BlueCross BlueShield of North Carolina

PO Box 2291
Durham, NC 27702-2291

00001-20180620218648015-1529563486119

JOEY BRYAN
LENOIR COUNTY GOVERNMENT
130 S QUEEN ST
KINSTON NC 28501-4941

Group Number: 082476

June 20, 2018

BlueOptHSA /082476/4QVZ/070118/062018

BlueOptions/082476/4SX6/070118/062018

BlueCross BlueShield of North Carolina

GROUP CONTRACT

June 20, 2018

JOEY BRYAN
LENOIR COUNTY GOVERNMENT
130 S Queen St
Kinston NC 28501-4941

Group Number: 082476

Dear Group Official:

Thank you for selecting Blue Cross and Blue Shield of North Carolina (BCBSNC). We appreciate the confidence you have expressed in our organization and consider every interaction an opportunity to exceed your expectations.

If you have questions concerning your coverage, call your Blue Cross and Blue Shield Account Manager, MEREDITH B HUNTER. Also visit our website at **bcbsnc.com** where you will find a variety of helpful information under the Employer section.

When you signed the Group Application at the time of enrollment, your signature(s) indicated that you accepted the terms of the enclosed Group Contract/Booklet for your legal files. **However, if you did not sign the Group Application, please sign and return the signature pages within 10 days to the attention of the Business Records Library, CSC, 1st Floor at the address indicated below.**

Again, thanks for choosing Blue Cross and Blue Shield of North Carolina.

Sincerely,

Steve Crist
Vice President, Group Markets

Enclosures:

- K50, Important Notice For Executive Contact
- Master BCBSNC Group Contract (1)
- HSA Account Services Agreement
    - Benefit Booklets:

BlueOptHSA /082476/4QVZ/070118/062018 BlueOptions/082476/4SX6/070118/062018

BlueCross BlueShield of North Carolina

GROUP ADMINISTRATOR TOOLKIT
www.bcbsnc.com/employers/

JOEY BRYAN
130 S Queen St
Kinston NC 28501-4941
Group Name: Lenoir County Government
Group Number: 082476

Dear Group Administrator:

Welcome! Thank you for choosing Blue Cross and Blue Shield of North Carolina for your health care needs. We are pleased to provide you with quality health care. For your convenience, the following tools are available on our website at **www.bcbsnc.com/employers/**. Our website contains a Group Administrator Toolkit which will help you access the most up-to-date versions of the Group Administrator's Guide as well as a variety of Blue Cross and Blue Shield of North Carolina forms that you may need.

- Provider Directory - "Find a Doctor"
- Member Drug Formulary - "Find a Drug"
- Administrative Forms - "Forms"
- Enrollment/Change Form (in English and Spanish)
- Declination of Coverage Form (in English and Spanish)
- Prescription Drug Reimbursement Form
- Subscriber/Member Claim Form
- Group Administrator's Guide - Provides answers to commonly asked questions about eligibility, enrollment, billing, how to handle claims and inquiries.

We hope you find our website **www.bcbsnc.com/employers/** useful and save it as a favorite link since features are routinely updated. If you do not have web access, please call Employer Services Line at the phone number below to request the contents of the Group Administrator toolkit. At Blue Cross and Blue Shield of North Carolina, we consider every interaction to be an opportunity to exceed expectations.

Again, thank you for choosing Blue Cross and Blue Shield of North Carolina.

Sincerely,

Blue Cross and Blue Shield of North Carolina

Employer Services Line	Customer Service
(Enrollment/Billing)	(Claims/Benefits)
1-877-237-6275	1-877-258-3334

Product/Group #/Benefit Package/Effective Date/Contract Print Date

BlueOptHSA /082476/4QVZ/070118/062018

BlueOptions/082476/4SX6/070118/062018

GROUP CONTRACT

Between

LENOIR COUNTY GOVERNMENT
(Plan Sponsor)

and

BLUE CROSS AND BLUE SHIELD OF NORTH CAROLINA

An Independent Licensee of the
Blue Cross and Blue Shield Association

Effective: July 1, 2018

This Group Contract is the legal contract between Lenoir County Government as Plan Sponsor and Blue Cross and Blue Shield of North Carolina. **Please read this Group Contract carefully.**

READ CAREFULLY

IMPORTANT CANCELLATION INFORMATION

Your Group Contract and/or Member's coverage may be canceled by the Insurer. This information is contained in the Terms and Termination section of your Group Contract. Please read this information carefully to understand the terms of your coverage.

IMPORTANT NOTICE FOR EXECUTIVE CONTACT

Upon the issuance or renewal of any policy, contract, certificate, or evidence of coverage of group health or life insurance, the insurer, corporation, or health maintenance organization shall give written notice to the insurance fiduciary of the provisions of G.S. 58-50-40.

The notice is as follows:

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

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GROUP CONTRACT

This Group Contract made and entered into this 20th day of June, 2018, by and between BLUE CROSS AND BLUE SHIELD OF NORTH CAROLINA, an independent licensee of the Blue Cross and Blue Shield Association, with its principal office located at 4613 University Drive (P.O. Box 2291, Durham, North Carolina 27702), Durham, North Carolina 27707 (hereinafter termed "BCBSNC,") and LENOIR COUNTY GOVERNMENT of KINSTON, NORTH CAROLINA (hereinafter termed "Plan Sponsor") (each, a "Party" and collectively, the "Parties"):

Witnesseth

THAT FOR AND IN CONSIDERATION of the mutual covenants and considerations stated in this agreement, the parties agree to establish a group insurance plan for employees of the Plan Sponsor as follows:

I. DEFINITIONS

Except as otherwise specifically stated herein, capitalized terms used in this Contract shall have the same meaning as is specified in the Glossary section of the benefit booklet(s) listed herein under "Incorporated Documents" and hereinafter referred to as "Benefit Booklet(s).

II. HEALTH BENEFIT PLAN

1. Health Benefits. BCBSNC shall provide Member benefits in accordance with the Benefit Booklet(s) attached hereto and herein incorporated by reference, except as may be otherwise provided in this Group Contract (hereinafter called "Contract") or any amendments hereto made from time to time. If there is any conflict between the provisions of the Benefit Booklet(s) and this Contract, as amended, the provisions of this Contract, as amended, shall prevail.
2. Prior Plan Carryover. BCBSNC will apply to this health benefit plan, any amount that has been accrued toward the Member's deductible and Out-of-Pocket Limit while covered under the Plan Sponsor's prior insurance carrier.
3. Participating Plans. BCBSNC may make an agreement with any appropriate entity (referred to as a Participating Plan) to administer in whole or in part, benefits for Covered Services to Members.
4. Alternate Benefit Plan. In exchange for or in addition to benefits specified in this Contract, BCBSNC may elect, in writing, to offer benefits for services furnished by any Provider or vendor pursuant to a BCBSNC approved Alternate Benefit Plan mutually agreed upon by BCBSNC and the Member or his or her representative. An "Alternate Benefit Plan" is defined as a BCBSNC approved plan of cost-effective care, services and benefits based on a cost/benefit analysis of care for selected Members which may differ from the services covered or benefits otherwise provided under this Contract.
5. Identification Cards. BCBSNC will provide Identification Cards for Subscribers or to a custodial parent or legal guardian under a court or administrative order. The Identification

Card is BCBSNC's property, and BCBSNC reserves the right to reclaim the card if it is misused or when a Subscriber or Member disenrolls.

6. Summary of Benefits and Coverage ("SBCs")/Notice of Material Modifications. BCBSNC shall provide the Plan Sponsor with an electronic copy of all applicable SBCs, as defined by the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act (collectively referred to as the Affordable Care Act or "ACA") and subsequent amendments and regulations, describing the benefits and coverage under this Contract.

   BCBSNC shall also post the SBCs online for Subscribers for convenience as of the effective date of coverage. The Plan Sponsor shall distribute applicable SBCs, either electronically or in a paper form as required, at designated times and within timeframes as required by applicable laws and regulatory guidance, to all Subscribers of the health benefit plan, including special enrollees and new hires, and to employees and their dependents who do not enroll in the health benefit plan. Upon receiving a request, each Party agrees that it shall distribute applicable SBCs to Subscribers at no cost. In the event the Plan Sponsor requests changes to the Group Health Plan that would affect the content of the SBC and which would occur other than in connection with renewal, the Plan Sponsor acknowledges their obligation to provide a notice of material modification as required by federal law.

   The Plan Sponsor shall indemnify and hold harmless BCBSNC for any loss, liability, damage, expense, settlement, cost or obligation (including reasonable attorney's fees) from any resulting assessments, penalties and/or regulatory charges (collectively, "Charges") incurred or paid by BCBSNC related to the failure of the Plan Sponsor to provide such SBCs or notices of material modification as required by law.

7. Benefit Booklets. BCBSNC shall provide Subscribers with an electronic copy of the Benefit Booklets describing this Contract's benefits and providing claims filing instructions through BCBSNC's website. BCBSNC will automatically deliver a paper copy of the Benefit Booklets to a custodial parent or legal guardian under a court or administrative order and will deliver a paper copy of the Benefit Booklets to Subscribers upon their request. At the Plan Sponsor's option, and upon request to BCBSNC, BCBSNC will deliver a paper copy of the Benefit Booklets directly to Subscribers at no additional cost.

