropriate health care setting and/or for the appropriate length of time.

Table of Contents:	**Key Words:**
• Rights and Responsibilities • PRIOR REVIEW • Concurrent Review • 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, Blue Cross NC has a UTILIZATION MANAGEMENT (UM) program. The UM program requires certain health care services to be reviewed and approved by Blue Cross NC in order to receive benefits. As part of this process, Blue Cross NC looks at whether health care services are MEDICALLY NECESSARY, given in the proper health care setting and/or for a reasonable length of time. Blue Cross NC 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 Blue Cross NC'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 Blue Cross NC 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.

Blue Cross NC's Responsibilities

As part of all UM decisions, Blue Cross NC 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. See "Who to Contact?"
- Limit what Blue Cross NC 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 Blue Cross NC does not receive all the needed information to approve coverage for a health care service within set time frames, Blue Cross NC 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.

IN-NETWORK PROVIDERS in North Carolina will request PRIOR REVIEW when necessary. IN-NETWORK inpatient facilities outside of North Carolina will also request PRIOR REVIEW for you, except for Veterans' Affairs (VA), SKILLED NURSING FACILITIES and military PROVIDERS. If you go to any other PROVIDER outside of North Carolina or to an OUT-OF-NETWORK PROVIDER in North Carolina, you are responsible for ensuring that you or your PROVIDER requests PRIOR REVIEW by Blue Cross NC. 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'S billed charges. The PLAN pays the ALLOWED AMOUNT for COVERED SERVICES rendered by an OUT-OF-NETWORK PROVIDER. **Failure to request PRIOR REVIEW and receive CERTIFICATION will result in a penalty.**

If PRIOR REVIEW is required by the PLAN, you or your PROVIDER must request PRIOR REVIEW regardless of whether this PLAN is your primary or secondary coverage (see "Coordination of Benefits (overlapping coverage)"). Also, the PLAN requires notification for MEMBERS who have Medicare as their primary coverage and who are admitted to a Medicare-certified HOSPITAL or NONHOSPITAL FACILITY. If neither you nor your PROVIDER requests PRIOR REVIEW and receives CERTIFICATION, this may result in an ADVERSE BENEFIT DETERMINATION.

To request PRIOR REVIEW, please call the numbers in "Who to Contact?"

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 Blue Cross NC's website at **www.BlueCrossNC.com** for the PRIOR REVIEW list, which is updated when new services are added or when services are removed. You can also call Blue Cross NC Customer Service at the number listed in "Who to Contact?"

If you fail to follow the procedures for filing a request for CERTIFICATION, Blue Cross NC 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.

Blue Cross NC 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 Blue Cross NC receives all necessary information. However, it will be no later than 15 calendar days from the date Blue Cross NC received the request. Blue Cross NC may extend this period one time for up to 15 calendar days if additional information is required. Blue Cross NC will let you or your PROVIDER know before the end of the initial 15-day period of the information needed. You will have 45 days to provide the requested information. As soon as Blue Cross NC receives all the requested information, or at the end of the 45 days, whichever is earlier, Blue Cross NC will make a decision within three business days. Blue Cross NC will 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. Blue Cross NC 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 Blue Cross NC needs more information to process your urgent review, Blue Cross NC 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. Blue Cross NC will make a decision on your request within a reasonable time but no later than 48 hours after receipt of requested information or within 48 hours after the time period given to the PROVIDER to submit necessary clinical information, whichever comes first.

An urgent review may be requested by calling Blue Cross NC Customer Service at the number given in "Who to Contact?"

Concurrent Reviews

Blue Cross NC 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 (such as, skilled nursing visits), 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 we receive the request.

In the event of an ADVERSE BENEFIT DETERMINATION, Blue Cross NC will let you and your PROVIDER know within three business days after receipt of all necessary clinical information, but no later than 15 calendar days after Blue Cross NC receives the request. Written confirmation of the decision will also be sent to your home by U.S. mail. For concurrent reviews, Blue Cross NC 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, and contains all necessary information, 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 we receive the request.

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

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

Retrospective Reviews (Post-Service)

Blue Cross NC 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 the PLAN.

Blue Cross NC 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 Blue Cross NC received the request for coverage. If the request for coverage does not include all necessary information and more information is needed, before the end of the initial 30 calendar day decision notification time period ends, Blue Cross NC will let you or your authorized representative know of the information needed. You or your authorized representative will then have up to 90 days to respond and provide the requested information. As soon as Blue Cross NC receives a response to its request for the needed information, from you or your authorized representative OR at the end of the 90 day time period and there has been no response to the request for the needed information from you or your authorized representative, whichever is earlier, Blue Cross NC will make a decision and give written notification of its decision within 15 calendar days. Regardless if additional information is needed, in the event of a NONCERTIFICATION, Blue Cross NC will let you and your PROVIDER know in writing within five business days after making the NONCERTIFICATION.

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

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 Blue Cross NC or by a representative of Blue Cross NC. 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 on our website at **www.bluecrossnc.com/members/health-plans** or by calling Care Management Nurse Support at the number listed in "Who to Contact?" You may also want to talk with your PCP or SPECIALIST.

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

Continuity of Care

Continuity of Care is a process that allows you 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 group changes health benefit plans or when your PROVIDER is no longer in

the Blue Options network. If your PCP or SPECIALIST leaves the Blue Cross NC PROVIDER network and they are currently treating you for an ongoing special condition that meets Blue Cross NC Continuity of Care criteria, Blue Cross NC will notify you 30 days before the PROVIDER'S termination. If a practitioner notifies Blue Cross NC of termination less than thirty (30) days prior to the effective date, Blue Cross NC shall notify the affected MEMBERS as soon as possible, but no later than thirty (30) calendar days after receipt of notification. 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 Blue Cross NC requirements for Continuity of Care. Continuity of Care is not offered when the MEMBER electively changes plans.

An ongoing special condition means:

- SERIOUS AND COMPLEX CONDITION
  - Acute illness (required specialized medical treatment to avoid death or permanent harm)
  - Chronic illness (life threatening, degenerative, potentially disabling, or CONGENITAL requiring treatment over a prolonged period of time)
- Course of institutional or inpatient care
- Scheduled to undergo nonelective SURGERY, including receipt of postoperative care with respect to such a SURGERY
- Pregnant and undergoing a course of treatment for the pregnancy (e.g., from initially visiting the DOCTOR through the pregnancy, including postpartum care)
- Terminally ill.

The allowed transitional period shall end on the earlier of (i) 90 days from the date of the PROVIDER termination; or (ii) the date on which the MEMBER is no longer a patient undergoing care of the ongoing special condition with respect to such PROVIDER or facility 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
- Terminal illness which shall extend through the remainder of the individual's life for care directly related to the treatment of the terminal illness; and
- Pregnancy which shall extend through the provision of 60 days of postpartum care.

Continuity of Care requests must be submitted to Blue Cross NC within 45 days of the PROVIDER termination date or within 45 days of the EFFECTIVE DATE for MEMBERS new to the Blue Cross NC 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 Blue Cross NC Customer Service at the number listed in "Who to Contact?" for more information.

