Benefit Booklet

For High Country Community Health

for

BlueOptions®

An Independent Licensee of the Blue Cross and Blue Shield Association

L1338, 7/13

BENEFIT BOOKLET

This benefit booklet, along with the GROUP CONTRACT, is the legal contract between your EMPLOYER and Blue Cross and Blue Shield of North Carolina. **Please read this benefit booklet carefully.**

Blue Cross and Blue Shield of North Carolina agrees to provide benefits to the qualified SUBSCRIBERS and eligible DEPENDENTS who are listed on the enrollment application and who are accepted in accordance with the provisions of the GROUP CONTRACT entered into between Blue Cross and Blue Shield of North Carolina and the SUBSCRIBER'S EMPLOYER. A summary of benefits, conditions, limitations, and exclusions is set forth in this Benefit Booklet for easy reference.

Blue Cross and Blue Shield of North Carolina has directed that this Benefit Booklet be issued and signed by the President and the Secretary.

BLUE CROSS AND BLUE SHIELD OF NORTH CAROLINA
Incorporated 1968 North Carolina

Attest:

President

Secretary

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

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RECENT CHANGES

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GETTING STARTED WITH BLUE OPTIONS

IMPORTANT INFORMATION REGARDING THIS HEALTH BENEFIT PLAN: In accordance with applicable federal law, Blue Cross and Blue Shield of North Carolina (Blue Cross NC) 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, Blue Cross NC 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 "Glossary" at the end of this benefit booklet. The terms "we," "us," and "Blue Cross NC" refer to Blue Cross and Blue Shield of North Carolina.

This Booklet

This booklet tells you about:

- Your COVERED SERVICES and exclusions or services that are not covered
- How your health benefit plan works
- How we share expenses for COVERED SERVICES
- Who is eligible to be covered under this health benefit 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 your health benefit plan.

PRIOR REVIEW and CERTIFICATION

Certain services require PRIOR REVIEW and CERTIFICATION in order for you to avoid a full denial of benefits. General categories of services requiring PRIOR REVIEW and CERTIFICATION are noted in "COVERED SERVICES." To determine if a specific service requires PRIOR REVIEW and CERTIFICATION, visit our 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. 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 this health benefit plan, and the right to enforce any claim arising under this health benefit 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 this group health 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 this health benefit plan. Under this health benefit 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 this health benefit plan, including but not limited to benefits, payments or procedures.

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**, 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.

- Depending on your plan, the manufacturer may, from time to time, provide a rebate, or discount for certain PRESCRIPTION DRUGS, or DURABLE MEDICAL EQUIPMENT. These rebates may be automatically applied to the ALLOWED AMOUNT of the PRESCRIPTION DRUG, or DURABLE MEDICAL EQUIPMENT, reducing the cost-sharing amounts you may owe. Which PRESCRIPTION DRUGS, or DURABLE MEDICAL EQUIPMENT receive rebates and how long the rebates are in place may change without notice.

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, if this health benefit plan includes copayments. Copayments are not credited to the deductible; however, they are credited to the TOTAL OUT-OF-POCKET LIMIT.
Deductible	The amount of money you must pay for COVERED SERVICES in a BENEFIT PERIOD before Blue Cross NC begins to pay for COVERED SERVICES. The deductible does not include coinsurance, charges in excess of the ALLOWED AMOUNT, amounts exceeding any maximum, or charges for noncovered services.
Coinsurance	The sharing of charges by Blue Cross NC and you for COVERED SERVICES, after you have met your BENEFIT PERIOD deductible. This is stated as a percentage. The coinsurance listed is your share of the cost of a COVERED SERVICE.
TOTAL OUT-OF-POCKET LIMIT	The TOTAL OUT-OF-POCKET LIMIT is the dollar amount you pay for COVERED SERVICES in a BENEFIT PERIOD before Blue Cross NC pays 100% of COVERED SERVICES. It includes ESSENTIAL HEALTH BENEFITS and non-essential health benefits. It does not include charges over the ALLOWED AMOUNT, premiums, penalties and charges for noncovered services.

Here is an **example** of what your costs could be for IN-NETWORK or OUT-OF-NETWORK services. 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
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%) $450**	**(40%) $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.

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

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 IDENTIFICATION CARDS (ID CARDS), get helpful wellness information and more.
Blue Cross NC Customer Service: 1-877-258-3334 TTY/TDD: 1-800-442-7028	For questions about your benefits, claims, new ID CARD requests, or to voice a complaint.
PRESCRIPTION DRUG Information: 1-877-258-3334 and **www.BlueCrossNC.com/umdrug**	You may visit our 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: MEMBERS call: 1-877-258-3334 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.**
HealthLine BlueSM: 1-877-477-2424	Talk to a nurse 24/7 to get timely information and help on a number of health-related issues. Nurses are on hand by phone in both English and Spanish.
Teladoc Telehealth: 1-800-835-2362 and	For 24/7 access to a DOCTOR regarding non-EMERGENCY medical issues, call or visit the website to ask for a

https://www.teladoc.com	consultation. DOCTORS will be able to diagnose and suggest a treatment that's appropriate.
Nurse Support: 1-888-229-8510	Talk to a Nurse Advocate about receiving support for managing asthma, diabetes, congestive heart failure, coronary artery disease (CAD) and chronic obstructive pulmonary disease (COPD), or hypertension. Please talk to your GROUP ADMINISTRATOR to see if this program is available to you.
My Pregnancy: **www.BCBSNC.com/mypregnancy**	The maternity program will provide you with support for managing your pregnancy. Please talk to your GROUP ADMINISTRATOR to see if this program is 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.

Value-Added Programs

Not all plans have these Value-Added programs. These programs are not covered benefits and are outside of this health benefit plan. To see if these programs are available, talk to your GROUP ADMINISTRATOR. Blue Cross NC does not accept claims or reimburse for these goods or services, and MEMBERS are responsible for paying all bills. 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:

- If applicable, multiple OFFICE VISITS or emergency room visits on the same day may result in multiple copayments
- Coinsurance percentages shown in this section are the part that you pay for COVERED SERVICES
- Amounts applied to deductible and coinsurance are based on the ALLOWED AMOUNT
- Amounts applied to the deductible also count toward any visit or day maximums 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.
- If a MEMBER uses Health Savings Account (HSA) funds to pay their PROVIDER and the PROVIDER refunds money to the MEMBER as a result of an overestimation of the MEMBER's deductible or coinsurance, the MEMBER must return this money to the HSA in order to avoid any tax impacts.
- To receive IN-NETWORK benefits, you must receive care from a Blue Options IN-NETWORK PROVIDER. **However, in certain situations, including in an EMERGENCY, you may receive care from an IN-NETWORK or OUT-OF-NETWORK PROVIDER. Please see "OUT-OF-NETWORK Benefit Exceptions" for additional information.**

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 our 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?"

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

Your actual expenses for COVERED SERVICES may exceed the stated coinsurance percentage or copayment amount because actual PROVIDER charges may not be used to determine the health benefit plan's and MEMBER'S payment obligations. For OUT-OF-NETWORK benefits, you may be required to pay for charges over the ALLOWED AMOUNT, in addition to any copayment or coinsurance amount.

BENEFIT PERIOD—04/01/2023 through 03/31/2024

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

Benefits	IN-NETWORK	OUT-OF-NETWORK
Deductibles, TOTAL OUT-OF-POCKET LIMITS and Benefit Maximums		
The following deductibles and maximums apply to the services listed below in the "Summary of Benefits" unless otherwise noted.		
Deductible		
Individual, per BENEFIT PERIOD	$3,500	$7,000
Family, per BENEFIT PERIOD	$7,000	$14,000
You have an embedded deductible which means MEMBERS must meet their individual deductible before COVERED SERVICES are paid according to the benefits under this health benefit plan. If DEPENDENTS are covered, you also have a combined family deductible. However, once the family deductible is met, COVERED SERVICES will be paid according to the benefits for all family MEMBERS. IN-NETWORK services are credited to your IN-NETWORK deductible and OUT-OF-NETWORK services are credited to your OUT-OF-NETWORK deductible.		
TOTAL OUT-OF-POCKET LIMIT		
Individual, per BENEFIT PERIOD	$7,000	$14,000
Family, per BENEFIT PERIOD	$14,000	$28,000
You have an embedded individual TOTAL OUT-OF-POCKET LIMIT and if DEPENDENTS are covered, you also have a combined family TOTAL OUT-OF-POCKET LIMIT. Once a MEMBER meets their individual TOTAL OUT-OF-POCKET LIMIT the health benefit plan will pay 100% of the ALLOWED AMOUNT for COVERED SERVICES for that individual. Once the family TOTAL OUT-OF-POCKET LIMIT is met, it is met for all MEMBERS. Charges for IN-NETWORK services apply to your IN-NETWORK TOTAL OUT-OF-POCKET LIMIT and charges for OUT-OF-NETWORK services apply to your OUT-OF-NETWORK TOTAL OUT-OF-POCKET LIMIT.		
LIFETIME MAXIMUMS per MEMBER	**Unlimited**	
Unlimited for all services unless otherwise noted below. Maximums are combined IN- and OUT-OF-NETWORK, unless noted otherwise. If you exceed any LIFETIME MAXIMUM, additional services of that type are not covered. In this case, you may be responsible for the entire amount of the PROVIDER's billed charge.		