8. Incorporated Documents. The following documents attached to this Contract are herein incorporated by reference as fully as if set forth herein:

   K50, Important Notice For Executive Contact
   BlueOptHSA /082476/4QVZ/070118/062018
   BlueOptions/082476/4SX6/070118/062018

9. Medicare Part D. The Plan Sponsor is responsible for all aspects of ensuring that the health benefit plan is in compliance with the requirements of the Medicare Modernization Act and the regulations implementing the Medicare Part D drug benefit found at 42 C.F.R. Part 423, including but not limited to the requirement that the Plan Sponsor provides notices of Creditable Coverage to Medicare eligible Members informing them whether

their Prescription Drug coverage under the health benefit plan is actuarially equivalent to the Medicare Part D benefit.

10. Medicare Modernization and SCHIP Extension Act of 2007 (MMSEA) - Sec. 111 (42 U.S.C. Section 1395y(b)(7)). The Plan Sponsor shall provide all necessary Plan Sponsor information for reporting required under MMSEA for group health plans and as requested by BCBSNC. The Plan Sponsor shall indemnify and hold harmless BCBSNC for any loss, liability, damage, expense, settlement, cost or obligation (including reasonable attorney's fees) from any resulting assessments, penalties and/or regulatory charges (collectively, "Charges") incurred or paid by BCBSNC related to the failure of the Plan Sponsor to provide the requested information.

11. Medical Loss Ratio Requirements. The Plan Sponsor shall provide all Plan Sponsor Employee information necessary for calculation and reporting of the medical loss ratio ("MLR") as required under ACA for health insurance issuers and as reasonably requested by BCBSNC. Further, any rebates issued by BCBSNC that are allocated to this Contract, due to the MLR being lower than the required minimum, will be paid to the Plan Sponsor, and it shall be the Plan Sponsor's sole responsibility to determine the disposition of such funds. The Plan Sponsor shall indemnify and hold harmless BCBSNC for any loss, liability, damage, expense, settlement, cost or obligation (including reasonable attorney's fees) from any resulting assessments, penalties and/or regulatory charges (collectively, "Charges") incurred or paid by BCBSNC related to the failure of the Plan Sponsor to provide the requested information or related to the disposition of rebate funds by the Plan Sponsor.

12. Flexible Spending Arrangement. As part of the health benefit plan, the Plan Sponsor may offer to Participants a Health and/or Dependent Care Flexible Spending Arrangement ("FSA") under Sections 105, 125, and 129 of the Internal Revenue Code ("Code") and the underlying regulations, which allows Participants to allocate pre-tax salary reduction contributions to an account (hereinafter referred to as "the Fund" or "Fund") and receive tax-free reimbursement for medical expenses and/or dependent care expenses. With respect to the Health and/or Dependent Care FSA provided by the Plan Sponsor, BCBSNC shall provide or arrange for the provision of administrative services as described in the Flexible Spending Arrangement Services Appendix ("FSA Services Appendix"). Unless otherwise specified in the FSA Services Appendix, the fee for the FSA administrative services is included as part of the Fees paid by the Plan Sponsor under this Contract. All other duties related to the FSA not set forth in the FSA Services Appendix are the responsibility of the Plan Sponsor.

13. Health Savings Account. The Plan Sponsor is making available to Subscribers a Health Savings Account (hereinafter referred to as "the Fund" or "Fund") under Section 233 of the Internal Revenue Code. The Fund is not part of the health benefit plan administered by BCBSNC. The Fund is administered by a third party administrator, and any contract between the Plan Sponsor and that third party administrator (hereinafter referred to as the "HSA Contract") will be entered into by the Plan Sponsor and its third party administrator separately. The Plan Sponsor may elect any third party administrator it chooses to be its

fund administrator; however BCBSNC makes a preferred third party administrator available to the Plan Sponsor. BCBSNC does not provide any services with respect to any non-preferred third party administrator.

BCBSNC provides the following services only with respect to the HSA administered by its preferred third party administrator: BCBSNC includes a fee for providing such third party administrator as part of BCBSNC's fee to the Plan Sponsor. BCBSNC then reimburses the third party administrator's administrative fee. BCBSNC receives a referral fee from the HSA administrator in exchange for combining the HSA account offering with BCBSNC's High Deductible Health Plan ("HDHP"). This referral fee is currently calculated based on a percentage of Subscriber's contributions to the Fund. The Plan Sponsor is solely responsible for funding of the HSA accounts, to the extent a contribution has been offered by the Plan Sponsor to Subscribers. In addition and on behalf of the third party administrator, BCBSNC may from time to time, print and mail information pertaining to the HSA to the Plan Sponsor's subscribers. All contractual materials related will be delivered directly by the preferred third party administrator. BCBSNC also provides initial information regarding the HSA, and collects enrollment information from the Plan Sponsor. All of the above services are provided by BCBSNC solely as a convenience to the Plan Sponsor, as a means of streamlining the transaction. The provision of these services is in no way intended to indicate or imply that BCBSNC is responsible for the administration of the Fund, or for any other risks, duties, or legal or contractual obligations related to the Fund. The Plan Sponsor further agrees that BCBSNC may align with a different preferred HSA administrator during the term of this Contract. If this occurs, the Plan Sponsor and BCBSNC will cooperate in an orderly transition to the new administrator.

Therefore, notwithstanding any provision of this Contract to the contrary, the Plan Sponsor acknowledges and agrees:

(i) that any HSA Contract is solely between the third party administrator and the Plan Sponsor,
(ii) that BCBSNC is not a party to any HSA arrangement,
(iii) that BCBSNC and any third party administrator are separate, unaffiliated legal entities,
(iv) that BCBSNC will have no responsibility for the administration of the Fund, and
(v) that BCBSNC will be held harmless from any and all liability relating to the administration (including but not limited to claims payments) and/or tax implications of the Fund.

The Plan Sponsor is solely responsible for determining the appropriate contribution levels and appropriate tax treatment of its contributions towards Subscribers' Funds. Improper contributions to a Fund can result in incorrect tax reporting by the Plan Sponsor and the Subscriber. BCBSNC offers no tax advice and assumes no liability with respect to incorrect contributions to a Fund by the Plan Sponsor, regardless of whether BCBSNC is informed in advance by the Plan Sponsor regarding such contributions. The Plan Sponsor should seek appropriate advice from a qualified tax advisor.

14. Access to Information. Subject to the limitations of Section XIII, Use And Disclosure Of Protected Health Information, BCBSNC will provide Group Health Plan data to third

party vendors at the request of the Plan Sponsor. BCBSNC will provide such information if (a) permitted by law and (b) the information relates to the services provided under this Agreement. BCBSNC shall have 90 days to respond to the Plan Sponsor's request for such information that satisfies the requirements of this provision. BCBSNC may charge a Fee for data where BCBSNC offers the services provided by the third party vendor. Such Fees, if applicable, are described in BCBSNC Reporting and Data Extract Fees, herein incorporated by reference.

III. ELIGIBILITY AND ENROLLMENT

1. Probationary Period. Employees must satisfy a 30 day orientation and/or probationary period prior to being eligible to enroll in coverage under this Contract.
2. Effective Date of Coverage.
   a. If Employees are eligible with or without eligible Dependents during the Plan Sponsor's Annual Enrollment Period and apply for coverage, their effective date will be the Plan Sponsor's original contract date.

   b. If Employees are eligible with or without eligible Dependents after the Plan Sponsor's Annual Enrollment Period, and apply for coverage within 30 days of being eligible, their effective date is the 1st day of the following month. If Employees or eligible Dependents do not apply for coverage within 30 days of being eligible to do so, then they must wait until the Plan Sponsor's next Annual Enrollment Period.
3. The Plan Sponsor agrees to offer the coverage herein provided to all eligible persons, as defined in the Benefit Booklet(s) and in compliance with all applicable federal and state laws, that may include but are not limited to the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended, the Public Health Service Act, as amended, the Internal Revenue Code of 1986, as amended, and ACA. The Plan Sponsor shall indemnify and hold harmless BCBSNC for any loss, liability, damage, expense, settlement, cost or obligation (including reasonable attorney's fees) from any resulting assessments, penalties and/or regulatory charges (collectively, "Charges") incurred or paid by BCBSNC related to the failure of the Plan Sponsor to comply with applicable federal and state laws referenced above. The Plan Sponsor further agrees to provide initial and subsequent enrollment information to BCBSNC either by having BCBSNC paper applications signed and sent to BCBSNC or by transmitting such information electronically using a BCBSNC-designated electronic format. The availability of the electronic transmission of enrollment information is dependent on group size. As to those who do not enroll, the Plan Sponsor may, at the request of BCBSNC, have a refusal card signed and returned to BCBSNC. BCBSNC reserves the right to perform an eligibility audit on a Group Health Plan upon reasonable notice. The Plan Sponsor shall provide necessary information to BCBSNC upon request.
4. Enrollment and administration of Member benefits shall be in accordance with this Contract, and the Benefit Booklet(s) are herein incorporated by reference, except to the extent modified by this Contract, as amended from time to time, or as otherwise required by applicable law regarding BCBSNC's obligation as a successor carrier to enroll persons

without regard to confinement, actively at work status, or pregnancy, if they are otherwise eligible, upon issuance of this Contract. The Plan Sponsor must furnish BCBSNC with any data required by BCBSNC for coverage of Members under this Contract. In addition, the Plan Sponsor must provide prompt notification to BCBSNC of the effective date of any changes in a Member's eligibility status under this Contract of which the Plan Sponsor has actual knowledge. The Plan Sponsor agrees that terminations to membership, excluding terminations as a result of fraud or intentional misrepresentation of material fact, will not be made effective retroactively more than 30 days prior to the date BCBSNC is notified of the change. The Plan Sponsor shall ensure that any retroactive Member termination forwarded to BCBSNC is in compliance with federal law, specifically with any prohibition on rescissions. BCBSNC will assume that the Plan Sponsor's request for a retroactive termination is compliant with the law. The Plan Sponsor is solely responsible for providing to the Member any notice related to retroactive terminations or rescissions that are required by law. The Plan Sponsor shall indemnify and hold harmless BCBSNC for any loss, liability, damage, expense, settlement, cost or obligation (including reasonable attorney's fees) from any resulting assessments, penalties and/or regulatory charges (collectively, "Charges") incurred or paid by BCBSNC related to a retroactive termination.