Delegated UTILIZATION MANAGEMENT

Blue Cross NC delegates certain UM services for particular benefits to other companies not associated with Blue Cross NC. Please see **www.bluecrossnc.com/providers/prior-authorization/services-requiring-ppa** for more information regarding 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 **www.BlueCrossNC.com** and search for "PRIOR REVIEW" for additional information, including those services subject to PRIOR REVIEW and CERTIFICATION.

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:**
• Steps to Follow • Internal Appeals • External Review	• ADVERSE BENEFIT DETERMINATION • GRIEVANCE • MEDICALLY NECESSARY

In addition to the UTILIZATION MANAGEMENT (UM) program, Blue Cross NC 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 Blue Cross NC 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 Blue Cross NC in connection with the claim being appealed. Please see the end of this section for contact information. References to Blue Cross NC throughout this section refer to Blue Cross NC or the 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 all appeals, 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.

Any request for review should include:

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

To request a form to submit a request for review, visit Blue Cross NC's website at **www.BlueCrossNC.com** or call Blue Cross NC Customer Service at the number given in "Who to Contact?"

NEED TO APPEAL A DECISION? *(cont.)*

All information related to a request for a review through Blue Cross NC's appeals process should be sent to:

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

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
www.ncdoi.gov/consumers/health-insurance/health-claim-denied

Phone: (855) 408-1212
Monday-Friday 8:00 a.m. – 5:00 p.m. EST

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

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

You will have exhausted the PLAN'S internal appeals process after pursuing a first level appeal. Unless specifically noted below, upon completion of the first level appeal you may: pursue a second level appeal; or pursue an external review; or pursue a civil action under 502(a) of ERISA. You will also be deemed to have exhausted the PLAN'S internal appeal process at any time it is determined that Blue Cross NC 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 Blue Cross NC's control). In the event you are deemed to have exhausted the PLAN'S internal appeal process, and unless specifically noted below, you may pursue an external review.

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
Blue Cross NC 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

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

Although you are not allowed to attend a first level appeal, you may provide and/or present written evidence and testimony. Blue Cross NC asks that you send all of the written material you feel is necessary to make a decision. Blue Cross NC will use the material provided in the request for review, along with other available information, to reach a decision. If your appeal is due to a NONCERTIFICATION, your appeal will be reviewed by a licensed medical DOCTOR who was not involved in the initial NONCERTIFICATION decision. You may receive, in advance, any new information or rationale that Blue Cross NC may use in making a decision, so that you may have an opportunity to respond prior to the notice of an ADVERSE BENEFIT DETERMINATION.

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

Quality of Care Complaints

For quality of care complaints, an acknowledgement will be sent by Blue Cross NC within ten business days. We will refer 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

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

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

- Name, address and phone number of the appeals coordinator
- A statement of your rights, including the right to:
  - request and receive all information that applies to your appeal from Blue Cross NC
  - 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 Blue Cross NC. The panel will include external physicians and/or benefit experts. This will be held within 45 days after Blue Cross NC receives a second level appeal request. Blue Cross NC will give you notice of the meeting date and time at least 15 days before the meeting. The meeting will be held by teleconference. You have the right to a full review of your appeal even if you do not 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 health benefit plan provisions on which the decision is based

- A statement that the MEMBER is entitled to receive reasonable access to, and copies of, all documents, records and other information relevant to the MEMBER'S claim for benefits upon request at no additional cost
- If applicable, a statement describing any voluntary appeals procedures and the MEMBER'S right to receive information about the procedures as well as the MEMBER'S right to bring a civil action under Section 502(a) of ERISA following an adverse determination upon review
- A copy of any internal rule, guideline, protocol or other similar criteria relied on in making the decision or a statement that such specific rule, guideline, protocol, or other similar criteria was relied upon in making the decision upon request at no charge
- Instructions on how to request an external, independent review from an independent review organization (IRO) upon completion of this review if not satisfied with the decision (available for NONCERTIFICATIONS only)
- The right to pursue other voluntary alternative dispute resolution options as applicable
- If the decision is based on MEDICAL NECESSITY or EXPERIMENTAL treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the PLAN to the MEMBER'S medical circumstances, or a statement that such explanation will be provided at no cost upon request; and
- The following statement: "You may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office."

Expedited Appeals (Available only for 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 Blue Cross NC Customer Service at the 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. Blue Cross NC will communicate the decision by phone to you and your PROVIDER as soon as possible, taking into account the medical circumstances. The decision will be communicated no later than 72 hours after receiving the request. A written decision will be communicated within four days after receiving the request for the expedited appeal. Information initially given by telephone must also be given in writing.

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

External Review

Federal law allows for an external review of certain ADVERSE BENEFIT DETERMINATIONS by an external, independent review organization (IRO). This service is administered by the PLAN at no charge to you. The PLAN will let you know of your right to request an external review each time you receive:

- an ADVERSE BENEFIT DETERMINATION,
- an appeal decision upholding an ADVERSE BENEFIT DETERMINATION, or
- a final internal ADVERSE BENEFIT DETERMINATION.

In order to request an external review, Blue Cross NC must receive your request within four (4) months after the date of receipt of a notice of an ADVERSE BENEFIT DETERMINATION or final internal ADVERSE BENEFIT DETERMINATION. To request an external appeal, send your request to the following:

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

Expedited External Review

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

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

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

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

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

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

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

ADDITIONAL TERMS OF YOUR COVERAGE

This section provides information on:

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

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. Blue Cross NC establishes coverage determination guidelines that specify how services and supplies must be billed in order for payment to be made under the PLAN.

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

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

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

Use and Disclosure of Protected Health Information (PHI)

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

The PLAN will use protected health information (PHI) to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, the PLAN will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations.

Payment includes activities undertaken by the PLAN to obtain premiums or determine or fulfill its responsibility for coverage and provision of PLAN benefits that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

- Determination of eligibility, coverage and cost sharing amounts;
- Coordination of benefits;
- Adjudication of health benefit claims (including appeals and other payment disputes);
- Subrogation of health benefit claims;
- Establishing employee contributions;
- Risk adjusting amounts due based on enrollee health status and demographic characteristics;
- Billing, collection activities and related health care data processing;
- Claims management and related health care data processing, including auditing payments, investigating and resolving
- payment disputes and responding to participant inquiries about payments;
- Obtaining payment under a contract for reinsurance (including stop-loss excess of loss insurance);
- Medical necessity reviews or reviews of appropriateness of care or justification of charges;
- Utilization review, including pre-certification, preauthorization, concurrent review and retrospective review; and
- Reimbursement to the PLAN.

Health Care Operations include, but are not limited to, the following activities:

- Quality assessment;

- Population-based activities relating to improving health or reducing health care costs, protocol development,
- case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;
- Rating provider and PLAN performance, including accreditation, certification, licensing or credentialing activities;
- Underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance);
- Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
- Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the PLAN including formulary development and administration, development or improvement of payment methods or coverage policies;

Business management and general administrative activities of the PLAN, including, but not limited to:

- Management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements; or
- Customer service, including the provision of data analyses for policyholders, plan sponsors or other customers;
- Resolution of internal grievances; and
- Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a "covered entity" under HIPAA, or following the completion of the sale or transfer, will become a covered entity.