Benefits	IN-NETWORK	OUT-OF-NETWORK
INFERTILITY PRESCRIPTION DRUGS	Quantity limits apply, see **www.BlueCrossNC.com/umdrug;** PRESCRIPTION DRUGS indicated to treat INFERTILITY will be included in this benefit limit as they are approved by the U.S. Food and Drug Administration (FDA)	
INFERTILITY Services (in any place of service)	Three ovulation induction cycles, with or without insemination.	
Orthotic Devices for POSITIONAL PLAGIOCEPHALY	One device per MEMBER (includes dynamic orthotic cranioplasty (DOC) bands and soft helmets)	
Vein Treatment	Endovenous or microfoam-sclerotherapy procedures—one procedure per limb Liquid-sclerotherapy tributary vein treatment—three procedures per limb	
BENEFIT PERIOD MAXIMUMS Per MEMBER		
Maximums are per BENEFIT PERIOD and combined IN- and OUT-OF-NETWORK, unless noted otherwise. Any services in excess of these benefit maximums are not COVERED SERVICES. All day and visit limits are for IN- and OUT-OF-NETWORK benefits combined.		
Breast Pump and Supplies	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 **www.BlueCrossNC.com/preventive** for more information.	
Dialysis Treatment	Three hemodialysis treatments per week, more hemodialysis treatments are available if MEDICALLY NECESSARY	
Evaluation and Treatment of Obesity	Four visits, applies to office and outpatient setting	
Hearing Aids	When covered, one hearing aid per hearing-impaired ear every 36 months	
Nutritional Counseling	30 visits Visit limits do not apply to MENTAL ILLNESS diagnoses.	
REHABILITATIVE THERAPY and HABILITATIVE SERVICES (applies to home, office and outpatient setting)	30 visits per benefit period for physical/occupational therapy/chiropractic services. 30 visits per benefit period for speech therapy. Visit limits do not apply to MENTAL ILLNESS diagnoses.	

Benefits	IN-NETWORK	OUT-OF_NETWORK
SKILLED NURSING FACILITY	60 days	
PREVENTIVE CARE		
For PREVENTIVE CARE services that are not mandated by federal or state law, benefits will depend on where the services are received. This benefit is only for services that your PROVIDER indicates a primary diagnosis of preventive or wellness on the claim that is submitted to Blue Cross NC. Also see "PREVENTIVE CARE" in "COVERED SERVICES."		
Federally-mandated PREVENTIVE CARE Services	No Charge	30% after deductible
Available in an office-based, outpatient, or ambulatory surgical setting, or URGENT CARE center. For the most up-to-date list of PREVENTIVE CARE services that are covered under federal law, including general preventive services and screenings, immunizations, well-baby/well-child care, and women's PREVENTIVE CARE, see our website at **www.BlueCrossNC.com/preventive** or call Blue Cross NC Customer Service at the number in "Who to Contact?" Nutritional counseling visits are covered IN-NETWORK regardless of diagnosis.		
State-mandated PREVENTIVE CARE Services	No Charge	30% after deductible
The following services are state-mandated and required to be offered both IN- and OUT-OF-NETWORK: gynecological exams, cervical cancer screening, ovarian cancer screening, screening mammograms, colorectal screening, bone mass measurement, prostate-specific antigen tests, and newborn hearing screening.		
Provider's Office		
OFFICE VISIT Services		
PRIMARY CARE PROVIDER or SPECIALIST	20% after deductible	50% after deductible
Includes all OFFICE VISITS for medical, INFERTILITY, REHABILITATIVE THERAPY and HABILITATIVE SERVICES, pre-natal/post-delivery care (not included in the global maternity delivery fee), obesity treatment/weight management, office SURGERY, x-rays, diagnostic imaging and lab tests. If you see your PCP for mental health or substance use disorder related services, these services are included as well.		
Teladoc Telehealth	20% after deductible	Not Applicable

Benefits	IN-NETWORK	OUT-OF-NETWORK
Telehealth services are also available from a local IN-NETWORK or OUT-OF-NETWORK PROVIDER; see "Office Services" in "COVERED SERVICES."		
URGENT CARE		
URGENT CARE Centers	20% after deductible	50% after deductible
EMERGENCY and Ambulance Services		
EMERGENCY SERVICES	20% after deductible	20% after deductible
Ambulance Services	20% after deductible	20% after deductible
See "COVERED SERVICES" for more information regarding coverage of emergency and air ambulance services.		
AMBULATORY SURGICAL CENTER		
Ambulatory Surgical Services	20% after deductible	50% after deductible
Outpatient		
Outpatient Services	20% after deductible	50% after deductible
Includes physician services, HOSPITAL and HOSPITAL-based services, HOSPITAL-based or OUTPATIENT CLINIC services, outpatient diagnostic services, and therapy services including REHABILITATIVE THERAPY and HABILITATIVE SERVICES and OTHER THERAPIES including dialysis, obesity treatment/weight management. See Benefit Maximums for visit maximums.		
Outpatient diagnostic Mammography (physician and HOSPITAL-based services)	0% after deductible	30% after deductible
See PREVENTIVE CARE for coverage of screening mammograms.		
Inpatient		
Inpatient Services	20% after deductible	50% after deductible
Includes physician services, HOSPITAL and HOSPITAL-based services, including, but not limited to medical, INFERTILITY, therapies, obesity treatment/weight management, transplants, 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.		
SKILLED NURSING FACILITY		
SKILLED NURSING FACILITY	20% after deductible	50% after deductible

Other Services		
Home health care, HOSPICE services, private duty nursing	20% after deductible	50% after deductible
DURABLE MEDICAL EQUIPMENT, MEDICAL SUPPLIES, orthotic devices, PROSTHETIC APPLIANCES	20% after deductible	50% after deductible
CT Scans, MRIs, MRAs and PET scans in any location, including a physician's office	20% after deductible	50% after deductible
Mental Health And Substance Use Disorder Services		
Mental Health Office Services	20% after deductible	50% after deductible
Mental Health Inpatient, Outpatient, and RESIDENTIAL TREATMENT FACILITY SERVICES	20% after deductible	50% after deductible
Substance Use Disorder Office Services	20% after deductible	50% after deductible
Substance Use Disorder Inpatient, Outpatient, and RESIDENTIAL TREATMENT FACILITY SERVICES	20% after deductible	50% after deductible
CERTIFICATION Requirements		
Certain services, regardless of the location, require PRIOR REVIEW and CERTIFICATION by Blue Cross NC in order to receive benefits. IN-NETWORK PROVIDERS in North Carolina will request PRIOR REVIEW when necessary. IN-NETWORK inpatient FACILITIES outside of North Carolina will also request PRIOR REVIEW for you except for Veterans' Affairs (VA) and military providers. Otherwise, if you go to an OUT-OF-NETWORK PROVIDER in North Carolina or to any other PROVIDER outside of North Carolina, you are responsible for ensuring that you or your PROVIDER requests PRIOR REVIEW by Blue Cross NC. Blue Cross NC delegates PRIOR REVIEW and CERTIFICATION for particular benefits to other companies not associated with Blue Cross NC. Please see **https://www.BlueCrossNC.com/content/services/medical-policy/index.htm** for a detailed list of these companies and benefits. While some benefits have been identified under "COVERED SERVICES," the list of benefits and/or companies may change from time to time; for the most up-to-date information visit **https://www.BlueCrossNC.com/content/services/medical-policy/index.htm. Failure to request PRIOR REVIEW and receive CERTIFICATION will result in a full denial of benefits. See "COVERED SERVICES" and**		

Benefits	IN-NETWORK	OUT-OF-NETWORK
"PRIOR REVIEW (Pre-Service)" in "UTILIZATION MANAGEMENT" for additional information. To request PRIOR REVIEW, please see the numbers in "Who to Contact?"		
Benefits	**IN-NETWORK**	**OUT-OF-NETWORK**
PRESCRIPTION DRUGS		
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 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. For PRESCRIPTION DRUGS received from an OUT-OF-NETWORK pharmacy, you will also pay any charges over the ALLOWED AMOUNT. See Essential C FORMULARY at **http://www.bcbsnc.com/essentialC**. 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 **ncbop.org/faqs/Pharmacist/faq_NTIDrugs.htm** for a current list of these drugs; or 2) your PROVIDER required the use of a BRAND-NAME PRESCRIPTION DRUG to treat your condition. Applicable copayment or coinsurance amounts would still apply.		
PRESCRIPTION DRUGS	20% after deductible	20% after deductible
Designated Preventive PRESCRIPTION DRUGS	20%	20%
Diabetic Supplies, Spacers and Peak Flow Meters	20% after deductible	20% after deductible
Your EMPLOYER has chosen an enhanced preventive PRESCRIPTION DRUG benefit. Certain PRESCRIPTION DRUGS will not be subject to the deductible if prescribed for preventive reasons, such as lowering cholesterol or high blood pressure. You may visit our website at **www.BlueCrossNC.com** or call Blue Cross NC Customer Service at the number listed in "Who to Contact?" for a list of preventive PRESCRIPTION DRUGS. This list may change from time to time. Please note: your health benefit plan uses the Essential FORMULARY and has a 5 TIER pharmacy benefit, drugs listed as TIER 6 in the FORMULARY will be subject to your TIER 5 benefit, including any UTILIZATION MANAGEMENT or specialty requirements. Limits apply to INFERTILITY drugs, see "PRESCRIPTION DRUG Benefits" for a detailed description. Also see Essential C FORMULARY at **http://www.bcbsnc.com/essentialC**		

Benefits	IN-NETWORK	OUT-OF-NETWORK
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.**		
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.		

Rx SUM PPO, 5/22

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 ID 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 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. 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 the website at **www.BlueCrossNC.com** or call Blue Cross NC Customer Service at the number listed in "Who to Contact?" Here is a look at how it works:

	IN-NETWORK	OUT-OF-NETWORK
Type of PROVIDER	IN-NETWORK PROVIDERS are health care professionals and facilities that have contracted with 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. See "Glossary" for a description of ANCILLARY PROVIDERS and the criteria for	OUT-OF-NETWORK PROVIDERS are not designated as a Blue Options PROVIDER by Blue Cross NC. Also see "OUT-OF-NETWORK Benefit Exceptions."