5. Any Members eligible under this Contract are subject to the same eligibility requirements as are applicable to employees that apply under any other health benefit plan or health maintenance organization plan offered by the Plan Sponsor.

6. Special Eligibility.

   Retirees/Early Retirees

   Each employee of the Plan Sponsor covered as a Subscriber under the health benefit plan who retires from service prior to attainment of age 65, and who is qualified to receive benefits due to normal retirement as specified under the Plan Sponsor's Retirement Program will be eligible to continue as a Subscriber. Coverage for eligible retirees will continue until:

   Subscriber ceases to be eligible as a retired employee as specified under Plan Sponsor's Retirement Program;

   Subscriber fails to pay any applicable fees to the Plan Sponsor on or before the due date;

   termination of the Contract;

   whichever occurs first.

   An employee of the Plan Sponsor covered as a Subscriber under the health benefit plan who retires from service due to Disability Retirement as specified in the Plan Sponsor's Retirement Program will not be eligible to continue as a Subscriber unless and until the employee becomes qualified as a regular retiree under the Plan Sponsor's Retirement Program.

Coverage will be continued under the type coverage (Individual, Family) as was in effect immediately preceding retirement date and benefits will be the same as for all other Subscribers. Coverage will be available only to those eligible dependents of the Subscriber covered on the day immediately preceding the date of retirement.

The Plan Sponsor's Retirement Program requires 20 years of service and attainment of age 65.

Eligibility under the Plan Sponsor's Retirement Program will be determined at least 30 days prior to the employee's termination of employment and continuation of coverage must be elected within 30 days of the date of the employee's termination of employment.

Eligible retirees continued for coverage as Subscribers will be considered in the determination of enrollment percentages and contribution made by the Plan Sponsor toward the monthly fee will be made on the same basis as is made for all other Subscribers.

IV. WELLNESS PROGRAMS

1. Healthy Outcomes. BCBSNC shall make available to the Plan Sponsor a Health and Wellness Program which is designed to promote healthy behaviors of Members. Healthy Outcomes provides an integrated disease management and wellness offering that includes, but is not limited to, disease management, online wellness programs and resources (including a health assessment), case management and a 24/7 Nurseline. BCBSNC shall provide various communication tools to encourage the healthy behaviors and engagement of members in Healthy Outcomes. A more detailed description of this program is described on the Program Selection Chart, herein incorporated by reference.

2. Blue Rewards. BCBSNC shall make available to the Plan Sponsor a rewards program where members will be rewarded for a variety of activities, including but not limited to, activities that promote health and wellness, educate members on benefits and provider selection, and use of BCBSNC online tools. A more detailed description of this program is described on the Program Selection Chart, herein incorporated by reference.

   Employers with over 100 Employees may elect additional wellness programs as rewardable activities for active subscribers. Certain programs and/or activities require a direct contract between the Plan Sponsor and an approved third party vendor. BCBSNC shall have no liability or responsibility for the activities that are contracted for directly between the Plan Sponsor and a third party vendor.

   The Plan Sponsor shall be responsible for complying with all applicable federal and state laws with respect to the payment of any reward related to Blue Rewards, including without limitation reporting the amount of the reward on each Employee's Form W-2. BCBSNC shall provide the Plan Sponsor a summary of the total dollar amount of the rewards paid annually to each Employee.

   The Program Selection Chart, herein incorporated by reference, (i) provides detailed program information for the above referenced wellness programs; (ii) identifies any additional program components selected by the Plan Sponsor; and (iii) lists any additional fees (collectively referred to as "Wellness Program Fees") that may be associated with the selection of certain program components

or additional administrative fees such as paper health risk assessment fees and custom reporting fees. Some election options may be billed differently and/or limited by group size. BCBSNC may charge a late fee per day in the event payment of invoiced fees are not received by BCBSNC at its principal office within ten days of the due date.

3. Notwithstanding any contrary provision of this Agreement, groups (size 51+) are eligible for a premium credit for up to three subsequent contract years by purchasing the BCBSNC Fully Insured enhanced Healthy Outcomes solution and earning a WELCOA Well Workplace Award. Groups will need to submit proof of their WELCOA Well Workplace Award to BCBSNC, as described by the WELCOA Program Overview. The Plan Sponsor must earn either a Bronze, Silver, Gold, or Platinum Well Workplace Award. BCBSNC will take the results of the Well Workplace Award program into consideration when setting future rates for Plan Sponsor. Reductions in future renewal rates are not guaranteed. Participation in the Program is completely voluntary. Plan Sponsor is responsible for paying for the WELCOA membership and any other WELCOA service fees. WELCOA is an independent entity that is solely responsible for the services it provides. WELCOA is not affiliated with BCBSNC and does not sell Blue Cross or Blue Shield products or services.]

4. Human Resources Support Services. BCBSNC shall make available to the Plan Sponsor technology tools and software to perform payroll, human resources support services and benefit administration offered by Corban OneSource at no additional charge. The Plan Sponsor will contract separately with Corban OneSource for the services and Corban OneSource will provide all software and support for the technology.

V. FEES

1. Unless otherwise stipulated herein or by amendment hereto, coverage under this Contract is subject to the rating program approved by the North Carolina Insurance Department. Rates are guaranteed for a minimum period of 12 months from the effective date of this Contract, except as otherwise requested by the Plan Sponsor. Thereafter, any rate adjustment required under said rating program may be made by BCBSNC at any time upon 60 days written notice or issuance of the Plan Sponsor's finalized benefits, whichever is earlier, without requirement of signature by the Plan Sponsor. The medical rate page (MRP1), herein incorporated by reference, provides specific rate information for the Plan Sponsor.
2. If applicable, the Plan Sponsor agrees to collect the Members' fees and to transmit such fees along with the Plan Sponsor’s required contribution (hereinafter referred to as "Fees") to BCBSNC's principal office on or before the due date of such Fees.
3. BCBSNC may charge the Plan Sponsor a late fee in the event the Fees are not received by BCBSNC at its principal office within fifteen days of the due date. In addition, BCBSNC may charge the Plan Sponsor a returned payment fee to cover the added administrative cost of processing multiple payments if the Plan Sponsor's bank does not honor the Plan Sponsor's check or other form of payment.
4. In the event the Fees collected by the Plan Sponsor and any additional charges as specified in paragraph 3 of this section are not received by BCBSNC at its principal office within 30 days of the end of the last paid thru date, this Contract and Member coverage hereunder shall automatically

terminate as of that date. In the event BCBSNC does not exercise its right to automatically terminate on the 30th day, the right of termination will not be waived. Instead, beyond that 30th day BCBSNC will retain the right to terminate immediately for nonpayment upon written notice.

5. The Plan Sponsor agrees that BCBSNC's obligation to pay claims for a given billing period does not arise until the Fees, and any late fees or returned payment fees, have been received for that billing period. Fees will be applied chronologically, to the oldest unpaid billing period.

VI. ADMINISTRATION OF COBRA CONTINUATION COVERAGE

In the event that federal continuation of coverage requirements of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, apply to the Plan Sponsor, the obligations of the parties are as set forth in federal law except as described below:

1. Obligations of the Plan Sponsor for the health product

   a. The Plan Sponsor retains responsibility for all aspects of the administration of COBRA, pertaining to the group health insurance coverage provided by this Contract. BCBSNC is not the plan administrator or plan sponsor for purposes of COBRA, and has no responsibility for the Plan Sponsor's COBRA administration obligations except as indicated in paragraph 2 of this section.

2. Obligations of BCBSNC for the health product

   a. To the extent required by COBRA, and upon timely receipt of premiums and proper enrollment forms and election of coverage, BCBSNC will provide coverage to qualified beneficiaries after the period that their coverage would normally cease under the Contract.

3. This provision shall not be interpreted to grant to any Member any continuation rights in excess of those required by COBRA. Further, this Contract shall be interpreted, if necessary, so as to comply with COBRA and any changes to COBRA that are mandatory with respect to the Plan Sponsor.

VII. NORTH CAROLINA HEALTH PROVIDER ARRANGEMENTS

Member/Blue Options Participating Provider/BCBSNC Relationship

1. BCBSNC has contracts with certain Providers of health care services for the provision of, and payment for, health care services rendered to all Members entitled to health care benefits under this Contract. BCBSNC's payment to Providers may be based on an amount other than the Provider's actual charges, including without limitation, a fixed amount per Member per month (capitation), an amount per confinement or episode of care, agreed upon schedule of fees, or other methodology as agreed upon by BCBSNC and the Provider. Under certain circumstances, a contracting Provider may receive payments from BCBSNC greater than the charges with respect to services rendered to an eligible Member, or BCBSNC may pay less than charges for services, due to the negotiated contracts. The Member is not entitled to receive any portion of the payments made under the terms of contracts with Providers. The Member's liability when defined as a percent of charge, shall be calculated based on the lesser of the Allowed Amount or the Provider's actual charge for Covered Services rendered to a Member.