With an authorization, the PLAN will disclose PHI to other plans for purposes related to administration of these plans. The PLAN will disclose PHI to the PLAN Sponsor only upon receipt of a certification from the PLAN Sponsor that the plan documents have been amended to incorporate appropriate provisions.

The PLAN Sponsor agrees to:

- Not use or further disclose PHI other than as permitted or required by the plan document or as required by law;
- Ensure that any agents, including a subcontractor, to whom the PLAN Sponsor provides PHI received from the PLAN agree to the same restrictions and conditions that apply to the PLAN Sponsor with respect to such PHI;
- Not use or disclose PHI for employment related actions and decisions unless authorized by an individual;

- Not use or disclose PHI in connection with any other benefit or employee benefit plan of the PLAN Sponsor unless authorized by an individual;
- Report to the PLAN any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;
- Make PHI available to an individual in accordance with HIPAA's access requirements;
- Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- Make available the information required to provide an accounting of disclosures;
- Make internal practices, books, and records relating to the use and disclosure of PHI received from the PLAN available to the HHS Secretary for the purposes of determining the PLAN'S compliance with HIPAA; and
- If feasible, return or destroy all PHI received from the PLAN that the PLAN Sponsor still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose of which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destructions infeasible).

In accordance with HIPAA, only the following employees may be given access to PHI:

- The Human Resources Director
- The Benefits Director

The persons described above may only have access to and use and disclose PHI for plan administration functions that the PLAN Sponsor performs for the PLAN.

If the persons described above do not comply with this plan document, the PLAN ADMINISTRATOR shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

Electronic Protected Health Information

Electronic Protected Health Information generally means protected health information that is transmitted or maintained in any electronic media. When Electronic Protected Health Information will be created, received, maintained or transmitted to or by the PLAN Sponsor on behalf of the PLAN, the Plan Sponsor shall reasonably safeguard the Electronic Protected Health Information as follows:

- PLAN Sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic Protected Health Information that PLAN Sponsor creates, receives, maintains or transmits of behalf of the PLAN;
- PLAN Sponsor shall ensure that the adequate separation that is required by the HIPAA Privacy Rule is supported by reasonable and appropriate security measures;
- PLAN Sponsor shall ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect such information; and

- PLAN Sponsor shall report to the PLAN within a reasonable time after PLAN Sponsor becomes aware, any Security Incident that results in unauthorized access, use, disclosure, modification, or destruction of the PLAN'S Electronic Protected Health Information.

Blue Cross NC's Disclosure of Protected Health Information (PHI)

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

Administrative Discretion

Blue Cross NC shall have the discretionary authority to use its discretion to construe and to interpret the terms of the PLAN and to determine the amount of benefits, and its decision on such matters is final and conclusive. Such determinations include decisions concerning coverage of services, care, treatment or supplies, and reasonableness of charges. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect. Blue Cross NC medical policies are guides considered by Blue Cross NC when making coverage determinations.

North Carolina PROVIDER Reimbursement

Blue Cross NC has contracts with certain PROVIDERS of health care services for the provision of, and payment for, health care services provided to all MEMBERS entitled to health care benefits. Blue Cross NC's payment to PROVIDERS may be based on an amount other than the billed charges, including without limitation, an amount per confinement or episode of care, agreed upon schedule of fees, capitated fees, amounts based on cost, quality, utilization or other outcomes, or other methodology as agreed upon by Blue Cross NC and the PROVIDER. Under certain circumstances, a contracting PROVIDER may receive payments from Blue Cross NC greater than the charges for services provided to an eligible MEMBER, or Blue Cross NC may pay less than charges for services, due to negotiated contracts. The MEMBER is not entitled to receive any portion of the payments made under the terms of contracts with PROVIDERS. The MEMBER'S liability when defined as a percent of charge shall be calculated based on the lesser of the ALLOWED AMOUNT or the PROVIDER'S billed charge for COVERED SERVICES provided to a MEMBER.

Some OUT-OF-NETWORK PROVIDERS have other agreements with Blue Cross NC that affect their reimbursement for COVERED SERVICES provided to Blue Options MEMBERS. These PROVIDERS agree not to bill MEMBERS for any charges higher than their agreed upon, contracted amount. In these situations, MEMBERS will be responsible for the difference between the Blue Options ALLOWED AMOUNT and the contracted amount. OUT-OF-NETWORK PROVIDERS may bill you directly. If you are billed, you will be responsible for paying the bill and filing a claim with Blue Cross NC.

Services Received Outside of North Carolina

Blue Cross NC has a variety of relationships with other Blue Cross and/or Blue Shield licensees, generally referred to as "Inter-Plan Arrangements." As a MEMBER of the PLAN, you have access to PROVIDERS outside the state of North Carolina. Your ID CARD tells PROVIDERS that you are a MEMBER of the PLAN. While the PLAN maintains its contractual obligation to provide benefits to MEMBERS for COVERED SERVICES, the Blue Cross and/or Blue Shield licensee in the state where you receive services ("Host Blue") is responsible for contracting with and generally handling all interactions with its participating PROVIDERS. If you receive inpatient FACILITY SERVICES from an IN-NETWORK PROVIDER outside of North Carolina, except for Veterans' Affairs (VA), SKILLED NURSING FACILITIES and military PROVIDERS, the PROVIDER is responsible for requesting PRIOR REVIEW. If you see any other PROVIDER outside the State of North Carolina, you are responsible for ensuring that you or the PROVIDER requests PRIOR REVIEW by Blue Cross NC. Failure to request PRIOR REVIEW and obtain CERTIFICATION will result in a penalty. If you experience an EMERGENCY while traveling outside the state of North Carolina, go to the nearest EMERGENCY or URGENT CARE facility.

All claim types are eligible to be processed through Inter-Plan Arrangements, as described above, except for DENTAL SERVICES (unless provided under your medical benefits), PRESCRIPTION DRUG or vision care benefits that may be administered by a third party contracted by Blue Cross NC to provide the specific service or services. Whenever you obtain health care services outside the area in which the Blue Cross NC network operates, the claims for these services may be processed through one of these Inter-Plan Arrangements, which include the BlueCard Program and may include Negotiated National Account Arrangements available between Blue Cross NC and other Blue Cross and/or Blue Shield licensees.

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

- The billed charges for your COVERED SERVICES, or
- The negotiated price that the "Host Blue" passes on to Blue Cross NC.

This "negotiated price" can be:

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

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

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

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

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

If you receive COVERED SERVICES from a nonparticipating PROVIDER outside the state of North Carolina, the amount you pay will generally be based on either the Host Blue's nonparticipating PROVIDER local payment or the pricing arrangements required by applicable state law. However, in certain situations, the PLAN may use other payment bases, such as billed charges, to determine the amount the PLAN will pay for COVERED SERVICES from a nonparticipating PROVIDER. In other exception cases, Blue Cross NC may pay such a claim based on the payment it would make if Blue Cross NC were paying a nonparticipating PROVIDER for the same covered healthcare services inside of Blue Cross NC's service area, where the Host Blue's corresponding payment would be more than Blue Cross NC's in-service area nonparticipating PROVIDER payment, or in Blue Cross NC's sole and absolute discretion, Blue Cross NC may negotiate a payment with such a PROVIDER on an exception basis. In any of these situations, you may be liable for the difference between the nonparticipating PROVIDER'S billed amount and any payment the PLAN would make for the COVERED SERVICES.