	IN-NETWORK	OUT-OF-NETWORK
	determining where services are received. The list of IN-NETWORK PROVIDERS may change from time to time. IN-NETWORK PROVIDERS are listed on our 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 noncovered 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 noncovered expenses. For EMERGENCY SERVICES, see "OUT-OF-NETWORK Benefit Exceptions" and "EMERGENCY and Ambulance Services" for additional information.
Referrals	Blue Cross NC does not require you to obtain any referrals.	
After-hours Care	If you need non-EMERGENCY 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	IN-NETWORK PROVIDERS in North Carolina are responsible for	OUT-OF-NETWORK PROVIDERS are not obligated by contract to

	requesting PRIOR REVIEW when necessary. IN-NETWORK PROVIDERS outside of North Carolina, except for Veterans' Affairs (VA) and military providers, are responsible for requesting PRIOR REVIEW for inpatient FACILITY SERVICES. For all other COVERED SERVICES received outside of North Carolina, **you** are responsible for ensuring that you or your PROVIDER requests PRIOR REVIEW by Blue Cross NC even if you see an IN-NETWORK PROVIDER. See "Who to Contact?" for information on who to call for PRIOR REVIEW and to obtain CERTIFICATION for mental health and substance use disorder services and all other medical services. PRIOR REVIEW is not required for 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, in or outside of North Carolina, requests PRIOR REVIEW by Blue Cross NC or its designee when necessary.** See "Who to Contact?" for information on who to call for PRIOR REVIEW and to obtain CERTIFICATION for mental health and substance use disorder services and all other medical services. Failure to request PRIOR REVIEW and obtain CERTIFICATION will result in a full denial of benefits. 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	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

	recover the full cost of the PRESCRIPTION minus any applicable copayment or coinsurance you owe, return to the IN-NETWORK pharmacy within 14 days of receiving your PRESCRIPTION so that it can be reprocessed with your correct eligibility information and the pharmacy will make a refund to you. If 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.	MEMBER. For EMERGENCY SERVICES, see "OUT-OF-NETWORK Benefit Exceptions" and "EMERGENCY and Ambulance Services."

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 from an OUT-OF-NETWORK PROVIDER*
- When you receive MEDICALLY NECESSARY air transport ambulance 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 benefit exception if the MEMBER gives consent. Please see **https://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, see our website at **www.BlueCrossNC.com** and type "access to care" in the search bar. If you believe an IN-NETWORK PROVIDER is not reasonably available, you can help assure that benefits are paid at the correct benefit level by calling 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'll also want to verify that these PROVIDERS are in the Blue Options network by visiting **www.BlueCrossNC.com** or calling Blue Cross NC Customer Service at the number listed in "Who to Contact?" The list of SURGERIES and specialties, and participating PROVIDERS under this program may change from time to time.

Carry Your ID CARD

Your ID CARD identifies you as a 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 our 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 DOCTOR with your medical history. You should participate actively in all decisions related to your health care and discuss all treatment options with your health care PROVIDER regardless of cost or benefit coverage. PCPs are trained to deal with a broad range of health care issues and can help you determine when you need a SPECIALIST. PROVIDERS from medical specialties such as family practice, internal medicine and pediatrics may participate as PCPs.

Please visit our website at **www.BlueCrossNC.com** and click on Find a Doctor 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 our 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 aren't covered by your health benefit plan. Keep in mind as you read this section Blue Options covers only those services that are MEDICALLY NECESSARY. Also check the "Summary of Benefits" for any benefit maximums and limitations that may apply to your benefits. We've grouped these COVERED SERVICES listed below to make it easier for you to find what you're 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

Your health benefit plan covers care you receive as part of an OFFICE VISIT, including:

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

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

Telehealth services from a local PROVIDER: You can also check with your PROVIDER to see if telehealth services are available. Telehealth services are available IN-NETWORK and OUT-OF-NETWORK and are separate from your telehealth benefit with 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 telecommunications system. It is important to understand that your benefit will vary depending upon the type of PROVIDER you see for these services.

Your health benefit 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 this health benefit 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."

> 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.

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

PREVENTIVE CARE

This health benefit plan covers PREVENTIVE CARE services that can help you stay safe and healthy.

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

Federally-Mandated PREVENTIVE CARE Services

Under federal law, you can receive certain covered PREVENTIVE CARE services from an IN-NETWORK PROVIDER, as described below, at no cost to you. Please log on to our website at **www.BlueCrossNC.com/preventive** or call Blue Cross NC Customer Service at the number in "Who to Contact?" for up-to-date preventive coverage information on PREVENTIVE CARE that is covered under federal law, including general preventive services and screenings, immunizations, well-baby/well-child care, women's PREVENTIVE CARE, nutritional counseling visits, and certain over-the-counter medications. Nutritional counseling visits

are separate from the obesity-related OFFICE VISITS noted in the "Summary of Benefits." Certain over-the-counter medications are covered only as indicated and when a PROVIDER'S PRESCRIPTION is presented at a pharmacy.

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

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

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

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

Situation	Example	Reason/Result
How your PREVENTIVE CARE service is filed	A colonoscopy includes a primary diagnosis of non-preventive.	Certain PREVENTIVE CARE services will not pay in full because the primary diagnosis filed on the claim is something other than PREVENTIVE CARE. In this instance, the colonoscopy is subject to any applicable copayment, deductible or coinsurance.
Services that are not considered PREVENTIVE	A routine wellness exam includes an additional	The Vitamin D test will not be covered as a

	procedure, such as a Vitamin D serum test.	federally-mandated PREVENTIVE CARE service. This service will be denied as it is not considered a PREVENTIVE CARE service by the United States Preventive Services Task Force (USPSTF).
Place of service (where you receive your PREVENTIVE CARE service)	A mammogram is performed in a setting that is not considered an office, such as a HOSPITAL.	Certain PREVENTIVE CARE services will not be paid in full because they are not performed in an office-based, outpatient or ambulatory setting or URGENT CARE center. In this example, the mammogram is subject to deductible and coinsurance.

This health benefit 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 at 1-877-258-3334 for the most up-to-date information on tobacco cessation benefits.

State-Mandated PREVENTIVE CARE Services

The following benefits are available IN-NETWORK and OUT-OF-NETWORK.

Bone Mass Measurement Services

This health benefit 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 your 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.

The PROVIDER search on our website at **www.BlueCrossNC.com** can help you find office-based PROVIDERS or you can call Blue Cross NC Customer Service at the number listed in "Who to Contact?" for this information.

Gynecological Exam and Cervical Cancer Screening

The cervical cancer screening benefit includes the examination and laboratory tests for early detection and screening of cervical cancer, and 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 prostate-specific antigen (PSA) test or an equivalent serological test will be covered per male MEMBER per BENEFIT PERIOD. More PSA tests will be covered if recommended by a DOCTOR.

Screening Mammograms

This health benefit 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
- Fitting for contact lenses, glasses or other hardware
- Diagnostic services used for prevention or screening that are not recognized as recommended PREVENTIVE CARE services (Grade A or B) by the United States Preventive Services Task Force, and filed with a preventive/wellness diagnosis, including, but not limited to:
  - Albumin (urine) testing
  - Chest x-rays
  - EKGs
  - Iron level testing
  - Testosterone level testing

- Thyroid function testing
- Urinalysis
- Vitamin B or D serum testing.

For information on how these services would be covered as diagnostic, see "Diagnostic Services" in "COVERED SERVICES."

EMERGENCY and Ambulance Services

EMERGENCY SERVICES

This health benefit plan provides benefits for EMERGENCY SERVICES which are available IN- and OUT-OF-NETWORK.

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. • 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.	• 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.
• 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.	• 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 our Decision?", please see **https://www.cms.gov/nosurprises** for additional options and a full statement of your rights under federal law regarding surprise billing.

Ambulance Services

This health benefit plan covers services in a ground ambulance traveling:

- From a MEMBER'S home or scene of an accident or EMERGENCY to a HOSPITAL
- Between HOSPITALS
- Between a HOSPITAL and a SKILLED NURSING FACILITY when such a facility is the closest one that can provide COVERED SERVICES appropriate to your condition. Benefits may also be provided for ambulance services from a HOSPITAL or SKILLED NURSING FACILITY to a MEMBER'S home when MEDICALLY NECESSARY.

This health benefit 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 MEMBER 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 Services Exclusions (Ground or Air)

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

URGENT CARE

This health benefit 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 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, services will be denied.**

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.

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 like REHABILITATIVE THERAPY and HABILITATIVE SERVICES. Usually, a HOME HEALTH AGENCY coordinates the services your DOCTOR orders for you. Services from a HOME HEALTH aide may be eligible for coverage only when the care provided supports a skilled service being delivered in the home.

Home health skilled nursing care requires PRIOR REVIEW and CERTIFICATION or services will not be covered.

HOSPICE Services

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

This health benefit 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 solution for a MEMBER transitioning from an acute care setting to the home setting and is not meant to be for long-term permanent or custodial care. Also see “Care Management.”

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

Private Duty Nursing Exclusion

– Services provided by a close relative or a member of your household

Family Planning

Maternity Care

Maternity care, 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 MEMBERS, except DEPENDENT CHILDREN. Together these make up the global maternity delivery fee. See the chart below for additional information. Maternity benefits for DEPENDENT CHILDREN cover only treatment for COMPLICATIONS OF PREGNANCY. 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 "Summary of Benefits" for limits on breast pumps and breast pump supplies. If this health benefit plan has an OFFICE VISIT copayment and you change PROVIDERS during pregnancy, terminate 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	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	Deductible and coinsurance apply. For the first 48/96 hours, only one deductible and admission copayment, if applicable, is required for both mother and baby. These are covered under the mother.