BCBSNC may, from time to time, make additional payments to contracting Providers providing health care services. These payments may be based on BCBSNC's evaluation of the quality and cost-effectiveness of the health care services provided to Members. The method, frequency and amount of such payments shall be determined solely by BCBSNC. Any payments of this type made by BCBSNC shall not serve to increase or decrease any payments due or owing by the Member.

2. The relationship between BCBSNC and In-Network Providers is that of an independent contractor relationship; Hospitals, Nonhospital Facilities, Doctors or Other Professional Providers are not agents or employees of BCBSNC, nor is BCBSNC or any employee of BCBSNC, an employee or agent of Hospitals, Nonhospital Facilities, Doctors or Other Professional Providers. BCBSNC shall not be liable for any claim or demand on account of damages arising out of, or in any manner connected with, injuries suffered by the Member while receiving care in any Hospital or Nonhospital Facility or provided by any Doctor or Other Professional Provider, except BCBSNC may have liability for claims brought under Article 1G of Chapter 90 of the North Carolina General Statutes.

   In-Network Providers maintain the Provider-patient relationship with Members and are solely responsible to Members for all health services. Certain Members may, for personal reasons, refuse to accept procedures or treatment by an In-Network Provider. In-Network Providers may regard such refusal to accept their recommendations as incompatible with continuance of the Provider-patient relationship and as obstructing the provision of proper Medical Care. In-Network Providers shall use their best efforts to render all necessary and appropriate professional services in a manner compatible with a Member's wishes insofar as this can be done consistently with the In-Network Provider's judgment as to the requirements of proper medical practice. If a Member refuses to follow a recommended treatment or procedure, and the In-Network Provider believes that no professional acceptable alternatives exist, such Member shall be so advised.

   Neither the Plan Sponsor nor any Member is the agent or representative of BCBSNC, and neither shall be liable for any acts or omissions of BCBSNC, its agents or employees or of In-Network Providers or any other person or organization with which BCBSNC has made or hereafter shall make arrangements for the performance of services under this Contract.

Relationship Between Provider, BCBSNC, and Member Enrolled on Blue Options Plan of Coverage

3. The choice of a Provider is solely the Member's. BCBSNC does not furnish Covered Services but only facilitates payment for Covered Services received by Members. BCBSNC is not liable for any act or omission of any Provider. BCBSNC has no responsibility for a Provider's failure or refusal to render Covered Services to a Member.

   The use of an adjective such as Participating or Non-Participating as applied to any Provider is not a statement as to the existence of a principal/agent or employer/employee relationship or as to the ability of the Provider.

4. Recoveries of overpayments from Participating Providers can arise in several ways, including, but not limited to, anti-fraud and abuse audits, Provider/Hospital audits, credit balance audits, utilization review refunds, and unsolicited refunds. In some cases, BCBSNC will engage third parties to assist in identification or collection of overpayment amounts. The fees of such a third party are deducted from the recovery. Recovery amounts, net of fees, if any, will be applied in accordance with applicable BCBSNC Policies, which generally require correction on a claim-by-claim or prospective basis.

VIII. INTER-PLAN ARRANGEMENTS

A. Definitions

In addition to the defined terms contained in the Glossary section of the Benefit Booklet(s), the following definitions apply to this provision. Where a term is defined in both sections, the definitions set forth herein shall control when interpreting this section.

1. "Inter-Plan Arrangements" means a national arrangement for extending access to cost-effective health care outside of BCBSNC's service area, through Blue Cross and/or Blue Shield Licensees (Plans and certain Plan affiliates) that have agreed to participate.

2. "Host Blue" means the independent Blue Cross and/or Blue Shield Licensees (Plans and certain Plan affiliates) that participate in Inter-Plan Arrangements and provide PROVIDER network access and claim pricing for other independent Blue Cross and/or Blue Shield Licensees (Plans and certain Plan affiliates), including BCBSNC, when Members receive medical services in that Host Blue's service area.

B. Services Received Outside Of North Carolina

BCBSNC has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Arrangements." Inter-Plan Arrangements operate under rules and procedures issued by the Blue Cross Blue Shield Assocuation ("Association"). Whenever Members access health care services outside the geographic area BCBSNC serves, the claim for those services may be processed through one of these Inter-Plan Arrangements and presented to BCBSNC for payment.

Typically, Members, when accessing care outside the geographic area BCBSNC serves, obtain care from healthcare Providers that have a contractual agreement (i.e. are "Participating Providers") with the Host Blue. In some instances, Members may obtain care from non-participating healthcare Providers. BCBSNC's payment practices in both instances are described below.

All claim types are eligible to be processed through Inter-Plan Arrangements, as described above, except for all Dental Care Benefits except when paid as medical claims/benefits, and those Prescription Drug Benefits or Vision Care Benefits that may be administered by a third party contracted by BCBSNC to provide the specific service or services.

1. BlueCard® Program

Under the BlueCard® Program, when Members receive covered health care services within the geographic area served by a Host Blue, BCBSNC will remain responsible to the Plan Sponsor for fulfilling BCBSNC's contract obligations. However, the Host Blue will be responsible for providing such services as contracting and handling substantially all interactions with its Participating Providers. The financial terms of the BlueCard Program are described generally below.

a. Liability Calculation Method Per Claim

The calculation of Member liability on claims for covered health care services processed through the BlueCard Program will be based on the lower of the participating Provider's billed covered charges or the negotiated price made available to BCBSNC by the Host Blue.

The methods employed by a Host Blue to determine a negotiated price may vary among Host Blues based on the terms of each Host Blue's Provider contracts. The negotiated price made available to BCBSNC by a Host Blue may represent a payment that is one of the following:

(i) an actual price. An actual price is a negotiated payment without any other increases or decreases ("Actual Price"), or

(ii) an estimated price. An estimated price is a negotiated payment increased or reduced by a percentage to take into account certain payments negotiated with the Provider and other claim- and non-claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, Provider refunds not applied on a claim-specific basis, retrospective settlements, and performance-related bonuses or incentives ("Estimated Price"), or

(iii) an average price. An average price is a percentage of billed covered charges, representing the aggregate payments negotiated by the Host Blue with all of its Providers or a similar classification of its Providers and other claim- and non-claim-related transactions ("Average Price"). Such transactions may include the same ones as noted above for an estimated price.

Host Blues using either the Estimated Price or Average Price may, prospectively increase or reduce the Estimated Price or Average Price to correct for over- or underestimation of past prices. However, the amount paid by the Member is a final price; no future price adjustment will be applied to claims already paid. The method of claims payment by Host Blues is taken into account by BCBSNC in determining the premiums of Plan Sponsor.

In some instances federal or state laws or regulations may impose a surcharge, tax or other fee that applies to insured accounts. If applicable, BCBSNC will include any such surcharge, tax or other fee in determining the Plan Sponsor's premium.

b. Return of Overpayments

Under the BlueCard Program, recoveries from a Host Blue or its Participating Providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, Provider/ Hospital bill audits, credit balance audits, utilization review refunds, and unsolicited refunds. If recovery amounts are passed on a claim-by-claim basis from a Host Blue to BCBSNC, they will be credited to the Plan Sponsor. In some cases, the Host Blue will engage a third party to assist in identification or collection of overpayments/recovery amounts. The fees of such a third party may be charged to the Plan Sponsor as a percentage of the recovery.

2. Negotiated National Account Arrangements

As an alternative to the BlueCard Program, claims for covered healthcare services may be processed through a negotiated national account arrangement with a Host Blue.

If BCBSNC has arranged for a Host Blue to make available a custom healthcare Provider network in connection with this contract, then the terms and conditions set forth in our negotiated national account arrangement with such Host Blue shall apply.

a. Liability Calculation Method

Member liability calculation will be based on the lower of the participating Provider's billed covered charges or negotiated price (Refer to the description of negotiated priced under Section 1.a, Liability Calculation Method Per Claim, above) made available to BCBSNC by the Host Blue that allows the Plan Sponsor's Members access to negotiated participation agreement networks of specified participating healthcare Providers outside of BCBSNC's service area.

3. Non-participating Healthcare Providers Outside BCBSNC's Service Area

a. Liability Calculation Method

When covered healthcare services are received outside of BCBSNC's service area from non-participating healthcare Providers, the amounts a Member pays for such services will generally be based on either the Host Blue's non-participating healthcare Provider local payment or the pricing arrangements required by applicable state law. In these situations, the Member may be responsible for the difference between the amount that the non-participating healthcare Provider bills and the payment that BCBSNC will make for the Covered Services as set forth in this paragraph. Payments for out-of-network emergency services are governed by applicable federal and state law.

In some exception cases, BCBSNC may pay claims from non-participating healthcare Providers outside of BCBSNC's service area based on the Provider's billed charge, such as in situations where a Member did not have reasonable access to a participating Provider, as determined by BCBSNC in its sole and absolute discretion or by applicable state law. In other exception cases, BCBSNC may pay such a claim based on the payment it would make if BCBSNC were paying a non-participating Provider for the same covered healthcare services inside of BCBSNC's service area, as described elsewhere in this Contract where the Host Blue's corresponding payment would be more than BCBSNC's in-service area non-participating Provider payment, or in BCBSNC's sole and absolute discretion, BCBSNC may negotiate a payment with such a Provider on an exception basis. In any of these exception situations, the Member may be responsible for the difference between the amount that the non-participating healthcare Provider bills and the payment BCBSNC will make for the Covered Services as set forth in this paragraph.