Value-Based Programs: BlueCard® Program

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

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

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

Blue Cross Blue Shield Global Core:

If you are outside the United States (hereinafter "BlueCard service area"), you may be able to take advantage of the 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 Blue Cross NC to obtain precertification for non-EMERGENCY inpatient services.

Outpatient Services

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

Submitting a Blue Cross Blue Shield Global Core Claim

When you pay for COVERED SERVICES outside the BlueCard service area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a claim form and send the claim form with the PROVIDER'S itemized bill(s) to the service center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from Blue Cross NC, the service center or online at

www.BCBSglobalcore.com. If you need assistance with your claim submission, you should call the service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week.

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 the third party, the third party's insurer or any other source as a result of the MEMBER'S injuries. The lien is in the amount of benefits paid by the PLAN for the treatment of the illness, injury or condition for which another party is responsible.

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

The MEMBER acknowledges that the PLAN'S recovery rights are a first priority claim against all potentially responsible parties and are to be paid to the PLAN before any other claim for the MEMBER'S damages. The PLAN shall be entitled to full reimbursement first from any potentially responsible party payments, even if such payment to the PLAN will result in a recovery to the MEMBER which is insufficient to make the MEMBER whole or to compensate the MEMBER in part or in whole for the damages sustained. It is further understood that the PLAN 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 Blue Cross NC has been delegated authority by the PLAN ADMINISTRATOR to assert and pursue the right of subrogation and/or reimbursement on behalf of the PLAN. The MEMBER shall fully cooperate with Blue Cross NC's efforts to recover benefits paid by the PLAN. It is the duty of the MEMBER to notify Blue Cross NC in writing of the MEMBER'S intent to pursue a claim against any potentially responsible party, within 30 days of the date when any notice is given to any party, including an insurance company or

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

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

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

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

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

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

Recovery of Overpayment

If the amount of the payments made by Blue Cross NC is more than it should have paid under the PLAN, it may recover the excess from one or more of the persons it has paid or for whom it has paid, or any other person or organization that may be responsible for the benefits or services provided for the MEMBER. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Notice of Claim

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

Notice of Benefit Determination

Blue Cross NC will provide an explanation of benefits determination to the MEMBER or the MEMBER'S authorized representative within 30 days of Blue Cross NC'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 (unless the PLAN has chosen to provide an explanation of benefits for additional claims where the MEMBER does not have a financial liability other than a copayment).

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

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

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

Upon receipt of a denial of benefits, you have the right to file an appeal with Blue Cross NC. See "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. For plans that are subject to ERISA, this means that you must timely file an initial claim (if applicable) and timely file and complete a first level appeal of any ADVERSE BENEFIT DETERMINATION before bringing suit under ERISA. For plans that are not subject to ERISA, this means that you must file and complete a first level appeal and, for those COVERED SERVICES and items subject to a second level appeal, you must also file and complete a second level appeal. To confirm whether your plan is subject to ERISA, you should contact your PLAN ADMINISTRATOR.

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 for non-ERISA plans, a second level appeal, if required) 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.

Please see "Need to Appeal a Decision?" for details regarding the appeals process.

Evaluating New Technology

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

Coordination of Benefits (Overlapping Coverage)

If a MEMBER is also enrolled in another health plan, the PLAN may take into account benefits paid by the other plan. If state law provides automatic coverage for a set number of days following the birth of a newborn, Blue Cross NC may take into account benefits paid by another plan and the newborn would be considered covered for purposes of coordination of benefits.

Additionally, this PLAN always pays secondary to any medical payment, Personal Injury Protection (PIP) or no-fault coverage under any automobile policy available to you and to any plan or program which is required by law. All MEMBERS should review their automobile insurance policy to ensure that uncoordinated medical benefits have been chosen so that the automobile insurance policy is the primary payer.

Coordination of benefits (COB) means that if a MEMBER is covered by more than one insurance plan or automobile policy as described above, benefits under one insurance plan are determined before the benefits are determined under the second insurance plan. The insurance plan that determines benefits first is called the primary insurance plan. The other insurance plan is called the secondary insurance plan.

Benefits paid by the secondary 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 health insurance plans include a COB provision. Payment by Blue Cross NC under the PLAN takes into account whether or not the PROVIDER is a participating PROVIDER. If the PLAN is the secondary plan, and the MEMBER uses a participating PROVIDER, the PLAN will coordinate up to the ALLOWED AMOUNT. The participating PROVIDER has agreed to accept the ALLOWED AMOUNT as payment in full.

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

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

Blue Cross NC, on behalf of the PLAN may request information about the other plan from the MEMBER. A prompt reply will help Blue Cross NC process payments quickly. There will be no payment until primary coverage is determined. It is important to remember that even when benefits from other health plans are taken into account, **benefits for COVERED SERVICES under this PLAN are still subject to program requirements, such as PRIOR REVIEW and CERTIFICATION procedures.**

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.

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

When a person is covered by 2 group health plans, and	Then	Primary	Secondary
One plan does not have a COB provision	The plan without the provision is	√	
	The plan with the provision is		√
The person is the participant under one plan and a DEPENDENT under the other	The plan covering the person as the participant is	√	
	The plan covering the person as a DEPENDENT is		√
The person is covered as a DEPENDENT CHILD under both plans and parents are either: 1) married or living together; or 2) divorced/separated or not living together and a court decree* states that they have joint custody without specifying which parent is responsible for the DEPENDENT CHILD's health care coverage; or 3) divorced/separated or not living together and a court decree* states	The plan of the parent whose birthday occurs earlier in the calendar year (known as the birthday rule*, see exception below) is	√	

When a person is covered by 2 group health plans, and	Then	Primary	Secondary
that both parents have responsibility for the DEPENDENT CHILD's health care coverage; or 4) divorced/separated or not living together with no court decree for coverage for the DEPENDENT CHILD'S health care coverage and the person is age 18 or older	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 *Exception: If DEPENDENT CHILD is age 18 or older the *birthday rule will be used to determine primary only if the parents are still married or living together.*	√	
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. Unless otherwise stated, a court decree is not applicable to a DEPENDENT CHILD age 18 years or older. If a court decree does specify coverage over the age of 18 the court decree will succeed any prior rule.*		
The person is covered as a DEPENDENT CHILD under both plans and parents are divorced/separated or not	The plan of the parent primarily responsible for health coverage under the court decree is	√	

When a person is covered by 2 group health plans, and	Then	Primary	Secondary
living together, and coverage is stipulated in a court decree*	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 Blue Cross NC has actual knowledge of those terms of the court decree, benefits under that parent's plan are	√	
The person is 18 years old or older and is covered as a SUBSCRIBER/EMPLOYEE under one plan and a DEPENDENT CHILD under the other	The plan that covers a person as a SUBSCRIBER/EMPLOYEE is	√	
	The plan that covers a person as a DEPENDENT CHILD is		√
The person is 18 years old or older and is covered as a spouse under one plan and a DEPENDENT CHILD under the other	The plan that has been in effect longer is	√	
	The plan that has been in effect the shorter amount of time is		√
The person is 18 years old or older and is covered as a DEPENDENT CHILD under both plans with the SUBSCRIBER'S relationship to the person being a biological parent under one of the plans and a step-parent (married to the same biological parent) under the other	The plan of the biological parent is	√	
	The plan of the step-parent is		√
The person is 18 years old or older and is covered as a DEPENDENT CHILD under both plans with the SUBSCRIBER'S relationship	The plan of the biological parent is	√	

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

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

FEDERAL NOTICES

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

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 non-diseased breast to produce a symmetrical appearance without regard to the lapse of time between the mastectomy and the reconstructive SURGERY
- Prostheses and physical complications of all stages of the mastectomy, including lymphedemas.