	Mother	Newborn	Payment
	received within 72 hours of discharge.	permanent hearing loss. (Please see PREVENTIVE CARE in "Summary of Benefits.")	
Post-delivery services	All care for the mother after the baby's birth that is related to the pregnancy. PRIOR REVIEW and CERTIFICATION are required for inpatient stays extending beyond 48/96 hours or services will be denied.	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 or services will be denied.	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 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 except DEPENDENT CHILDREN (see " Family Planning Exclusions").

COMPLICATIONS OF PREGNANCY

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

INFERTILITY Services

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

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

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

SEXUAL DYSFUNCTION Services

This health benefit 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 female tubal occlusion 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.

Family Planning Exclusions

- Assisted reproductive technologies as defined by the Centers for Disease Control and Prevention, including, but not limited to, in vitro fertilization (IVF) with fresh or frozen embryos, ovum or embryo placement, intracytoplasmic sperm injection (ICSI), zygote intrafallopian transfer (ZIFT), specialized sperm retrieval techniques, and gamete intrafallopian transfer (GIFT) and associated services
- Oocyte and sperm donation
- Cryopreservation of oocytes, sperm, or embryos
- Services performed by a doula
- Expenses INCURRED by any MEMBER who receives compensation from a third party in exchange for a medical procedure, such as surrogacy-related medical expenses
- Expenses INCURRED by a surrogate parent not covered as a MEMBER under the health benefit plan
- Care or treatment of the following:
  - maternity for DEPENDENT CHILDREN, except as specifically covered by this health benefit plan
  - termination of pregnancy (abortion) for DEPENDENT CHILDREN, except as allowed by state law when the life of the MEMBER would be endangered if the unborn child was carried to term or the pregnancy is the result of rape or incest
  - 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

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

Home Infusion Therapy Services

Home infusion therapy is covered for the administration of PRESCRIPTION DRUGS directly into a body organ or cavity or via intravenous, intraspinal, intramuscular, subcutaneous or epidural routes, under a plan prescribed by a DOCTOR. These services must be provided under the supervision of a licensed, registered, or certified 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

OTHER COVERED THERAPIES

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

Certain diagnostic procedures, including but not limited to, CT scans, PET scans, MRIs, genetic and other lab testing and sleep studies (including associated DURABLE MEDICAL EQUIPMENT), may require PRIOR REVIEW and CERTIFICATION or services will not be covered. Blue Cross NC may delegate UTILIZATION MANAGEMENT of sleep studies 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 Blue Cross NC.

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

Your benefits cover 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

This health benefit 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. These drugs are covered under your medical benefit rather than your PRESCRIPTION DRUG benefit. Coverage of some of these drugs may be limited to certain PROVIDER settings (such as office, outpatient, AMBULATORY SURGERY CENTER, or provided by HOME HEALTH AGENCY). For a list of drugs covered under your medical benefit that are covered only at certain PROVIDER settings, visit our 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

This health benefit 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 our 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

This health benefit plan provides benefits for participation in clinical trials phases I, II, III, and IV. Coverage is also provided for Centers for Medicare & Medicaid Services (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

This health benefit plan provides benefits for services provided by a duly licensed DOCTOR, DOCTOR of dental SURGERY or DOCTOR of dental medicine for diagnostic, therapeutic or surgical procedures, including oral SURGERY involving bones or joints of the jaw, when the procedure or dental treatment is related to one of the following conditions:

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

This health benefit 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 this health benefit 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 this health benefit 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

This health benefit 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 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.

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 Blue Cross NC. Blue Cross NC 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

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

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

Cochlear Implants

This health benefit 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.

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

Your coverage provides benefits for the purchase, fitting, adjustments, repairs, and replacement of PROSTHETIC APPLIANCES. The PROSTHETIC APPLIANCE must replace all or

part of a body part or its function. The type of PROSTHETIC APPLIANCE will be based on the functional level of the MEMBER.

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

Therapeutic contact lenses may be covered when used as a corneal bandage for a medical condition. Benefits include a one-time replacement of eyeglass or contact lenses due to a PRESCRIPTION change after cataract SURGERY.

PROSTHETIC APPLIANCES Exclusions

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

Surgical Benefits

Surgical services by a professional or facility PROVIDER on an inpatient or outpatient basis, including preoperative and postoperative care and care of complications, are covered.

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

Surgical benefits include, but are not limited to:

- diagnostic SURGERY such as biopsies, and reconstructive SURGERY performed to correct CONGENITAL defects that result in functional impairment of newborn, adoptive, and FOSTER CHILDREN
- MEDICALLY NECESSARY bariatric SURGERY
- 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.
- 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 our 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

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

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

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

Transplants Exclusions

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

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

Blue Distinction® Centers

You may want to go to a Blue Distinction® Center (BDC) to receive your surgical procedure. 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
- cardiac care
- knee or hip replacement
- maternity care
- transplants
- substance use disorder treatment and recovery
- spine SURGERY.

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

Mental Health and Substance Use Disorder Services

This health benefit 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).

Please note that partial hospitalization is not covered as part of an OFFICE VISIT.

Autism Spectrum Disorder Services

Your health benefit 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. PRIOR REVIEW and CERTIFICATION are required in advance for ADAPTIVE BEHAVIOR TREATMENT or services will not be covered. Coverage includes assessments and treatment, which must be MEDICALLY NECESSARY, and ordered by a licensed physician or licensed psychologist. ADAPTIVE BEHAVIOR TREATMENT must be provided or supervised by the following professionals who are licensed and certified to provide this treatment:

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

Visit our 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, in EMERGENCY situations, please notify Blue Cross NC of your 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 or services will not be covered. See the 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 **https://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.

Mental Health and Substance Use Disorder Services Exclusion

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

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")
- Spacers for metered dose inhalers and peak flow meters
- 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
- PRESCRIPTION DRUGS related to treatment of SEXUAL DYSFUNCTION
- Insulin and diabetic supplies such as: insulin needles, syringes, glucose testing strips, ketone testing strips and tablets, 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."

- Certain PRESCRIPTION DRUGS related to treatment of INFERTILITY.

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 submit your own claim. Any charges over the ALLOWED AMOUNT are your responsibility.

	If you had an EMERGENCY and went to an OUT-OF-NETWORK pharmacy, we recommend that you call Blue Cross NC Customer Service at the number listed in "Who to Contact?" so that the claim can be processed at the IN-NETWORK level.
How the type of PRESCRIPTION DRUG may determine the amount you pay	Your PRESCRIPTION DRUG benefit has a closed 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. On a closed FORMULARY PROVIDERS can prescribe from a list of GENERIC and brand medications from each therapeutic category. Some medications on the list and those not on the list must go through a non-FORMULARY or RESTRICTED-ACCESS (STEP THERAPY) DRUGS OR DEVICES exception process for MEDICAL NECESSITY to be reimbursed under the PRESCRIPTION benefit. 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 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).
	Your EMPLOYER has chosen an enhanced preventive PRESCRIPTION DRUG benefit. Certain PRESCRIPTION DRUGS will not be subject to deductible if prescribed for preventive reasons, such as lowering cholesterol or high blood pressure. A drug may not be considered preventive if it is being prescribed to treat an existing symptomatic illness, injury, or condition. You may visit our website at **www.BlueCrossNC.com** or call Blue Cross NC Customer Service at the number listed in "Who to Contact?" for a list of preventive PRESCRIPTION DRUGS. This list may change from time to time.
How your PRESCRIPTION is dispensed	In some cases, a PROVIDER may prescribe a total dosage of a drug that requires two or more different drugs in a compound

	to be dispensed. In these cases if you have copayments for PRESCRIPTION DRUGS, 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. Please see "Summary of Benefits." If you need to receive an extended supply (greater than a 30-day supply and up to a 90-day supply), visit our 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 **www.BlueCrossNC.com/umdrug.** Examples of these drug categories include (but are not limited to) INFERTILITY Drugs, 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 are 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 **www.BlueCrossNC.com** for more details.
SPECIALTY DRUGS	Blue Cross NC has a separate pharmacy network for purchasing select SPECIALTY DRUGS ("Specialty Network"). These SPECIALTY DRUGS (which include specialty GENERIC or BRAND-NAME PRESCRIPTION DRUGS, as well as BIOLOGIC or BIOSIMILAR PRESCRIPTION DRUGS) must be dispensed by a pharmacy participating in the Specialty Network in order to receive IN-NETWORK benefits. These drugs are limited to a 30-day supply or less. For a list of PRESCRIPTION DRUGS that are considered SPECIALTY DRUGS, visit our website at **www.BlueCrossNC.com.**
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; • 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)

<table>
<tr><td></td><td>
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>
<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) DRUG 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>Blue Cross NC 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</td></tr>
</table>

	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.
Benefit Limitations	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; 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.**

Blue Cross NC may develop a lock-in program which would require that a MEMBER select a single prescriber and single pharmacy to obtain certain covered PRESCRIPTION DRUGS that are considered controlled substances. The program applies to a MEMBER who meets any of the following conditions:

(1) filled six or more PRESCRIPTIONS for covered substances in a period of two consecutive months
(2) received PRESCRIPTIONS for covered substances from three or more health care PROVIDERS in a period of two consecutive months
(3) recommended to Blue Cross NC as a candidate for the lock-in program by a health care PROVIDER.

No MEMBER will be subject to this program until they have been notified by us in writing. You will not be required to use the single prescriber or single pharmacy for other PRESCRIPTION DRUGS covered under the health benefit plan.