4. Special Cases: Value-Based Programs

BCBSNC has included a factor for bulk distributions from Host Blues in the Plan Sponsor's premium for Value-Based Programs when applicable under this Contract.

If BCBSNC has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to Members, BCBSNC will follow the same procedures for Value-Based Programs as noted above for the BlueCard Program.

5. Blue Cross Blue Shield Global Core

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

a. Inpatient Services

In most cases, if Members contact the service center for assistance, hospitals will not require Members to pay for covered inpatient services, except for any applicable deductible, copayment and/or coinsurance amounts. In such cases, the hospital will submit Member claims to the service center to initiate claims processing. However, if the Member paid in full at the time of service, the Member must submit a claim to obtain reimbursement for Covered Services. Members must contact BCBSNC to obtain precertification for non-emergency inpatient services.

b. Outpatient Services

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

c. Submitting a Blue Cross Blue Shield Global Core Claim

When Members pay for Covered Services outside the BlueCard service area, they must submit a claim to obtain reimbursement. For institutional and professional claims, Members should complete a claim form and send the claim form with the provider's itemized bill(s) to the Service Center address on the form to initiate claims processing. The claim form is available from BCBSNC, the service center or online at www.bcbsglobalcore.com. If Members need assistance with their claim submissions, they 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.

IX. COORDINATION OF BENEFITS

1. BCBSNC shall provide coordination of benefit ("COB") services to the Plan Sponsor in accordance with the description of these services in the Benefit Booklet and applicable laws. COB applies to the Health and/or Dental Plan(s) under this Contract when an Employee or the Employees' covered Dependent has health or dental care coverage under more than one Plan. For purposes of COB, a Health or Dental Plan includes any of the following which provides benefits or services for, or because of, medical/dental care or treatment:

   a. Group insurance coverage, exclusive of school accident, blanket, franchise individual, automobile or homeowner coverage;

b. Blue Cross and/or Blue Shield coverage;

c. Health maintenance organization and other prepayment group coverage;

d. Coverage under labor management trusteed plans, union welfare plans, employer organization plans, or employee benefit organization plans; and

e. Coverage under a governmental plan or required or provided by law, except Medicaid coverage or any plan with benefits in excess to those of any private insurance program or other non-governmental program.

2. Effect on Benefits

a. When BCBSNC coordinates benefits under this section, the benefits that would be payable under this Contract shall be reduced to the extent necessary so that the sum of such reduced benefits and all the benefits payable for such Covered Services under all other Health or Dental Plans, shall not exceed the Allowed Amount for such Covered Services.

b. When this provision operates to reduce the total amount of benefits otherwise payable as to a person covered under this Contract, each benefit that would be payable shall be reduced independently and such reduced amount will be charged against any applicable benefit limit of this Contract.

c. BCBSNC will not affirmatively investigate the existence of any Plan, nor will BCBSNC determine the amount of benefits payable under any Plan except this Contract. Except as otherwise provided in the Benefit Booklet(s), the payment of benefits under this Contract shall be affected by the benefits payable under another Plan only to the extent that BCBSNC is furnished with information regarding another Plan by the Plan Sponsor or Member or any other organization or person.

3. Facility of Payment

Whenever payments should have been made under this Contract in accordance with this provision, but the payments have been made under another Plan, BCBSNC has the right to pay to any organization that has made such payment any amount it determines to be warranted to satisfy the intent of this provision. Amounts so paid shall be deemed to be benefits paid under this Contract and to the extent of the payments for Covered Services, BCBSNC shall be fully discharged from liability under this Contract.

4. Right of Recovery

a. Whenever payments have been made by BCBSNC for Covered Services in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, irrespective of to whom paid, BCBSNC shall have the right to recover the excess from among the following, as BCBSNC shall determine: any person to or for whom such payments are made, any insurance company, or any other organization.

b. The Subscriber, personally and on behalf of Dependents shall, upon request, execute and deliver such documents as may be required and do whatever else is necessary to secure BCBSNC's rights to recover the excess payments.

X. WORKERS' COMPENSATION

BCBSNC may seek reimbursement for medical or dental payments made under this Contract from a Member, the Member's employer, or the workers' compensation carrier that is liable or responsible for a specific medical charge according to a final adjudication of the claim under a state's workers' compensation laws, or an order of a state's Industrial Commission or other applicable regulatory agency approving a settlement agreement. Upon the admission or adjudication that the claim of a Member is compensable, the party or parties liable are required to notify BCBSNC, in writing, of the admission or adjudication of compensability. The Plan Sponsor agrees that in the event the Plan Sponsor or its workers' compensation carrier is liable or responsible for medical or dental expenses reimbursed by BCBSNC pursuant to this Contract, the Plan Sponsor will notify BCBSNC of a final adjudication or admission of compensability.

XI. TERM AND TERMINATION

1. This Contract shall be effective for a period of 12 months beginning on the 1st day of July, 2018, and, unless terminated as hereafter provided, shall be automatically renewed for a period of one year upon the terms and conditions herein set forth.

2. The Plan Sponsor may terminate this Contract at any time by providing prior written notice to BCBSNC. In the event that the Plan Sponsor has obtained other health coverage, written notice may be provided after the requested termination date, but no later than 30 days after the requested termination date. Any claims paid for dates of service occurring after the requested termination date will be reprocessed and any premium amounts paid for dates of coverage after the requested termination date will be refunded. In accordance with NCGS 58-50-40, the Plan Sponsor must provide timely notification of the termination of this Contract to every Subscriber.

3. BCBSNC may terminate this Contract for any of the following reasons so long as written notice is given:

   a. nonpayment of Fees, Healthy Outcomes Fees, Paper Fees, late fees or returned payment fees, by the Plan Sponsor. The termination will be effective as of 12:01 a.m. on the day following the paid through date;

   b. fraud or intentional misrepresentation of a material fact by the Plan Sponsor or, with respect to coverage of individual Members, the Members or their representatives;

      i. BCBSNC may rescind the Contract upon discovery of any fraud or intentional misrepresentation of a material fact by the Plan Sponsor by providing 30 days advance written notice. The Plan Sponsor shall forfeit any Fees theretofore paid to the extent of any liability incurred by BCBSNC. The Plan Sponsor is responsible for any additional costs incurred by BCBSNC which are related to the fraud or intentional misrepresentation and not covered by the Fees subject to forfeiture. These remedies are without prejudice to any other remedies available to BCBSNC under the law.

      ii. BCBSNC may rescind a Subscriber's or Member's coverage under the Contract for health upon discovery of any fraud or intentional misrepresentation of a material fact by the Subscriber or Member by providing 30 days advance written notice. The Subscriber and/or Member shall forfeit any Fees theretofore paid to the extent of any liability incurred by

BCBSNC. The Subscriber and/or Member is responsible for any additional costs incurred by BCBSNC which are related to the fraud or misrepresentation and not covered by the Fees subject to forfeiture.

c. when the Plan Sponsor fails to comply with contribution or participation rules required under the terms of coverage. Coverage will be terminated upon 30 days prior notice;

d. BCBSNC ceases to offer all coverage in the market applicable to the Plan Sponsor (i.e., the small employer market or the large employer market) or in both markets, provided that notice is given to the Plan Sponsor, Subscribers and their covered dependents and the North Carolina Department of Insurance 180 days prior to cancellation;

e. BCBSNC ceases to offer a health insurance product in the market applicable to the Plan Sponsor (i.e., the small employer market or the large employer market) that is being provided to the Plan Sponsor pursuant to this Contract, provided that notice is given to the Plan Sponsor and to Subscribers and their covered dependents 90 days prior to cancellation and:

i. if the Plan Sponsor is a small employer group under state law, the Plan Sponsor is given the option to enroll in any small employer product offered by BCBSNC;

ii. if the Plan Sponsor is not a small employer group under state law, the Plan Sponsor is given the option to enroll in a product chosen by BCBSNC that is currently offered for sale in the large group market by BCBSNC.

4. Termination of the Contract automatically terminates all Members' coverage except as may be provided herein. It is the responsibility of the Plan Sponsor to notify all Members of the termination of the coverage when the Contract is terminated pursuant to paragraph 2 above. It is the responsibility of BCBSNC to notify all Members of the termination of coverage when the Contract is terminated pursuant to paragraph 3 above. Coverage will be terminated effective on the date this Contract is terminated, regardless of whether the required notice is given. Issuance of a nongroup contract to affected Members and Subscribers will be as required by North Carolina law; or if not required by law, at the option of BCBSNC and upon the terms offered by BCBSNC.

XII. USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. In connection with the performance of its duties and obligations under this Contract, BCBSNC receives, uses and discloses Protected Health Information ("PHI") (as that term is defined in 45 Code of Federal Regulations Section 160.103, as amended from time to time) about Members as permitted and required by law. BCBSNC's disclosure of PHI to the Plan Sponsor is highly regulated, and is limited by applicable laws, regulations and standards in many ways. This section sets forth BCBSNC and Plan Sponsor's agreements concerning disclosure of this PHI to the Plan Sponsor.

2. BCBSNC has imposed upon it significant limitations on the PHI that can be transmitted to the Plan Sponsor. Accordingly, in performance of this Contract, BCBSNC may, in certain situations, be required by law or corporate policy to refuse to provide certain PHI to the Plan Sponsor, even when requested by them.

3. The Plan Sponsor recognizes that, as a general matter, PHI will not be disclosed to them, unless this disclosure is permitted by law and BCBSNC corporate policy, and the Plan Sponsor has met its own

obligations allowing it to receive this information, including placing appropriate restrictions on any further use of this PHI.