See PROVIDER's Office, or for external prostheses, see PROSTHETIC APPLIANCES in Other Services in the "Summary of Benefits."

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

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

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 this 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.

The above timeframes may be extended by federal law. Please contact your PLAN ADMINISTRATOR with any questions.

Programs Outside Your Regular Benefits

The PLAN ADMINISTRATOR and Blue Cross NC may add programs that are outside your regular benefits. These programs may be changed from time to time. Following are examples of programs that may be included outside your regular benefits:

- Health and wellness programs, including discounts 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
- 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 Blue Cross NC's website
- Rewards or drawings for gifts based on participation in initiatives and/or programs to reduce health care costs
- Quarterly, semi-annual, and/or annual drawings for gifts, which may include club memberships and trips to special events, based on submitting activity diaries
- Charitable donations made on your behalf by Blue Cross NC
- Discounts or other savings on retail goods and services.

These discounts on goods and services may not be provided directly by the PLAN or Blue Cross NC, but may instead be arranged for your convenience. These discounts are outside the PLAN benefits. Neither the PLAN nor Blue Cross NC 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 Blue Cross NC is liable for third party PROVIDERS' negligent provision of the gifts. The PLAN ADMINISTRATOR or Blue Cross NC may stop or change these programs at any time.

Health and Wellness Programs

Blue Cross NC 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 for 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.

Full details on these programs, including a description of what's available and how to get started, are located on Blue Cross NC's website at **www.BlueCrossNC.com**. Programs are available at the discretion of your EMPLOYER. Check with your PLAN ADMINISTRATOR. To find out more about these programs or to determine which programs are available to you, log into **www.BlueConnectNC.com** or call Blue Cross NC Customer Service.

Health Information Services

If you have certain health conditions, Blue Cross NC or a representative of Blue Cross NC 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.

GLOSSARY

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 resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be EXPERIMENTAL or INVESTIGATIONAL or not MEDICALLY NECESSARY or appropriate. Rescission of coverage and initial eligibility determinations are also included as adverse benefit determinations.

ALLOWED AMOUNT

The maximum amount that Blue Cross NC determines is reasonable for COVERED SERVICES provided to a MEMBER. The allowed amount includes any Blue Cross NC payment to the PROVIDER, plus any deductible, coinsurance or copayment. For PROVIDERS that have entered into an agreement with Blue Cross NC, the allowed amount is the negotiated amount that the PROVIDER has agreed to accept as payment in full. The allowed amount may be based on a schedule of fees, capitated arrangement or other formula agreed upon between the PROVIDER and Blue Cross NC. Except as otherwise specified in "EMERGENCY and Ambulance Services," for PROVIDERS that have not entered into an agreement with Blue Cross NC, the allowed amount will be the lesser of the PROVIDER'S billed charge or an amount based on an OUT-OF-NETWORK fee schedule established by Blue Cross NC or through the BlueCard system that is applied to comparable PROVIDERS for similar services under a similar health benefit plan. Where Blue Cross NC has not established an OUT-OF-NETWORK fee schedule amount for the billed service, the allowed amount will be the lesser of the PROVIDER'S billed charge or an amount established by Blue Cross NC or through the BlueCard system using a methodology that is applied to comparable PROVIDERS who may have entered into an agreement with Blue Cross NC for similar services under a similar health benefit plan. Other than described above, Blue Cross NC will not pay the OUT-OF-NETWORK PROVIDER'S billed charge unless doing so is required by law. Calculation of the allowed amount is based on several factors including Blue Cross NC's medical, payment and administrative guidelines. Under the guidelines, some procedures charged separately by the PROVIDER may be combined into one procedure for reimbursement purposes.

AMBULATORY INFUSION SUITE

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.

BIOLOGIC

A complex large molecule drug produced from protein or living organisms.

BIOSIMILAR

PRESCRIPTION DRUG products approved by the U.S. Food and Drug Administration (FDA) that are subsequent versions of previously approved BIOLOGIC drugs, also known as follow-on biologics. Biosimilar drugs are manufactured after the patent and exclusivity protection of the BIOLOGIC drug has expired.

BRAND-NAME

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

CERTIFICATION

The determination by Blue Cross NC that an admission, availability of care, continued stay, or other services, supplies or drugs have been reviewed and, based on the information provided, satisfy Blue Cross NC's requirements for MEDICALLY NECESSARY services and supplies, appropriateness, health care setting, level of care and effectiveness.

COMPLICATIONS OF PREGNANCY

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

CONGENITAL

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

COSMETIC

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

COVERED SERVICE(S)

A service, drug, supply or equipment specified in this benefit booklet for which MEMBERS are entitled to benefits in accordance with the terms and conditions of the PLAN. Any services in excess of a BENEFIT PERIOD MAXIMUM or LIFETIME MAXIMUM are not covered services.

CREDITABLE COVERAGE

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

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 Blue Cross NC as a generally accepted form of care or treatment according to prevailing standards of dental practice.

DENTIST

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

DEPENDENT

A MEMBER other than the EMPLOYEE as specified in "When Coverage Begins and Ends."

DEPENDENT CHILD(REN)

A child, 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 for adoption), FOSTER CHILD, or 2) a child for whom legal guardianship has been awarded to the EMPLOYEE and/or spouse, or 3) a child for whom the EMPLOYEE and/or spouse is required by court or administrative order to provide coverage. 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, a doctor of pharmacy, or a doctor of psychology who must be licensed or certified in the state of practice and has a doctorate degree in psychology and at least two years clinical experience in a recognized health setting or has met the standards of the National Register of Health Service Providers in Psychology. All of the above must be duly licensed to practice by the state in which any service covered by the contract is performed, regularly charge and collect fees as a personal right, subject to any licensure or regulatory limitation as to location, manner or scope of practice. All services performed must be within the scope of license or certification to be eligible for reimbursement.

DURABLE MEDICAL EQUIPMENT

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

EDUCATIONAL TREATMENT

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

EFFECTIVE DATE

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

EMERGENCY(IES)

A medical condition including a mental health or substance use disorder 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 MEMBER, the health of the MEMBER or their unborn child in serious jeopardy,

b) serious impairment to bodily functions,

c) serious dysfunction of any bodily organ or part.

EMERGENCY SERVICES

Health care items and services furnished or required to screen for or treat an EMERGENCY medical condition, including but not limited to, 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

Asahi KASEI America, Inc.