Travel Benefit

The health benefit plan provides a travel benefit for pregnancy-related services (including prenatal, perinatal, and postpartum stages of pregnancy), gender affirming services, and mental health services. For information on travel and lodging reimbursement for transplant services, please see "Transplants" under "COVERED SERVICES".

The travel benefit includes expenses INCURRED to travel to a state where a COVERED SERVICE is available when all the following criteria are met. The COVERED SERVICE

- Is not available in the state in which the MEMBER resides, and
- Is not available within 100 miles of where the MEMBER resides, and
- Is not available via telehealth.

You must submit a travel benefit form to receive your travel benefit after the COVERED SERVICE was INCURRED. The travel benefit form is available from

www.bluecrossnc.com/members/member-booklets-forms-documents. A claim for the COVERED SERVICE must be received by Blue Cross NC in order for the travel benefit to be paid. For additional information, call Blue Cross NC Customer Service at the number listed in "Who to Contact?"

Travel Benefit Exclusion

– Infertility treatment and assisted reproductive technology (for example, in vitro fertilization (IVF) and intrauterine insemination (IUI))

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?" This health benefit 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 health benefit plan
- Services prohibited by state law 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 received in excess of any BENEFIT PERIOD MAXIMUM or LIFETIME MAXIMUM
- A benefit, drug, service or supply that is not specifically listed as covered in this benefit booklet
- Any benefit, drug, service, supply, test or charge that is duplicative or inclusive to other COVERED SERVICES.

In addition, this health benefit plan does not cover the following services, supplies, drugs or charges:

A

Acupuncture and acupressure

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

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

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

B

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

C

Claims not submitted to 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 this health benefit plan.

Services received either before or after the **coverage period** of this health benefit 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 this health benefit plan

DENTAL SERVICES provided in a HOSPITAL, except as described in "Dental Treatment Covered Under Your Medical Benefit"

The following **drugs**:

- A PRESCRIPTION DRUG not specifically covered in this health benefit plan
- 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 assisted reproductive technology
- 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
- 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
- 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
- PRESCRIPTION DRUGS for short-term and long-term use in the treatment of clinical obesity.

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 this health benefit plan

The following **equipment:**

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

EXPERIMENTAL services including services whose efficacy has not been established by controlled clinical trials, or are not recommended as a preventive service by the U.S. Public Health Service, except as specifically covered by this health benefit plan

F

ROUTINE **FOOT CARE** that is palliative, 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 your health benefit 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 this health benefit plan

M

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

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 is 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 the MEMBER or for treatment of **obesity**, except for MEDICALLY NECESSARY bariatric SURGERY, or as specifically covered by this health benefit plan.

P

Body **piercing**

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

- Cannot legally provide or legally charge for the services or services are outside the scope of the PROVIDER'S license or certification
- Provides and bills for services from a licensed health care professional who is in training
- Is in a MEMBER'S immediate family
- Is not recognized by 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 substance use disorder and mental health treatment), or any similar facility or institution.

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

S

Services or supplies that are:

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

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

T

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

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

The following types of **therapy:**

- Music therapy, recreational or activity therapy, and all types of animal therapy. Remedial reading and all forms of special education and supplies or equipment used similarly, except as specifically covered by this health benefit 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 this health benefit 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 your health benefit 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 this health benefit 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. For the most up-to-date PREVENTIVE CARE services that are covered under federal law, see our website at **www.BlueCrossNC.com/preventive.**

W

Wigs, hairpieces and hair implants for any reason

WHEN COVERAGE BEGINS AND ENDS

This section provides information on who is eligible and how to qualify for coverage under this health benefit plan:

Table of Contents:	**Key Words:**
• Enrolling in this Health Benefit Plan • Adding or Removing a DEPENDENT • Qualified Medical Child Support Order • Types of coverage • Reporting Changes • Continuing Coverage • When Coverage under this Health Benefit Plan Ends • Termination of MEMBER coverage	• EMPLOYEE • DEPENDENTS • GROUP ADMINISTRATOR

EMPLOYEES shall be added to coverage no later than 90 days after their first day of employment.

The term "EMPLOYEE" means a nonseasonal person who works full-time, 30 or more hours per week and is otherwise eligible for coverage. In some cases, and where permitted by applicable law, your EMPLOYER may allow eligibility to extend to other persons, such as RETIREES or part-time EMPLOYEES.

For DEPENDENTS to be covered under this health benefit plan, you must be covered and your DEPENDENT must be one of the following:

- Your spouse under an existing marriage that is legally recognized under any state law
- Your same sex domestic partner, so long as you and your same sex domestic partner have attested to the GROUP ADMINISTRATOR, in writing to the following:
  1. That you and your same sex domestic partner are both mentally competent
  2. That you and your same sex domestic partner are both at least the age of consent for marriage in the state of North Carolina
  3. That you and your same sex domestic partner are not related by blood to a degree of closeness that would prohibit legal marriage in North Carolina
  4. That you and your same sex domestic partner are not married to anyone else
  5. That you and your same sex domestic partner are mutually responsible for the cost of basic living expenses as evidenced by joint home ownership, common investments, or some other similar evidence of financial interdependence
  6. That you and your same sex domestic partner live together and intend to do so permanently
  7. That you do not currently have a same sex domestic partner covered under this health benefit plan

8. That you have not had a same sex domestic partner covered under this health benefit plan at any time within the past 12 months before adding this same sex domestic partner unless the previous same sex domestic partnership was terminated by death.

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

- You, your spouse's or your domestic partner's DEPENDENT CHILDREN through the end of the month of their 26th birthday, adoptive children from date of placement for adoption and FOSTER CHILDREN from date of placement in the foster home.
- A DEPENDENT CHILD, who in accordance with North Carolina law, is and continues to be either intellectually disabled or physically disabled and incapable of self-support may continue to be covered under this health benefit 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 Blue Cross NC.

Enrolling in this Health Benefit Plan

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

See also "Adding or Removing a DEPENDENT."

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

- You or your DEPENDENTS become eligible for coverage under this health benefit plan
- You obtain a DEPENDENT through birth, court or administrative order, adoption, placement in anticipation of adoption, or foster care placement of an eligible child
- You or your DEPENDENTS lose coverage under another health benefit plan, and each of the following conditions is met:
  - you and/or your DEPENDENTS are otherwise eligible for coverage under this health benefit 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 health benefit plan within 60 days
- You or your DEPENDENTS become eligible for premium assistance with respect to coverage under this health benefit plan under Medicaid or the Children's Health Insurance Program (CHIP) and apply for coverage under this health benefit plan within 60 days.

Adding or Removing a DEPENDENT

Do you want to add or remove a DEPENDENT? You must notify your GROUP ADMINISTRATOR and fill out any required forms.

For coverage to be effective on the first day of the month following the date the DEPENDENT becomes eligible, your form must be completed within **30** days after the DEPENDENT becomes eligible. However, if you are adding a newborn child, a child legally placed for adoption, a child placed by court or administrative order or a FOSTER CHILD, and adding the DEPENDENT CHILD would not change your coverage type or premiums, the change will be effective on the date the child becomes eligible (the date of birth for a newborn, the date of placement for adoption for adoptive children, or the date of placement of a FOSTER CHILD in your home), as long as coverage was effective on that date. In these cases, notice is not required by Blue Cross NC within **30** days after the child becomes eligible, but it is important to provide notification as soon as possible.

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 GROUP 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 Blue Cross NC; 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 your GROUP ADMINISTRATOR.

Types of Coverage

These are the types of coverage available:

- EMPLOYEE-only coverage—This health benefit plan covers only you
- EMPLOYEE-child coverage—This health benefit plan covers you and one DEPENDENT CHILD
- EMPLOYEE-children coverage—This health benefit plan covers you and your DEPENDENT CHILDREN

Reporting Changes

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

Continuing Coverage

Under certain circumstances, your eligibility for coverage under this health benefit plan may end. You may have certain options such as enrolling in Medicare, continuing health insurance under this health benefit plan, or purchasing an individual conversion policy.

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 health benefit plan when you become eligible for Medicare, consult your GROUP ADMINISTRATOR, who will advise you about continuation of coverage under this health benefit plan.

Continuation Under Federal Law

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

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

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

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

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

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

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

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

You or your DEPENDENTS must notify the GROUP ADMINISTRATOR within 60 days of the following QLEs:

- Divorce
- Ineligibility of a DEPENDENT CHILD.

You and/or your DEPENDENTS will be offered continuation coverage within 14 days of the date that the COBRA administrator is notified of one of these events resulting in the

termination of your coverage. Eligible persons have 60 days to elect or reject continuation coverage. Following election, applicable fees must be paid to the COBRA administrator within 45 days.

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

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

If you are covered by this health benefit plan and called to the uniformed services, as defined in the Uniformed Services Employment and Reemployment Rights Act (USERRA), consult your GROUP ADMINISTRATOR. Your GROUP ADMINISTRATOR will advise you about the continuation of coverage and reinstatement of coverage under this health benefit plan as required under USERRA.

If you have any questions about your COBRA rights or continuation of coverage, please contact your GROUP ADMINISTRATOR.

Continuation Under State Law

Under state law, you and your covered DEPENDENTS (which may include a domestic partner and their children) of any size EMPLOYER group have the option to continue group coverage for 18 months from the date that you and/or your DEPENDENTS cease to be eligible for coverage under this health benefit plan. You and your DEPENDENTS are not eligible for continuation under state law if:

- Your insurance terminated because you failed to pay the appropriate contribution
- You or your DEPENDENTS are eligible for another group health benefit plan
- You or your DEPENDENTS were covered less than three consecutive months prior to termination.