4. The Plan Sponsor also recognizes that, in certain circumstances required or permitted by law or by BCBSNC policy, BCBSNC may take reasonable steps to remove, scramble or otherwise eliminate individual identifiers from certain information that is provided to the Plan Sponsor.

5. BCBSNC recognizes that there are limited situations where the Plan Sponsor has a legitimate business need for PHI and where such PHI may be supplied in compliance with both the applicable law and with BCBSNC corporate policy. In these limited situations, BCBSNC may disclose PHI that is reasonably necessary for the Plan Sponsor to fulfill its legitimate business need.

6. Where PHI is provided to the Plan Sponsor for any purpose, the Plan Sponsor agrees to the following obligations:

   a. It agrees that this PHI cannot be used in connection with any decision affecting the Employee.

   b. The Plan Sponsor shall indemnify and hold harmless BCBSNC from any loss, liability, damage, expense, settlement, cost or obligation (including reasonable attorneys' fees) from any resulting assessments, penalties and/or regulatory charges (collectively, "Charges") incurred or paid by BCBSNC related to the release of PHI by BCBSNC to the Plan Sponsor or from the Plan Sponsor's subsequent use of such information.

   c. It agrees that only the appropriately designated Group Plan Administrator, or his or her designee, or an appropriately designated representative of the Plan Sponsor, may have any access to PHI. In order for even these designated individuals to receive PHI, the Plan Sponsor must have appropriate security and confidentiality measures in place to prevent unauthorized access by other personnel.

   d. It agrees that this PHI will only be used or disclosed as required or permitted by the Standards for Privacy of Individually Identifiable Health Information, 45 Code of Federal Regulations, Parts 160 and 164.

XIII. GENERAL PROVISIONS

1. BCBSNC as Independent Corporation. The Plan Sponsor on behalf of itself and its participants, hereby expressly acknowledges its understanding that this policy constitutes a Contract solely between the Plan Sponsor and BCBSNC which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans, permitting BCBSNC to use the Blue Cross and Blue Shield Service Marks in the State of North Carolina and that BCBSNC is not contracting as an agent of the Blue Cross and Blue Shield Association. The Plan Sponsor on behalf of itself and its participants, further acknowledges and agrees that it has not entered into this policy based upon representations by any person other than BCBSNC and that no person, entity or organization other than BCBSNC shall be held accountable or liable to the Plan Sponsor for any of BCBSNC's obligations to the Plan Sponsor created under this policy. This paragraph shall not create any additional obligations whatsoever on the part of BCBSNC other than those obligations created under other provisions of this agreement.

2. Non-Agency Relationship. The Plan Sponsor is agent of the Members and not of BCBSNC.

3. Entire Agreement. This Contract, the group enrollment application, Member enrollment information (submitted on paper applications or transmitted electronically using a BCBSNC-designated format), Endorsements, amendments, or documents incorporated by reference shall constitute the entire Agreement between the parties and voids and supersedes all previous writings, agreements, and contracts, if any, between the Plan Sponsor and BCBSNC. All statements made by the Plan Sponsor or by an individual Member shall, in the absence of fraud, be deemed representations and not warranties, and no such statement shall be used in defense to a claim under this Contract unless it is contained in a written application.

4. Amendments. No agent or employee of BCBSNC is authorized to change the form or content of this Contract except to make necessary and proper insertions in blank spaces. Such changes can be made only through an amendment authorized and signed by an officer of BCBSNC.

   Only the Board of Trustees of BCBSNC or its authorized designee, may waive or vary any provisions of this Contract.

   This Contract can be amended by BCBSNC at any time to be effective upon 45 days prior written notice to the Plan Sponsor or at a later date as specified in such notice, unless the Plan Sponsor shall cancel this Contract by giving 30 days prior written notice of termination.

5. Force Majeure. To the extent that a natural disaster, war, riot, civil insurrection, labor dispute, epidemic, complete or partial destruction of facilities, atomic explosion or other release of nuclear energy, or any other cause not within the control of BCBSNC results directly or indirectly in the facilities, personnel, subcontractor(s), network Providers, or financial resources of BCBSNC not being available for a period of time (the "force majeure period") to provide or arrange for services or benefits under this Contract, BCBSNC's non-performance shall not be considered a breach of this Contract and BCBSNC's obligation to provide such services or benefits during the force majeure period shall be limited to the requirements that BCBSNC make a good faith effort to provide or arrange for the provision of such services or benefits within the resulting limitations on the availability of its facilities, personnel, or resources. After such force majeure period, BCBSNC shall resume performance of its obligations under this Contract.

6. Notices. Any notice required under this Contract must be in writing. Notice given to the Plan Sponsor will be sent to the address as entered in BCBSNC's records. Notice given to BCBSNC will be sent to BCBSNC's address of record. Notice given to a Member will be sent to the Member's address as it appears on the records of BCBSNC or in care of the Plan Sponsor. The Plan Sponsor, BCBSNC, or a Member, may, by written notice, indicate a new address for giving notice. Any notice to the Plan Sponsor, Subscriber, or Member shall be considered to have been conveyed to and received by such individuals when deposited in the United States mail addressed to the Plan Sponsor, Subscriber or Member at the address shown on BCBSNC's records.

7. Contract Violations. The waiver by either party of a breach or violation of any provision of this Contract shall not be construed to be a waiver of any subsequent breach thereof.

8. North Carolina Contract. This Contract is made, executed and delivered in the State of North Carolina, and it and the Member coverage provided hereunder shall be governed

under the laws of the State of North Carolina, except to the extent preempted by federal law.

9. Assignment. This Contract, the right to receive benefits hereunder, and the right to receive payment for services, shall not be assigned, sublet or transferred by the Plan Sponsor, without the consent of BCBSNC.

10. Invalid Provisions and Severability. In the event any provision of this Contract conflicts with the laws under which this Contract is to be construed, or if any provision is held invalid by a court with jurisdiction over BCBSNC, such provision shall be deleted from this Contract and the Contract shall be construed to give effect to the remaining provisions of the Contract.

    Typographical errors will not invalidate otherwise valid coverage.

11. Headings. The headings contained herein are for the convenience of reference only and are not intended to define, limit or describe the scope or intent of any provision of this Contract.

12. Confidentiality. "Confidential information" shall mean information disclosed from one Party ("disclosing Party") to the other ("receiving Party") relating to the disclosing Party's pricing, pricing methodology, technical, marketing, products, services, business affairs, proprietary and trade secret information in oral, graphic, written, electronic or machine readable form, and the terms and conditions of this Contract. Each receiving Party agrees to protect the confidentiality of the disclosing Party's Confidential Information and agrees not to use Confidential Information for any purposes other than in connection with the obligations under this Contract. Each Party shall maintain the Confidential Information of the other Party in confidence using at least the same degree of care as it employs in maintaining in confidence its own proprietary and confidential information, but in no event less than a reasonable degree of care. Both Parties agree not to disclose Confidential Information to any third party except as permitted under applicable law or regulation or under this Section 12. The Plan Sponsor may disclose the Confidential Information to its attorney(s) or consultant(s), provided that such persons have first executed an agreement, with terms at least as stringent as those in this Contract, to keep confidential all Confidential Information that the Plan Sponsor discloses to them. The Plan Sponsor agrees not to solicit Confidential Information pertaining to any plan sponsor which is not a party to this Contract. BCBSNC may disclose the Confidential Information to its attorney(s) or any third party. The obligations of this section shall survive termination of this Contract.

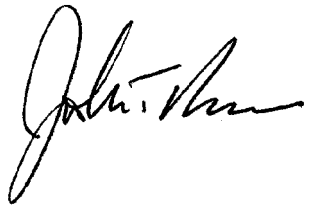
GROUP SIGNATURES FOR:
Plan Sponsor: LENOIR COUNTY GOVERNMENT
Group Number: 082476

Signed For: LENOIR COUNTY GOVERNMENT:

Because this Contract is being offered only in conjunction with a signed Group Apply Form from Blue Cross and Blue Shield of North Carolina, Group's signature on the Group Apply Form will constitute the Plan Sponsor's agreement to this Contract, without requirement of additional signature.

BLUE CROSS AND BLUE SHIELD OF NORTH CAROLINA

Witness:



By:

President

Date:
June 20, 2018

Date:
June 20, 2018

BCBSNC SERVICE CONTRACT
FLEXIBLE SPENDING ARRANGEMENT SERVICES APPENDIX

The following represents the specific services provided by Blue Cross and Blue Shield of North Carolina (" BCBSNC") or its designee in accordance with the Contract to which this Service Appendix is attached and the corresponding responsibilities of the Plan Sponsor. This Services Appendix is incorporated into and made a part of the Contract. The effective date of this Service Appendix is the effective date of the Contract. The responsibilities of the parties set forth in this Service Appendix are in addition to any responsibilities set forth in the Contract. If there is a conflict between this Service Appendix and the Contract, the Contract controls.

In consideration for the mutual promises set forth below and for the Fees set forth in the Contract, the Plan Sponsor and BCBSNC agree as follows:

I. DEFINITIONS

Except as otherwise specifically stated herein, capitalized terms in this Service Appendix shall have the same meaning as is specified in the Contract.

A. "Health Flexible Spending Arrangement" ("Health FSA") means a flexible spending arrangement established by the Plan Sponsor as described in Internal Revenue Code sections 105 and 125 and the underlying regulations.

B. "Dependent Care Flexible Spending Arrangement" ("Dependent Care FSA") means a flexible spending arrangement established by the Plan Sponsor as described in Internal Revenue Code sections 129 and 125 and the underlying regulations.