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. No annual or lifetime dollar limits can apply to essential health benefits.

EXPERIMENTAL

See INVESTIGATIONAL.

FACILITY SERVICES

COVERED SERVICES provided and billed by a HOSPITAL or NONHOSPITAL FACILITY. All services performed must be within the scope of license or certification to be eligible for reimbursement.

FORMULARY

The list of outpatient PRESCRIPTION DRUGS, insulin, and certain over-the-counter drugs that may be available to MEMBERS.

FOSTER CHILD(REN)

Children under age 18 i) for whom a guardian has been appointed by any clerk of superior court 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.

GENERIC

A PRESCRIPTION DRUG that has the same active ingredient as a BRAND-NAME drug, has the same dosage form and strength as the BRAND-NAME drug, and has the same mechanism of action in the body as the BRAND-NAME drug. The classification of a PRESCRIPTION DRUG as a generic is determined by Blue Cross NC based on commercially available data resources, and other external classification sources, such as the U.S. Food and Drug Administration (FDA) and nationally-recognized drug databases.

GRIEVANCE

Grievances include dissatisfaction with our decisions, policies or actions related to the availability, delivery or quality of health care services, or with the contractual relationship between the MEMBER and Blue Cross NC.

HABILITATIVE SERVICES

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

HOMEBOUND

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

HOME HEALTH 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 Blue Cross NC.

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 Blue Cross NC.

HOSPITAL

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

IDENTIFICATION CARD (ID CARD)

The card issued to MEMBERS upon enrollment which provides EMPLOYER/MEMBER identification numbers, 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

A disease condition, or status characterized by any of the following:

a) The inability to achieve a successful pregnancy based on a patient's medical, sexual, and reproductive history, age, physical findings, diagnostic testing, or any combination of those factors.

b) The need for medical intervention, including, but not limited to, the use of donor gametes or donor embryos to achieve a successful pregnancy either as an individual or with a partner

c) In patients having regular, unprotected intercourse and without any known etiology for either partner suggestive of impaired reproductive ability, evaluation should be initiated at 12 months when the female partner is under 35 years of age and at 6 months when the female partner is 35 years of age or older.

IN-NETWORK

Designated as participating in the Blue Options network. Blue Cross NC's payment for in-network COVERED SERVICES is described in this benefit booklet as in-network benefits or in-network benefit levels.

IN-NETWORK PROVIDER

A HOSPITAL, DOCTOR, other medical practitioner or PROVIDER of medical services and supplies that has been designated as a Blue Options PROVIDER by Blue Cross NC or a PROVIDER participating in the BlueCard Program. ANCILLARY PROVIDERS outside North Carolina are considered IN-NETWORK only if they contract directly with the Blue Cross or Blue Shield plan in the state where services are received, even if they participate in the BlueCard Program.

INVESTIGATIONAL (EXPERIMENTAL)

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

a) Services or supplies requiring federal or other governmental body approval, such as drugs and devices that do not have unrestricted market approval from the 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 Blue Cross NC's evaluation of the therapeutic value of the service or supply

c) There is inconclusive evidence that the service or supply has a beneficial effect on health outcomes

d) The service or supply under consideration is not as beneficial as any established alternatives

e) There is insufficient information or inconclusive scientific evidence that, when utilized in a non-investigational setting, the service or supply has a beneficial effect on health outcomes and is as beneficial as any established alternatives.

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

LICENSED PRACTICAL NURSE (LPN)

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

LIFETIME MAXIMUM

The benefit maximum of certain COVERED SERVICES, such as INFERTILITY services, INFERTILITY drugs and cranial bands (including dynamic orthotic cranioplasty (DOC) bands, orthotic devices for correction of POSITIONAL PLAGIOCEPHALY and soft helmets), that will be reimbursed on behalf of a MEMBER while covered under the PLAN. Services in excess of any lifetime maximum are not COVERED SERVICES, and MEMBERS may be responsible for the entire amount of the PROVIDER'S billed charge. See "Summary of Benefits" for any limits that may apply.

MEDICAL SUPPLIES

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

MEDICALLY NECESSARY (or MEDICAL NECESSITY)

Those COVERED SERVICES or supplies that are:

a) Provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease.

b) Except as allowed under G.S. 58-3-255, not for EXPERIMENTAL, INVESTIGATIONAL, or COSMETIC purposes.

c) Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms.

d) Within generally accepted standards of medical care in the community.

e) Not solely for the convenience of the insured, the insured's family, or the PROVIDER.

For medically necessary services, nothing in this subdivision precludes an insurer from comparing the cost-effectiveness of alternative services, or supplies when determining which of the services or supplies will be covered.

MEMBER

An EMPLOYEE or DEPENDENT, who is currently enrolled in the PLAN and for whom premium is paid.

MENTAL ILLNESS

(1) When applied to an adult MEMBER, an illness which so lessens the capacity of the individual to use self-control, judgment, and discretion in the conduct of his/her affairs and social relations as to make it necessary or advisable for him/her to be under treatment, care, supervision, guidance, or control; and (2) when applied to a DEPENDENT CHILD, 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-V").

NONCERTIFICATION

An ADVERSE BENEFIT DETERMINATION by Blue Cross NC that a service covered under the PLAN has been reviewed and does not meet Blue Cross NC's requirements for MEDICAL NECESSITY, 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 Blue Cross NC. All services performed must be within the scope of license or certification to be eligible for reimbursement.

OFFICE VISIT

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

- Medical care
- SURGERY
- Diagnostic Services
- REHABILITATIVE THERAPY and HABILITATIVE SERVICES
- MEDICAL SUPPLIES
- Mental health and substance use disorder services (evaluation and diagnosis, group therapy, individual and family counseling, and intensive outpatient program services (less than four hours per day and minimum of nine hours per week)).

OTHER PROFESSIONAL PROVIDER

A person or entity other than a DOCTOR who is accredited and licensed or certified in the state where located to provide COVERED SERVICES, and which is acceptable to Blue Cross NC. 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 Blue Cross NC. All services performed must be within the scope of license or certification to be eligible for reimbursement.

OTHER THERAPY(IES)

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

a) Cardiac rehabilitative therapy—reconditioning the cardiovascular system through exercise, education, counseling and behavioral change

b) Chemotherapy (including intravenous chemotherapy)—the treatment of malignant disease by chemical or biological antineoplastic agents which have received full, unrestricted market approval from the 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 Blue Options network, and not certified in advance by Blue Cross NC to be considered as IN-NETWORK. Payment for out-of-network COVERED SERVICES is described in this benefit booklet as out-of-network benefits or out-of-network benefit levels.

OUT-OF-NETWORK PROVIDER

A PROVIDER that has not been designated as a Blue Options PROVIDER by Blue Cross NC.

OUT-OF-POCKET LIMIT

The maximum amount listed in "Summary of Benefits" that is payable by the MEMBER in a BENEFIT PERIOD before the PLAN pays 100% of COVERED SERVICES. It includes deductible, coinsurance, and any applicable copayments.

OUTPATIENT CLINIC(S)

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

PLAN

The EMPLOYER health benefit plan established by Asahi KASEI America, Inc. to provide health benefits for participants.