You and/or your DEPENDENTS must notify the GROUP ADMINISTRATOR if you or your DEPENDENTS intend to continue coverage and pay the applicable fees within 60 days following the end of eligibility. Upon receipt of the notice of continuation and applicable fees, Blue Cross NC will reinstate coverage back to the date eligibility ended. The state law continuation benefits run concurrently and not in addition to any applicable federal continuation rights.

Under state law, continuation of coverage under this health benefit plan will end at the completion of the applicable continuation period or earlier if:

- Your EMPLOYER ceases to provide a health benefit plan to EMPLOYEES
- The continuing person fails to pay the monthly fee
- The continuing person obtains similar coverage under another group plan.

When My Coverage Under This Health Benefit Plan Ends

Persons who have elected to continue with individual coverage will be contacted by the GROUP ADMINISTRATOR within 180 days before the end of their continuation period and offered individual conversion coverage.

If you or your DEPENDENTS are no longer eligible for coverage under this health benefit plan, you may transfer to individual conversion coverage. For continuous coverage, ensure that your premiums are paid during the continuation period. Blue Cross NC must be notified within 31 days of loss of eligibility. You must complete an Individual Enrollment Application and pay the applicable premium. Services during the 31-day conversion period will be covered only if the premium is received before the end of the 31-day period. Other options for enrollment in health insurance coverage may be available to you when your coverage in this health benefit plan ends, including, but not limited to, enrollment via the Health Insurance Marketplace.

Persons who have exhausted their continuation coverage rights may also be eligible for a federally-mandated product many insurance companies must offer. If you meet the following requirements, check with Blue Cross NC or another insurance carrier to see if you qualify:

- The applicant has 18 or more months of prior CREDITABLE COVERAGE
- The applicant's most recent coverage was group coverage
- The applicant is not eligible for Medicare or another group health insurance plan.

Certificate of CREDITABLE COVERAGE

Blue Cross NC or its designee will supply a Certificate of CREDITABLE COVERAGE when your or your DEPENDENT's coverage under this health benefit plan ends or you exhaust continuation of coverage. Keep the Certificate of CREDITABLE COVERAGE in a safe place. You may request a Certificate of CREDITABLE COVERAGE from Blue Cross NC Customer Service while you are still covered under this health benefit plan and up to 24 months following your termination. You may call Blue Cross NC Customer Service at 1-877-258-3334 (toll-free), Monday through Friday except holidays or visit our website at **www.BlueCrossNC.com.**

Termination of MEMBER Coverage

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 this health benefit plan

- No IN-NETWORK PROVIDER is able to establish or maintain a satisfactory DOCTOR-patient relationship with a MEMBER, as determined by Blue Cross NC
- A MEMBER exhibits disruptive, abusive, or fraudulent behavior toward an IN-NETWORK PROVIDER.

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

A MEMBER'S coverage will be terminated immediately by Blue Cross NC for the following reasons:

- Fraud or intentional misrepresentation of a material fact by a MEMBER. 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 Our 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 health benefit 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.

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 setting and for a reasonable length of time. Blue Cross NC will honor a CERTIFICATION to cover medical services or supplies under this health benefit plan unless the CERTIFICATION was based on:

- A material misrepresentation about your health condition
- You were not eligible for these services under this health benefit 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 our appeals process (see "Need to Appeal Our 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.
- Limit what we ask 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 this health benefit 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) 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 billed charges. Blue Cross NC 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 full denial of benefits.

If PRIOR REVIEW is required by Blue Cross NC, you or your PROVIDER must request PRIOR REVIEW regardless of whether this health benefit plan is your primary or secondary coverage (see "Coordination of Benefits (Overlapping Coverage)"). If neither you nor your PROVIDER requests PRIOR REVIEW and receives CERTIFICATION, this may result in an ADVERSE BENEFIT DETERMINATION. The list of services that need PRIOR REVIEW may change from time to time.

General categories of services with this requirement are noted in "COVERED SERVICES." The list of services that require PRIOR REVIEW may change from time to time. For a detailed list of these services and the most up-to-date information 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?"

If you fail to follow the procedures for filing a request, 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 days if additional information is required and Blue Cross NC will let you and your PROVIDER know before the end of the initial 15-day period of the information needed and the date by which Blue Cross NC expects to make a decision. You will have 45 days to provide the requested information. As soon as Blue Cross NC receives 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 after we receive 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, 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, your HOSPITAL'S or other facility's UM department and/or your PROVIDER know within three business days after receipt of all necessary clinical information, but no later than 15 calendar days after 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, 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, 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 this health benefit 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 more information is needed, before the end of the initial 30-day period, Blue Cross NC will let you know of the information needed. You will then have 90 days to provide the requested information. As soon as Blue Cross NC gets the requested information, or at the end of the 90 days, whichever is earlier, Blue Cross NC will make a decision within 15 calendar days. 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 this health benefit 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 Blue Cross NC 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. Blue Cross NC is not obligated to give the same benefits or services to a MEMBER at a later date or to any other MEMBER. Information about these services can be found by calling Blue Cross NC Customer Service. You may also want to talk to 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 EMPLOYER changes health benefit plans or when your PROVIDER is no longer in the Blue Options network. If your PCP or SPECIALIST leaves our PROVIDER network and they are currently treating you for an ongoing special condition that meets our Continuity of Care criteria, Blue Cross NC will notify you in writing 30 days before the PROVIDER'S termination, as long as Blue Cross NC receives timely notification from the PROVIDER. To be eligible for Continuity of Care, you must be actively being seen by an OUT-OF-NETWORK PROVIDER for an ongoing special condition and the PROVIDER must agree to abide by Blue Cross NC's requirements for Continuity of Care.

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
- 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 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 Our Decision?"). Claims for approved Continuity of Care services will be subject to your 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 **https://www.BlueCrossNC.com/content/services/medical-policy/index.htm** 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** and search for "PRIOR REVIEW" for additional information, including those services subject to PRIOR REVIEW and CERTIFICATION.

NEED TO APPEAL OUR 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 our 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 health benefit plan or Blue Cross NC in connection with the claim being appealed. 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 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.

Any request for review should include:

- SUBSCRIBER'S ID number
- SUBSCRIBER'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 our website at **www.BlueConnectNC.com** or call Blue Cross NC Customer Service at the number listed in "Who to Contact?"

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:

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

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

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

If a claims denial is based on medical judgment, including determinations about whether a certain treatment, drug or other item is EXPERIMENTAL, INVESTIGATIONAL, or not MEDICALLY NECESSARY or appropriate, 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 Blue Cross NC's internal appeals process after pursuing a first level appeal. Unless specifically noted below, upon completion of the first level appeal you may (1) pursue a second level appeal; (2) pursue an external review; or (3) pursue a civil action under 502(a) of ERISA or under state law, as applicable. You will be deemed to have exhausted Blue Cross NC's internal appeals 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 Blue Cross NC's internal appeals process and, unless specifically noted below, you may pursue items (2) or (3) described above.

Timeline for Appeals

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

	First Level Appeal	Second Level Appeal	Expedited Appeal
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

Internal Appeals

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 North Carolina licensed medical DOCTOR who was not involved in the initial NONCERTIFICATION decision. You may receive, in advance, any new information or rationale that 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 defer the complaint to our quality assurance committee for review and consideration or any appropriate action against the PROVIDER. State law does not allow for a second-level GRIEVANCE review for GRIEVANCES concerning quality of care

Second Level Appeal

Second Level Appeal Timeline

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

Otherwise, if you do not agree with the first level appeal decision, you have the right to a second level appeal. Second level appeals are not allowed for benefits or services that are clearly excluded by this benefit booklet, or quality of care complaints. Within ten business days after 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
- Availability of Health Insurance Smart NC including address and phone number
- A statement of your rights, including the right to:
  - request and receive from us all information that applies to your appeal
  - take part in the second level appeal meeting
  - present your case to the review panel
  - submit supporting material before and during the review meeting
  - ask questions of any member of the review panel
  - be assisted or represented by a person of your choosing, including a family MEMBER, an EMPLOYER representative, or an attorney
  - pursue other voluntary alternative dispute resolution options as applicable.

The second level appeal meeting will be conducted by a review panel arranged by 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. 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
- 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 this health benefit plan to the MEMBER'S medical circumstances, or a statement that such explanation will be provided at no cost upon request; and
- The following statement: "You may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

Expedited Appeals (Available only for NONCERTIFICATIONS)

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

You can request an expedited second level review even if you did not request that the initial review be expedited. To start the process of an expedited appeal, you can call Blue Cross NC Customer Service at the phone number given in "Who to Contact?" An expedited review will take place in consultation with a medical DOCTOR. All of the same conditions for a first level or second level appeal apply to an expedited review. 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 (Available only for NONCERTIFICATIONS)

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

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

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

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

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

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

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

Standard External Review

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

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

Expedited External Review

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

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

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

If your request is not accepted for expedited review, the NCDOI may:

(1) accept the case for standard external review if you have completed the internal appeals process; or

(2) require the completion of the internal appeals process and another request for an external review. An expedited external review is not available for retrospective (post-service) ADVERSE BENEFIT DETERMINATIONS.

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

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

(Mail)

North Carolina Department of Insurance
Health Insurance Smart NC
1201 Mail Service Center
Raleigh, NC 27699-1201

(In person)

North Carolina Department of Insurance
For the physical address for Health Insurance Smart NC, please visit the webpage:

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

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

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

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

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

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

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

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

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

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

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

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

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

Please note that you may also give this additional information to the NCDOI within the seven-day deadline rather than sending it directly to the IRO and Blue Cross NC. The NCDOI

will forward this information to the IRO and Blue Cross NC within two days after receiving the additional information.

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

If you are no longer covered by Blue Cross NC at the time Blue Cross NC receives notice of the IRO's decision to reverse the ADVERSE BENEFIT DETERMINATION, Blue Cross NC will only provide coverage for those services or supplies you actually received or would have received prior to disenrollment if the service had not been noncertified when first requested.