C. "Overpayments" means payments made to or on behalf of a Participant that are determined by Plan Sponsor or BCBSNC to exceed the amount payable under the Dependent Care FSA.

D. "Participant" means an eligible employee of the Plan Sponsor who elects either a Health FSA and/or a Dependent Care FSA.

II. BCBSNC RESPONSIBILITIES

A. Services. BCBSNC will provide consulting services for and will assist the Plan Sponsor in the administration of a Health FSA and/or a Dependent Care FSA as described in this Services Appendix. The services to be performed by BCBSNC under this Services Appendix will be ministerial in nature and will generally be performed in accordance with the terms of the Health FSA and/or a Dependent Care FSA established by the Plan Sponsor and BCBSNC's standard operating procedures. No communication or documents provided by BCBSNC or its agents, contractors, or designee to Employer or Members shall be considered tax or legal advice.

B. Bonding. In accordance with section 412 of ERISA, BCBSNC is not required to maintain a fidelity bond in connection with the Health FSA and/or a Dependent Care FSA, and BCBSNC will not obtain or maintain such a bond.

C. Plan Documentation and Forms. BCBSNC will provide Plan Sponsor with electronic copies of sample documents and forms related to the administration of the Health and/or Dependent Care FSA. BCBSNC will administer the Health and/or Dependent Care FSA as described in these documents. All plan documents shall conform to the available options that are possible in the BCBSNC administration systems. The available options will be disclosed to Plan Sponsor prior to implementation of the Health and/or Dependent Care FSA. BCBSNC will not administer any of the Health and/or Dependent Care FSA outside of such available options, unless mutually agreed upon. Notwithstanding the provisions of this Section, adoption, distribution and maintenance of all plan documents for the Health and/or Dependent Care FSA, including compliance with applicable laws and regulations, is solely the responsibility of the Plan Sponsor in accordance with Section III(C).

D. No Liability for Claims and Expenses. BCBSNC is responsible for processing claims for benefits and appeals under the Health and/or Dependent Care FSA and for arranging for the payment thereof from funds made available by the Plan Sponsor from the Plan Sponsor's general assets. BCBSNC does not insure or underwrite the Health and/or Dependent Care FSA liability of Plan Sponsor and is not financially responsible for the claims payable under and/or expenses incident to the Health and/or Dependent Care FSA. BCBSNC has no duty or obligation to defend any legal action or proceeding brought to recover benefits under the Health and/or Dependent Care FSA; however, BCBSNC will provide to Plan Sponsor and Plan Sponsor's legal counsel, upon request and subject to any limitations described in this Services Appendix, any documentation in BCBSNC's possession received pursuant to performing services under this Services Appendix that may relate to such claim for benefits and/or expenses.

E. Claims and Appeals. After receipt of a claim for benefits, BCBSNC will determine whether the claim is eligible for payment from the Benefit Plan. If the facts as stated in such claim or as determined by investigation by BCBSNC entitle the Member or Provider to receive payment from the Benefit Plan, BCBSNC will arrange for proper payment as noted below. If BCBSNC determines that the claim should be denied, BCBSNC will send a denial, with reasons for the denial, to the Member, in accordance with applicable laws and regulations. BCBSNC may adjust any disputed benefit claim previously denied. Upon request, Member may submit an appeal to BCBSNC for any and all previously denied claims. The determination of BCBSNC, made in accordance with the Benefit Plan procedures on any claim for benefits is final, subject to final review by Plan Sponsor. In the event this Services Appendix is terminated, all requests for reimbursement submitted to BCBSNC after the effective date of termination will be returned to the Plan Sponsor, or at the Plan Sponsor's request, submitted to another third party. BCBSNC will have no further responsibility with respect to such claims submitted after the effective date of termination.

1. Payment of Claims for the Health FSA. With regard to the Health FSA, BCBSNC will not reimburse or pay a Member's claim unless the Member has properly substantiated such claim as required under IRS guidance. In the event that BCBSNC pays a Member's Health FSA Claim via an electronic payment card, in accordance with IRS regulations, Members may be required to substantiate that claim after payment to the extent the payment cannot be

automatically substantiated. Plan Sponsor agrees to follow BCBSNC substantiation policies, in accordance with IRS regulations.

2. Payment of Claims for the Dependent Care FSA. With regard to the Dependent Care FSA, BCBSNC will not reimburse a Member's claim unless the Member has sufficient funds in his/her Dependent Care FSA at the time the claim is submitted and has properly substantiated such claim, automatic or otherwise, as required under IRS guidance. If the Member does not have sufficient funds in his/her Dependent Care FSA at the time the claim is submitted, the reimbursement request will be denied and/or held by BCBSNC and processed when such funds are available.

3. Debit Card Payments and Declines. If the Plan Sponsor elects to allow for debit card payments, the fact that a payment by a debit card is approved or declined at the point of sale is not determinative of the validity of the expenses. In the sole determination of BCBSNC, if a transaction does not require submission of additional documentation, such a transaction shall be considered an approved claim for the purpose of ERISA. If a debit card is declined at the point of sale, it shall not be considered a claim denial and no written explanation shall be provided to the Member.
4. No Pre-approval of Claims. BCBSNC shall not be providing any approval of claims prior to the performance of services or expenses being incurred. All claims shall be adjudicated only after the services have been performed.

F. Bankruptcy of Plan Sponsor. Notwithstanding any other provision of this Services Appendix, in the event of the filing by or against the Plan Sponsor of a petition for relief under the Federal Bankruptcy Code, BCBSNC shall have the right to suspend the payment of claims for Health and/or Dependent Care FSA benefits unless and until an order is obtained from the bankruptcy court, in form and substance acceptable to BCBSNC, authorizing such payment and the Plan Sponsor has deposited the funds necessary to pay such claims in full.

G. Undeliverable/Uncashed Claim Payments. BCBSNC will follow either its or its designees standard policies and procedures for handling claim payment checks that are either returned to BCBSNC as undeliverable or are not cashed by the payee.

H. Electronic Payment Card (Health FSA Only). BCBSNC may make an electronic payment card available to Health FSA Participants through which eligible medical expenses may be paid.

I. BCBSNC Authority to Pursue Recovery. BCBSNC has the authority, but not the duty, to pursue recovery of Health and/or Dependent Care FSA Overpayments, including without limitation, amounts identified through claims audit, subject to overpayment policies and processes. Any contrary provision of this Services Appendix notwithstanding, BCBSNC shall have no responsibility or liability for or to collect any excess or erroneous payments made to or on behalf of Participants more than two (2) years before any claims audit or claim for recovery of such amounts is initiated by the Plan Administrator. Further, BCBSNC shall have no responsibility or liability for or to collect any claims paid at the direction of either the Plan Sponsor or the Plan Administrator or due to the Plan Sponsor's or the Plan Administrator's error. Plan Sponsor acknowledges and agrees that BCBSNC will not be obligated to commence collection action to recover overpayments.

J. Nondiscrimination Testing. Upon Plan Sponsor's written request, BCBSNC will send a form to Plan Sponsor requesting necessary information to conduct nondiscrimination testing. BCBSNC will conduct the test based on information provided and will not be responsible for confirming the accuracy of any information provided by the Plan Sponsor. Plan Sponsor will compensate BCBSNC for nondiscrimination testing in accordance with BCBSNC's schedule of fees for this optional service. BCBSNC will conduct the tests based on its interpretations of the applicable rules, but Plan Sponsor is solely responsible for reviewing the results (and the methodology used by BCBSNC) with its own legal counsel.

K. Reports . BCBSNC will make available an electronic portal that will allow Plan Sponsor to generate reports of Benefit Plan activity. In addition, upon request of Plan Sponsor, BCBSNC will make available to Plan Sponsor information reasonably available to BCBSNC, which is reasonably necessary for Plan Sponsor to prepare reports for the Internal Revenue Service and Department of Labor, including without limitation Schedule C to Form 5500 Data.

L. Subcontracting. BCBSNC may subcontract any services provided under this Services Appendix at any time during the term of the Contract.

M. Status of BCBSNC. BCBSNC has disclosed to the best of its knowledge to Plan Sponsor in this Service Appendix, prior to execution, all services to be provided to the Health and/or Dependent Care FSA, the compensation or fees to be received by BCBSNC, and the manner of receipt of such compensation or fees. The Parties acknowledge and agree that (a) BCBSNC does not provide any services to the Health and/or Dependent Care FSA as a fiduciary either within the meaning of Section 3(21) of the Employee Retirement Income Security Act (ERISA) or under the Investment Advisors Act of 1940 and (b) BCBSNC does not expect to participate in or otherwise acquire a financial or other interest in any transaction to be entered into by the Health and/or Dependent Care FSA in connection with this Service Appendix.

III. PLAN SPONSOR RESPONSIBILITIES

A. Establishment and Operation of Health and/or Dependent Care FSA. Plan Sponsor has sole responsibility for establishment and operation of the Health and/or Dependent Care FSA. Plan Sponsor will have sole discretionary authority and responsibility for construing and interpreting the provisions of the Health and/or Dependent Care FSA and deciding all questions of fact arising under the Health and/or Dependent Care FSA. Plan Sponsor understands that it is Plan Sponsor's responsibility to pay any fee or penalty arising from the Health and/or Dependent Care FSA that is assessed by the Internal Revenue Service, the Department of Labor, and/or other federal or state governmental agencies.