PLAN ADMINISTRATOR

Asahi KASEI America, Inc.

PLAN SPONSOR

Asahi KASEI America, Inc.

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.

PREFERRED PROVIDER BENEFIT PLAN

A health benefit plan offered by an insurer in which COVERED SERVICES are available from health care PROVIDERS who are under a contract with the insurer and in which enrollees are given incentives through differentials in deductibles, coinsurance, or copayments to obtain covered health care services from contracted health care PROVIDERS.

PRESCRIPTION

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

PRESCRIPTION DRUG

A drug that has been approved by the U.S. Food and Drug Administration (FDA) and is required, prior to being dispensed or delivered, to be labeled "Caution: federal law prohibits dispensing without PRESCRIPTION," or labeled in a similar manner, and is appropriate to be administered without the presence of a medical supervisor.

PREVENTIVE CARE

Medical services provided by or upon the direction of a DOCTOR or OTHER PROVIDER 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 Blue Cross NC as a PCP.

PRIOR REVIEW

The consideration of benefits for an admission, availability of care, continued stay, or other services, supplies or drugs, based on the information provided and requirements for a determination of MEDICAL NECESSITY of services and supplies, appropriateness, health care

setting, or level of care and effectiveness. Prior review results in CERTIFICATION or 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 for care of a terminally ill MEMBER. Respite care is provided in-home or at an alternative location for a short stay, often in an inpatient HOSPICE setting. Services include support of activities of daily living such as feeding, dressing, bathing, routine administration of medicines, and can also include intermittent skilled nursing services that the caregiver has been trained to provide.

RESTRICTED-ACCESS (STEP THERAPY) DRUGS OR DEVICES

Covered PRESCRIPTION DRUGS or devices for which reimbursement by Blue Cross NC is conditioned on: (1) Blue Cross NC's giving CERTIFICATION to prescribe the drug or device or (2) the PROVIDER prescribing one or more alternative drugs or devices before prescribing the drug or device in question.

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.

SERIOUS AND COMPLEX CONDITION

The term "serious and complex condition" means, with respect to a participant, beneficiary, or enrollee under a group health plan or group or individual health insurance coverage:

a) in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or

b) in the case of a chronic illness or condition, a condition that is:

   i. life-threatening, degenerative, potentially disabling, or CONGENITAL; and
   ii. requires specialized medical care over a prolonged period of time.

SEXUAL DYSFUNCTION

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

SKILLED NURSING FACILITY

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

SPECIALIST

A DOCTOR who is recognized by Blue Cross NC as specializing in an area of medical practice.

SPECIALTY DRUG(S)

Those medications classified by Blue Cross NC 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.

SPECIFIED SEX-TRAIT MODIFICATION PROCEDURES

Any pharmaceutical or surgical intervention that is provided for the purpose of attempting to align an individual's physical appearance or body with an asserted identity that differs from the individual's sex either by: (1) intentionally disrupting or suppressing the normal development of natural biological functions, including primary or secondary sex-based traits; or (2) intentionally altering an individual's physical appearance or body, including amputating, minimizing or destroying primary or secondary sex-based traits such as the sexual and reproductive organs. Such term does not include procedures undertaken (1) to treat a person with a medically verifiable disorder of sexual development, or (2) for purposes other than attempting to align an individual's physical appearance or body with an asserted identity that differs from the individual's sex.

STEP THERAPY

See RESTRICTED-ACCESS (STEP THERAPY) DRUGS OR DEVICES

SUBSCRIBER

The person who is eligible for coverage under this health benefit 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 Blue Cross NC.

TIER 1 DRUGS

The PRESCRIPTION DRUG tier which consists of the lowest cost tier of PRESCRIPTION DRUGS, most are GENERIC.

TIER 2 DRUGS

The PRESCRIPTION DRUG tier which consists of medium-cost PRESCRIPTION DRUGS, most are GENERIC and some BRAND-NAME PRESCRIPTION DRUGS.

TIER 3 DRUGS

The PRESCRIPTION DRUG tier which consists of high-cost PRESCRIPTION DRUGS, most are BRAND-NAME PRESCRIPTION DRUGS.

TIER 4 DRUGS

The PRESCRIPTION DRUG tier which consists of the higher-cost PRESCRIPTION DRUGS, most are BRAND-NAME PRESCRIPTION DRUGS, and some SPECIALTY DRUGS.

TIER 5 DRUGS

The PRESCRIPTION DRUG tier which consists of some of the highest-cost PRESCRIPTION DRUGS, most are SPECIALTY DRUGS.

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.

OTHER IMPORTANT PLAN INFORMATION

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 - Group Health Plan for Asahi KASEI Health and Welfare Plan

Name, Address and Telephone Number of PLAN SPONSOR

Asahi KASEI America, Inc.
Attn: Evan Sizemore
13800 South Lakes Drive
Charlotte, NC 28273
(704) 587-8574

Other EMPLOYERS Adopting the plan(s)

N/A

Employer Identification Number of PLAN SPONSOR

13-2698638

Identification of PLAN ADMINISTRATOR

Asahi KASEI America, Inc.
13800 South Lakes Drive
Charlotte, NC 28273

Benefits Provided by PLAN(S)

Medical Insurance—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 Group Number 14163742 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. This PLAN year ends Dec 2026.

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

Exception process for ACA preventive services

A cost share waiver exception process exists for preventive medications and devices in certain circumstances. If a healthcare PROVIDER certifies that you are clinically unable to utilize the medications/devices available at $0 cost share, then the requested alternate drug/device may be provided at $0 cost share for the MEMBER when the required criteria is met. Exception forms and instructions can be found at **www.bluecrossnc.com/umdrug**. The cost share waiver does not apply when an OUT-OF-NETWORK or non-contracting pharmacy PROVIDER is used. Cost share is waived only when the medication or device is prescribed for PREVENTIVE CARE. If you have questions about the exceptions process, call Blue Cross's Customer Service number listed in "Who to Contact?" or on the back of your ID CARD.

Assignability

Benefits payable under the PLAN may be used to make direct payments to service providers. Unless the law requires otherwise, benefits may not be subject in any manner to alienation by anticipation, sale, transfer, assignment, bankruptcy, pledge, attachment, charge or encumbrance of any kind. Any attempt to alienate, sell, transfer, assign, pledge, attach, charge or otherwise encumber any benefit amount will be void. The PLAN will not be liable for or subject to any part of your debts or liabilities. If, by reason of your bankruptcy or other event happening at any such time, an amount payable under the PLAN would not be enjoyed by you, then the PLAN ADMINISTRATOR may terminate your interest in any such amount and shall hold or apply it to your benefit or to your dependent's benefit, in the manner the PLAN ADMINISTRATOR may deem proper. Aside from this, amounts payable under the PLAN may be assigned as provided in the PLAN.