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

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 • Recovery of Overpayment • North Carolina PROVIDER Reimbursement • Services Received Outside of North Carolina • 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

The only legally binding benefits are described in this benefit booklet, which is part of the GROUP CONTRACT between Blue Cross NC and your EMPLOYER. The terms of your coverage cannot be changed or waived unless Blue Cross NC agrees in writing to the change.

If a MEMBER resides with a custodial parent or legal guardian who is not the SUBSCRIBER, Blue Cross NC 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 SUBSCRIBER or custodial parent or legal guardian receives payment, it is his or her responsibility to pay the PROVIDER.

Benefits for COVERED SERVICES specified in this health benefit plan will be provided only for services and supplies that are performed by a PROVIDER as specified in this health benefit 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 this health benefit plan.

Any amounts paid by Blue Cross NC 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.

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

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

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

At Blue Cross NC, we take your privacy seriously. We handle all PHI as required by state and federal laws and regulations and accreditation standards. We have developed a privacy notice that explains our procedures.

> To obtain a copy of the privacy notice, visit our website at **www.BlueCrossNC.com** or call Blue Cross NC Customer Service at the number listed in "Who to Contact?"

Administrative Discretion

Blue Cross NC shall have the discretionary authority to construe and to interpret the terms of the health benefit plan and to determine the amount of benefits, and its decision on such matters is final and conclusive subject only to the MEMBER'S appeals process set out in the "Need to Appeal our Decision?" section. 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.

Recovery of Overpayment

If a benefit payment is made by Blue Cross NC to or on your behalf, which exceeds the benefit amount that you are entitled to receive, Blue Cross NC has the right

- To require return of the overpayment; or
- To reduce the amount of the overpayment by deducting it from any future benefit payment made to or on behalf of you or another person in your family.

The right of recovery of overpayment does not affect any other right of recovery Blue Cross NC may have with respect to such overpayment. To the extent that Blue Cross NC is required to bring an action for recovery of an overpayment under this policy, Blue Cross NC

shall be entitled to recover all costs, including attorneys' fees, from you in the prosecution of any action.

The term "overpayment" includes, but is not limited to, any overpayment made to a PROVIDER in relation to treatment provided to you, any mistaken payment, or any payment made on a claim subject to any service or treatment identified as an exclusion in this benefit booklet. The term "overpayment" does not include subrogation of benefits, the right to repayment of the full cost of all benefits provided by Blue Cross NC on your behalf to the extent you recover from another party.

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 Blue Cross NC, you have access to PROVIDERS outside the state of North Carolina. Your ID CARD tells PROVIDERS that you are a MEMBER of Blue Cross NC. While Blue Cross NC 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) 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 full denial of benefits. 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 us.

  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 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, Blue Cross NC may use other payment bases, such as billed charges, to determine the amount Blue Cross NC 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 non-participating 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 non-participating 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 Blue Cross NC would make for the COVERED SERVICES. Federal or state law, as applicable, will govern payments for OUT-OF-NETWORK EMERGENCY 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. These fees are part of the total cost of the claim and you will not be charged separately for them.

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

If you need medical assistance services (including locating a DOCTOR or HOSPITAL) outside the BlueCard service area, you should call the service center at 1-800-810-BLUE (2583) or call

collect at 1-804-673-1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

- **Inpatient Services**

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

- **Outpatient Services**

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

- **Submitting a Blue Cross Blue Shield Global Core Claim**

When you pay for COVERED SERVICES outside the BlueCard service area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a claim form and send the claim form with the PROVIDER'S itemized bill(s) to the service center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from Blue Cross NC, the service center or online at **www.BCBSglobalcore.com**. If you need assistance with your claim submission, you should call the service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week.

Notice of Claim

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

Limitation of Actions

You must complete all of the required steps under the health benefit 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 GROUP 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 health benefit plan's administrative claims and appeals procedures in a timely manner will cause you to lose your right to sue regarding an ADVERSE BENEFIT DETERMINATION and/or to recover benefits. Generally, this means that any claim, action or suit filed in court or in another tribunal will be dismissed.

Evaluating New Technology

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

Coordination of Benefits (Overlapping Coverage)

If a MEMBER is also enrolled in another group health plan, Blue Cross NC may take into account benefits paid by the other plan.

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

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

Important Information for MEMBERS Eligible for Medicare

If you are eligible for or enrolled in Medicare, Blue Cross NC 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 this health benefit plan can be found on **www.medicare.gov.** If you or your DEPENDENTS are covered under this health benefit plan, and are eligible for Medicare, **Blue Cross NC 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, Blue Cross NC 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 health benefit 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 this health benefit 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 this health benefit plan are complex and will not result in higher out-of-pocket costs in every instance.

When a person is covered by 2 group health plans, and	Then	Primary	Secondary
One plan does not have a COB provision	The plan without the provision is	√	
	The plan with the provision is		√
The person is the participant under one plan and a DEPENDENT under the other	The plan covering the person as the participant is	√	
	The plan covering the person as a DEPENDENT is		√
The person is covered as a DEPENDENT CHILD under both plans and parents are either: 1) married or living together; or 2) divorced/separated or not living together and a court decree* states that they have joint custody without specifying which parent is responsible for the DEPENDENT CHILD's health care coverage; or 3) divorced/separated or not living together and a court decree* states that both parents have responsibility for the DEPENDENT CHILD's health care coverage; or 4) divorced/separated or not living	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
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 noncustodial 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 living together, and coverage is stipulated in a court decree*	The plan of the parent primarily responsible for health coverage under the court decree is	√	
	The plan of the other parent is		√
	Note: If there is a court decree that requires a parent to	√	

When a person is covered by 2 group health plans, and	Then	Primary	Secondary
	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 health benefit 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 to the person being a biological parent under one of the plans and a	The plan of the biological parent is	√	

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

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

NOTE: If either the primary or the secondary plan covers a particular service, where Blue Cross NC is the secondary plan, Blue Cross NC 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 may request information about the other plan from the MEMBER. A prompt reply will help us process payments quickly. There will be no payment until primary coverage is determined. It is important to remember that even when benefits are coordinated with other group health plans, benefits for COVERED

SERVICES are still subject to program requirements, such as PRIOR REVIEW and CERTIFICATION procedures.

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, this health benefit plan provides for the following services related to mastectomy SURGERY:

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

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, copayment, deductible or coinsurance and limitations as applied to other medical and surgical benefits provided under this health benefit 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 health benefit 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 GROUP ADMINISTRATOR with any questions.

SPECIAL PROGRAMS

Programs Outside Your Regular Benefits

Blue Cross NC may offer or provide programs that are outside your regular benefits. These offers or programs may be changed from time to time. Following are examples of programs that may be included outside your regular benefits:

- Discounts or promotional offers on goods and services from other companies including certain types of PROVIDERS
- Health and wellness programs
- Services and/or programs aimed to improve social determinants of health
- 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
- Periodic drawings for gifts, which may include club memberships and trips to special events, based on submitting information
- Charitable donations made on your behalf by Blue Cross NC.

Blue Cross NC may not provide some or all of these items directly but may instead arrange these for your convenience. These discounts or promotional offers are outside your health plan benefits. Blue Cross NC is not 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 your health plan benefits. Blue Cross NC is not liable for third party PROVIDERS' negligent provision of the gifts. Blue Cross NC may stop or change these programs at any time.

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 this health benefit plan. Please note that some of these terms may not apply to this health benefit plan.

ADAPTIVE BEHAVIOR TREATMENT

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

ADVERSE BENEFIT DETERMINATION

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

ALLOWED AMOUNT

The maximum amount that 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 as described above, Blue Cross NC will not pay the OUT-OF-NETWORK PROVIDER'S billed charge unless doing so is required in order to comply with North Carolina Statutes. Calculation of the allowed amount is based on several factors including Blue Cross NC's medical, payment and administrative guidelines. Under the guidelines, some procedures charged separately by the PROVIDER may be combined into one procedure for reimbursement purposes.

AMBULATORY INFUSION SUITE

An AMBULATORY INFUSION SUITE is a free-standing facility that solely provides infusion services under the supervision of a nurse or medical director.

AMBULATORY SURGICAL CENTER

A NONHOSPITAL FACILITY with an organized staff of DOCTORS, which is licensed or certified in the state where located, and which:

a) Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an outpatient basis

b) Provides nursing services and treatment by or under the supervision of DOCTORS whenever the patient is in the facility

c) Does not provide inpatient accommodations

d) Is not other than incidentally, a facility used as an office or clinic for the private practice of a DOCTOR or OTHER PROVIDER.

ANCILLARY PROVIDER

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

- For independent clinical laboratories, services are received in the state where the specimen is drawn
- 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
- 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" and GROUP CONTRACT, during which charges for COVERED SERVICES provided to a MEMBER must be INCURRED in order to be eligible for payment by Blue Cross NC. 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 our requirements for MEDICALLY NECESSARY services and supplies, appropriateness, health care setting, level of care and effectiveness.

CLINICAL NECESSITY

Those COVERED SERVICES, materials or supplies that are:

a) Provided for the diagnosis, treatment, cure, or relief of a dental condition, illness, injury, or disease; and not for EXPERIMENTAL, INVESTIGATIONAL, or COSMETIC purposes, except as specifically covered by your dental benefit plan,

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

c) Within generally accepted standards of dental care in the community, and

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

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

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 this health benefit 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 SUBSCRIBER 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:

a) a SUBSCRIBER'S biological child, stepchild, legally adopted child (or child placed with the SUBSCRIBER and/or spouse or domestic partner for adoption), FOSTER CHILD, or

b) a child for whom legal guardianship has been awarded to the SUBSCRIBER and/or spouse or domestic partner, or

c) a child for whom the SUBSCRIBER and/or spouse or domestic partner has been 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, 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 physical impairment to bodily functions,

c) serious dysfunction of any bodily organ or part.

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

EMERGENCY SERVICES

Health care items and services furnished or required to screen for or treat an EMERGENCY medical condition, 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 this health benefit plan due to employment with the EMPLOYER and who is enrolled for coverage.

EMPLOYER

High Country Community Health.

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.

Your health plan may cover essential health benefits, in which case no annual or lifetime dollar limits can apply to these services.

EXPERIMENTAL

See INVESTIGATIONAL.

FACILITY SERVICES

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

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

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.

GROUP ADMINISTRATOR

A representative of the EMPLOYER designated to assist with MEMBER enrollment and provide information to SUBSCRIBERS and MEMBERS concerning this health benefit plan. The Group Administrator is the plan administrator for purposes of ERISA and has the discretionary authority and responsibility to manage and direct the operation of the Plan.

GROUP CONTRACT

The agreement between Blue Cross NC and the EMPLOYER. It includes the master group contract, the benefit booklet(s) and any exhibits or endorsements, the group enrollment application and medical questionnaire when applicable.

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 our MEMBERS upon enrollment which provides group/MEMBER identification numbers, names of the MEMBERS, and key benefit information, phone numbers and addresses.

INCURRED

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

INFERTILITY

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

IN-NETWORK

Designated as participating in the 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 this health benefit 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 orthotic devices for POSITIONAL PLAGIOCEPHALY, that will be reimbursed on behalf of a MEMBER while covered under this health benefit plan. Services in excess of any lifetime maximum are not COVERED SERVICES, and MEMBERS may be responsible for the entire amount of the PROVIDER'S billed charge.

MEDICAL SUPPLIES

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

MEDICALLY NECESSARY (or MEDICAL NECESSITY)

Those COVERED SERVICES or supplies that are:

a) Provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease; and, except for clinical trials as described under this health benefit plan, not for EXPERIMENTAL, INVESTIGATIONAL, or COSMETIC purposes,

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

c) Within generally accepted standards of medical care in the community, and

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

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

MEMBER

A SUBSCRIBER or DEPENDENT, who is currently enrolled in this health benefit 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 this health benefit plan has been reviewed and does not meet Blue Cross NC's requirements for MEDICAL NECESSITY/CLINICAL NECESSITY, appropriateness, health care setting, level of care or effectiveness or the prudent layperson standard for coverage of EMERGENCY SERVICES and, as a result, the requested service is denied, reduced or terminated. The determination that a requested service is EXPERIMENTAL, INVESTIGATIONAL or COSMETIC is considered a 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. Our 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.

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.

POSITIONAL PLAGIOCEPHALY

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

PRESCRIPTION

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

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.

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 preoperative and postoperative care

c) Other procedures as reasonable and approved by Blue Cross NC.

TOTAL OUT-OF-POCKET LIMIT

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

URGENT CARE

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

UTILIZATION MANAGEMENT (UM)

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

WAITING PERIOD

The amount of time that must pass before a MEMBER is eligible to be covered for benefits under the terms of this health benefit plan.

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

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

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

Blue Cross NC MEMBER RIGHTS and RESPONSIBILITIES (cont.)

- 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.
- 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 CONCERNING COVERAGE

LIMITATIONS AND EXCLUSIONS UNDER THE NORTH CAROLINA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or health insurance should know that the insurance companies and Health Maintenance Organizations (HMOs) licensed in this state to write these types of insurance are members of the North Carolina Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer or HMO becomes financially unable to meet its obligations. If this should happen, the guaranty association will assess its other member companies for the money to pay the claims of the insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the guaranty association is not unlimited, however. *And, as noted in the box* below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The North Carolina Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in North Carolina. You should not rely on coverage by the North Carolina Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. *However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.*

The North Carolina Life and Health Insurance Guaranty Association
4441 Six Forks Rd STE 106-153
Raleigh, North Carolina, 27609-5729
https://www.nclifega.org/
North Carolina Department of Insurance, Consumer Services Division
1201 Mail Service Center
Raleigh, North Carolina 27699-1201

The state law that provides for this safety-net coverage is called the North Carolina Life and Health Insurance Guaranty Association Act. *On the back of this page* is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the guaranty association.

COVERAGE

Generally, individuals will be protected by the life and health guaranty association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer or HMO. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;
- Their policy was issued by a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange;
- They acquired rights to receive payments through a structured settlement factoring transaction.

The association also does not provide coverage for:

- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed the average rate specified in the law;
- Dividends;
- Experience or other credits given in connection with the administration of a policy by a group contractholder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contractholders, not individuals), unless they fund a government lottery or a benefit plan of an employer, association or union, except that unallocated annuities issued to employee benefit plans protected by the Federal Pension Benefit Guaranty Corporation are not covered;
- A policy or contract commonly known as Medicare Part C, Medicare Part D, Medicaid or any regulations issued pursuant thereto.

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the association is obligated to pay out as follows:

(1) The guaranty association cannot pay out more than the insurance company would owe under the policy or contract.

(2) Except as provided in (3), (4) and (5) below, the guaranty association will pay a maximum of $300,000 per individual, per insolvency, no matter how many policies or types of policies issued by the insolvent company.

(3) The guaranty association will pay a maximum of $500,000 with respect to a health benefit plan.

(4) The guaranty association will pay a maximum of $1,000,000 with respect to the payee of a structured settlement annuity.

(5) The guaranty association will pay a maximum of $5,000,000 to any one unallocated annuity contract holder.

IMPORTANT INFORMATION ABOUT YOUR HEALTH SAVINGS ACCOUNT (HSA)

UNDERSTANDING THE RELATIONSHIP BETWEEN YOUR HEALTH PLAN AND YOUR HEALTH SAVINGS ACCOUNT (HSA)

The product offered by Blue Cross NC is a High Deductible Health Plan (HDHP) that is intended to be paired with a Health Savings Account (HSA). The HSA is not part of this health benefit plan administered by Blue Cross NC. The HSA is administered separately, through a company that is not affiliated with Blue Cross NC. Your rights with respect to the HSA are governed by a separate agreement with the HSA custodian. While Blue Cross NC may forward certain materials to you on behalf of the HSA custodian, Blue Cross NC assumes no responsibility for the administration of the HSA. Termination of your HDHP with Blue Cross NC does not terminate your HSA with the HSA custodian.

Your HDHP can qualify you, or someone else on your behalf, to contribute to a HSA, unless you are otherwise ineligible under applicable federal requirements. You must be covered under an HDHP to contribute, or have someone else contribute on your behalf, to an HSA. Factors that may make you ineligible to have contributions made to your HSA include, but may not be limited to, whether you are covered directly or as a DEPENDENT on other, disqualifying health coverage (including other health funds), whether you can be claimed as a DEPENDENT on another person's tax return, and whether you are enrolled in Medicare. In addition, the Tax Code limits the amount that may be contributed to an HSA. Even if Blue Cross NC collects information from you that may indicate your ineligibility to contribute to an HSA, or that may indicate your contribution limit, Blue Cross NC will not make these determinations, and it is your responsibility to do so. If you are unsure, please consult a qualified tax advisor.

Some expenses may not qualify for reimbursement under the Tax Code. Some DEPENDENTS may not qualify as DEPENDENTS for purposes of reimbursement from your fund. It is your responsibility to determine which, if any, of your and your dependents' medical expenses qualify for reimbursement from your HSA fund. If you are unsure, please consult a qualified tax advisor.

Know how much you owe when using your HSA

When you receive medical services, you are encouraged to establish a payment plan with your provider. Your provider can choose to collect an estimated amount from you at the time of service. Before using your HSA funds to pay for these services, you should ask what steps your provider has taken to ensure that they have not collected too much from you. The final determination of how much you owe your provider cannot be calculated until your claim has been submitted to your health plan and appropriate benefits and negotiated prices have been

IMPORTANT INFORMATION ABOUT YOUR HEALTH SAVINGS ACCOUNT (HSA) *(cont.)*

applied for your provider's services. It is your responsibility to make sure you know the tax implications if you use your HSA funds for medical expenses that may not be considered qualified.

If you have been issued a debit card in connection with your HSA, the following applies. The debit card is issued by the bank chosen by your HSA custodian. Although Blue Cross NC's name and marks may be included on the face of the debit card for your convenience, Blue Cross NC is not responsible or liable for administration of your debit card. The terms and conditions associated with your debit card are governed by your agreement with the bank issuing the card. It is your responsibility to ensure that the card is used only for qualified medical expenses. If you are unsure about whether an expense is a qualified medical expense, please consult a qualified tax advisor.

Go Online

Access your account via **BlueConnectNC.com.** Within your Member portal you can review your medical claims, view your HSA balance, and access your HSA account for more detailed information. Your personalized HSA account portal allows you to view your HSA fund balance, pay claims and track your expenses.

Know who to contact

Getting help in managing your HSA will involve working with the HSA administrator directly. Make sure you take the time to understand your HSA and how to get the most savings out of it.

Blue Cross and Blue Shield of North Carolina (Blue Cross NC) provides free aids to service people with disabilities as well as free language services for people whose primary language is not English. Please contact the Customer Service number on the back of your ID card for assistance.

Blue Cross and Blue Shield of North Carolina (Blue Cross NC) proporciona asistencia gratuita a las personas con discapacidades, así como servicios lingüísticos gratuitos para las personas cuyo idioma principal no es el inglés. Comuníquese con el número para servicio al cliente que aparece en el reverso de su tarjeta del seguro para obtener ayuda.