General Plan Provisions

Amendment and Termination

The EMPLOYER expects and intends to continue the PLAN indefinitely. However, the EMPLOYER reserves the right to amend or terminate the PLAN at any time and for any reason, by written action of the board of directors of the EMPLOYER. If the PLAN is amended or terminated, you and other active EMPLOYEES may not receive benefits as described in other sections of the PLAN. You may be entitled to receive different benefits, or benefits under different conditions. However, it is possible that you will lose all benefit coverage. This may happen at any time, if the EMPLOYER decides to terminate the PLAN or your coverage under the PLAN. In no event will

you become entitled to any vested rights under this PLAN. Further the provisions of this paragraph cannot be modified in any manner except by resolution of the board of directors of the EMPLOYER.

Compliance with Federal Laws

The provisions of the PLAN shall be construed, administered and enforced according to applicable Federal law and, to the extent not pre-empted, the laws of the State of North Carolina. The terms of this PLAN shall be construed and administered in a manner calculated to meet the minimum requirements of applicable law, including but not limited to, the Americans with Disabilities Act of 1990, the Family and Medical Leave Act of 1993, the Uniformed Services Employment and Reemployment Rights Act of 1994, the Health Insurance Portability and Accountability Act of 1996, the Newborns' and Mothers' Health Protection Act of 1996, and the Women's Health and Cancer Rights Act of 1998. To the extent a PLAN provision is contrary to or fails to address the minimum requirements of these Federal laws, the PLAN shall provide the coverage or benefit necessary to comply with such minimum requirements.

Judicial Review

The PLAN ADMINISTRATOR and any persons acting in a fiduciary capacity under the PLAN shall have the maximum legal discretion to make decisions concerning the operation and administration of the PLAN including, but not limited to, the provision or denial of benefits and factual determinations related thereto. Such decisions shall not be subject to further review unless determined to be an abuse of discretion.

BLUE OPTIONS

Blue Cross NC MEMBER RIGHTS AND RESPONSIBILITIES

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

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

As a Blue Cross NC MEMBER, you should:

- Present your Blue Cross NC ID CARD each time you receive a service
- Read your Blue Cross NC benefit booklet and all other Blue Cross NC MEMBER materials
- Call Blue Cross NC when you have a question or if the material given to you by Blue Cross NC is not clear
- Follow the course of treatment prescribed by your DOCTOR. If you choose not to comply, advise your DOCTOR.

Blue Cross NC MEMBER RIGHTS AND RESPONSIBILITIES *(cont.)*

- Provide Blue Cross NC and your DOCTORS with complete information about your illness, accident or health care issues, which may be needed in order to provide care
- Understand your health problems and participate in developing mutually agreed-upon treatment goals to the degree possible
- Make appointments for non-EMERGENCY medical care and keep your appointments. If it is necessary to cancel an appointment, give the DOCTOR's office at least 24-hours notice.
- Play an active part in your health care
- Be polite to network DOCTORS, their staff and Blue Cross NC staff
- Tell your place of work and Blue Cross NC if you have any other group coverage
- Tell your place of work about new children under your care or other family changes as soon as you can
- Protect your Blue Cross NC ID CARD from improper use
- Comply with the rules outlined in your MEMBER benefit guide.

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English
ATTENTION: If you speak any of the following languages, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-888-206-4697 (TTY: 711) or speak to your provider.

Spanish / Español
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayudas y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-888-206-4697 (TTY: 711) o hable con su proveedor.

Chinese / 中文
注意：如果您说中文，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-888-206-4697（文本电话：711）或咨询您的服务提供商。

Vietnamese / Việt
LƯU Ý: Nếu quý vị nói tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ được cấp miễn phí. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-888-206-4697 (Người khuyết tật: 711) hoặc trao đổi với nhà cung cấp dịch vụ của quý vị.

Korean / 한국어
알림: 한국어를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-888-206-4697 (TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오.

French / Français
ATTENTION: Si vous parlez français, vous pouvez bénéficier de services d'assistance gratuits. Vous avez également à votre disposition des outils et services supplémentaires vous permettant de fournir des informations dans un format accessible, sans frais. Appelez le 1-888-206-4697 (TTY : 711) ou parlez à votre fournisseur.

Arabic / العربية
تنبيه: إذا كنت تتحدث اللغة العربية، تتوفر لك خدمات مساعدة لغوية مجانية. كما تتوفر مساعدة وخدمات إضافية مناسبة لتقديم المعلومات بتنسيقات يمكن الوصول إليها مجانًا. يُرجى الاتصال على الرقم 1-888-206-4697 (TTY: 711) أو تحدث مع مزود الخدمة الخاص بك.

Hmong / Lus Hmoob
LUG CEEV TSHWJ XEEB: yog has tas koj has lug Hmoob muaj cov kev paab cuam txhais lug pub dlawb rua koj. Cov kev paab hab cov kev paab cuam ntxiv kws tsim nyog txhawm rua muab lug qha paub ua cov hom ntaub ntawv kws tuaj yeem nkaag cuag tau rua los kuj yeej tseem muaj paab dlawb tsis xaam tug nqe dlaab tsi tuab yaam nkaus. Hu rua 1-888-206-4697 (TTY: 711) los yog thaam nrug koj tug kws muab kev saib xyuas khu mob.

BLUE CROSS® BLUE SHIELD®, the Cross and Shield symbol and services marks are the marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans. Blue Cross NC is an independent licensee of the Blue Cross and Blue Shield Association.

Russian / РУССКИЙ
ВНИМАНИЕ: Если Вы говорите на русском, то Вам доступны бесплатные услуги языковой поддержки. Соответствующие инструменты и информационные сервисы также предоставляются бесплатно. Позвоните по телефону 1-888-206-4697 (TTY: 711) или обратитесь к своему поставщику услуг.

Tagalog
PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-888-206-4697 (TTY: 711) o makipag-usap sa iyong provider.

Gujarati / ગુજરાતી

ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હોવ તો, મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઑક્ઝિલરી સહાય અને ઍક્સેસિબલ ફૉર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 1-888-206-4697 (TTY: 711) પર કૉલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.

Mon-Khmer, Cambodian / ភាសាខ្មែរ
កំណត់ចំណាំ៖ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ សេវាកម្មជំនួយភាសាឥតគិតថ្លៃគឺមានផ្តល់ជូនសម្រាប់អ្នក។ ជំនួយ និងសេវាកម្មសម្រាប់ក្នុងការផ្តល់ព័ត៌មានតាមទម្រង់ដែលអាចចូលប្រើប្រាស់បានក៏មានផ្តល់ជូនដោយឥតគិតថ្លៃដែរ។ សូមទូរស័ព្ទទៅលេខ 1-888-206-4697 (TTY:711)
ឬនិយាយជាមួយផ្តល់សេវារបស់អ្នក។

German / Deutsch
WICHTIGER HINWEIS: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-888-206-4697 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.

Hindi/ हिंदी
ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएं भी निःशुल्क उपलब्ध हैं। 1-888-206-4697 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।

Laotian / ລາວ

ເຊີນຊາບ: ຖ້າທ່ານເວົ້າພາສາ ລາວ, ຈະມີບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ມີເຄື່ອງຊ່ວຍ ແລະ ການບໍລິການແບບບໍ່ເສຍຄ່າທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້. ໂທຫາເບີ 1-888-206-4697 (TTY: 711) ຫຼື ລົມກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ.

Japanese / 日本語

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