B. Information to BCBSNC. Plan Sponsor will furnish the information determined by BCBSNC to be necessary to satisfy its responsibilities under this Services Appendix. Such information will be provided to BCBSNC in the time and in the manner agreed to by Plan Sponsor and BCBSNC. BCBSNC will assume that all such information provided to BCBSNC by Plan Sponsor or a designee of Plan Sponsor (e.g. another third party administrator) is complete and accurate and is under no duty to question the completeness or accuracy of such information. Plan Sponsor understands that

BCBSNC cannot accurately perform its duties under this Services Appendix without accurate and timely information and that BCBSNC will have no liability to Plan Sponsor or any Participant as a consequence of inaccurate and/or untimely information provided to BCBSNC by Plan Sponsor, a Participant or a third party who has provided information to BCBSNC at Plan Sponsor's request, such as a previous administrator of the Health and/or Dependent Care FSA.

C. Plan Documents and Forms. Plan Sponsor is responsible for providing access to and/or distributing all forms, summary plan descriptions, and other plan documents associated with the Health and/or Dependent Care FSA to Participants and any other individuals as required by law. In addition, the Plan Sponsor is responsible for ensuring that the content of such documents is accurate, complete, and compliant with applicable laws and regulations. If Plan Sponsor wants to make changes to the sample documents provided by BCBSNC in accordance with Section II(C) above, Plan Sponsor will provide advance notice to BCBSNC. If the changes would affect BCBSNC's administration of the Health and/or Dependent Care FSA, then Plan Sponsor must provide advance notice and obtain BCBSNC's written approval and notice of fee charges (if any) of such changes.

D. Notification of Enrollment and Eligibility. Plan Sponsor shall be responsible for determining the eligibility of individuals to be Participants under the Health and/or Dependent Care FSA and will make eligibility determinations and administer an eligibility appeals process in compliance with all applicable laws, including but not limited to Section 503 of ERISA, the Internal Revenue Code and applicable state law. Plan Sponsor is responsible for notifying BCBSNC of any changes in coverage under the Health and/or Dependent Care FSA administered by BCBSNC for the Plan Sponsor. Plan Sponsor shall provide BCBSNC with current information pertaining to Participant eligibility no later than 45 days prior to the Effective Date. In addition, Plan Sponsor shall provide BCBSNC with updates to eligibility records, including timely notification of Participants whose coverage has terminated and the date such coverage terminated, in an agreed upon format, weekly or more often as needed, along with other information as reasonably may be required by BCBSNC for the administration of the Health and/or Dependent Care FSA consistent with the terms of this Contract. BCBSNC shall effect such an eligibility change no later than 15 business days following the date BCBSNC received such information from Plan Sponsor. The Plan Sponsor may make corrective changes to membership; provided however, Plan Sponsor acknowledges and agrees that such changes may not be made effective retroactively more than 30 days prior to the date BCBSNC is notified of the change, and in no case the change may be effective before the beginning of the plan year. Benefit payments under a Health and/or Dependent Care FSA made by BCBSNC based on Participant eligibility data reflected in BCBSNC's records as of the time of such payments, though incurred after the date a Participant's coverage terminates after corrective action is directed by Plan Sponsor, shall be the liability of Plan Sponsor.

E. Availability of Funds. Plan Sponsor will make funds available for eligible healthcare purchases through a mutually agreed upon method and frequency. Plan Sponsor agrees to abide by BCBSNC policies and processes regarding the continued availability of these funds. Claim reimbursements will be held if sufficient funds are not payable to pay claims.

F. FDR Debit Card Terms. In the event that Plan Sponsor elects to have debit cards issued to Participants in connection with the Health FSA, the following terms and conditions shall apply:

1. Plan Sponsor acknowledges that any and all data or information necessary to provide the FDR Program will reside on servers owned by or operated on behalf of BCBSNC.

2. Plan Sponsor hereby grants to BCBSNC and its service providers the right to receive, process and perform all required services in accordance with information and data that is submitted to BCBSNC in order for BCBSNC to provide the FDR Program. Plan Sponsor further grants to BCBSNC and its service providers the right to derive and use aggregate and statistical data from such information and data.

3. "Minimum Balance" means the balance that Plan Sponsor will deposit and maintain in the deposit account and which will be an amount mutually agreed upon by the Parties in accordance with the selected funding method. This amount as may be modified by BCBSNC from time to time in accordance with this Contract.

4. At BCBSNC's election (in its sole discretion), Plan Sponsor will pre-fund a deposit account established by BCBSNC or its service provider ("Deposit Account") with the Minimum Balance. In the event that Card Transactions reduce the balance in the Deposit Account to an amount less than the Minimum Balance, BCBSNC will provide Plan Sponsor notice of such balance and Plan Sponsor will immediately deposit additional funds to the Deposit Account by electronic funds transfer, either wire or ACH, in an amount sufficient to restore the Deposit Account to the Minimum Balance. In the event sufficient funds are not deposited to restore the Deposit Account to the Minimum Balance within twenty-four (24) hours of such notice, BCBSNC may immediately shut down the Deposit Account and all associated FDR Cards until the Minimum Balance is restored. BCBSNC may increase the Minimum Balance at its discretion should the balance of the Deposit Account fall below the Minimum Balance.

5. Plan Sponsor hereby grants to BCBSNC and its service provider a non-exclusive, non-transferable, royalty-free license to use Plan Sponsor's trademarks in connection with the FDR Program, in the forms and formats approved by Plan Sponsor on FDR Cards and other communications as determined by BCBSNC, to Participants with respect to the Accounts. Plan Sponsor agrees that the designated information will be printed on FDR Cards if service is offered.

G. Financial Information. At BCBSNC's request, the Plan Sponsor shall provide BCBSNC with relevant financial information about the Plan Sponsor sufficient to permit BCBSNC to determine whether the Plan Sponsor can meet its financial obligations under this Services Appendix.

H. Other Responsibilities. Plan Sponsor is responsible for all other duties related to its Health and/or Dependent Care FSA not otherwise set forth in this Services Appendix.

IV. INDEMNIFICATION

A. Indemnification by BCBSNC. BCBSNC will indemnify and hold harmless the Plan Sponsor, its directors, officers, employees (acting in the course of their employment, but not as Participants) and agents for that portion of any and all loss, liability, damage, penalty, expense, settlement, cost or

obligation (including reasonable attorneys' fees) which was caused solely and directly by BCBSNC's willful misconduct, criminal conduct, gross negligence, fraud or breach of fiduciary responsibility.

B. Indemnification by Plan Sponsor. Plan Sponsor will indemnify and hold harmless BCBSNC, its affiliates and their respective directors, officers, employees, and agents for that portion of any and all loss, liability, damage, penalty, expense, settlement, cost or obligation (including reasonable attorneys' fees): (i) which was caused by Plan Sponsor's willful misconduct, criminal conduct, gross negligence, breach of the Contract, fraud, or breach of fiduciary responsibility, related to or arising out of this Services Appendix or by Plan Sponsor, or by any other fiduciary of the Health and/or Dependent Care FSA other than BCBSNC, if applicable; (ii) resulting from or arising out of claims, demands, judgments, actions or lawsuits brought against BCBSNC in connection with services provided under this Services Appendix except to the extent that the claim, demand, judgment, action or lawsuit is subject to indemnification by BCBSNC as defined in Subsection A above; (iii) resulting from taxes, assessments, penalties and/or regulatory charges (collectively, "Charges") incurred or paid by BCBSNC in its discretion relating to the Health and/or Dependent Care FSA; or (iv) any claim, legal action or proceeding regarding unclaimed or abandoned property, or laws relating thereto, or any escheat obligations, as related to the Health and/or Dependent Care FSA administered pursuant to this Services Appendix, including any penalties and interest payable with respect thereto.

C. Procedures Related to Indemnification. The Party seeking indemnification under Subsections A or B above must notify the indemnifying Party within thirty (30) days in writing of any actual or threatened action, suit or proceeding to which it claims such indemnification applies. Failure to so notify the indemnifying Party will not be deemed a waiver of the right to seek indemnification, unless the actions of the indemnifying Party have been materially prejudiced by the failure of the other Party to provide notice within the required time period.

The indemnifying Party may take steps to be joined as a party to any proceeding in which indemnification has been claimed, and the Party seeking indemnification will not oppose any such joinder. Whether or not such joinder takes place, the indemnifying Party will provide the defense with respect to claims to which this Article applies and in doing so will have the right to control the defense and settlement with respect to such claims to the extent that the defense and settlement relates to the payment of monetary compensation.

The Party seeking indemnification may assume responsibility for the direction of its own defense at any time, in whole or in part, including the right to settle or compromise any claim against it without the consent of the indemnifying Party, provided that in agreeing to settle or compromise a claim contrary to the written objection of the indemnifying Party, after notice to the indemnifying Party, the Party seeking indemnification will be deemed to have waived its right to indemnification to the extent that it has assumed responsibility, except in cases where the indemnifying Party has declined to defend against the claim.

V. TERM AND TERMINATION

A. Term and Termination of Services Appendix. This Services Appendix will continue in effect until terminated by either Party. Either party may terminate this Services Appendix for any reason

effective no earlier than 90 days after written notice is provided to the other party. This Services Appendix will automatically terminate on the earliest of the following dates:

Ninety days after the initial written notice of a material breach is given by the other Party that is not cured within 30 days after written notice to the breaching Party describing the breach.

Immediately in the event a court of competent jurisdiction determines that the other Party has committed fraud in its acts, omissions, transactions, duties, obligations, or responsibilities under this Services Appendix;

The last day of the last period that a Fee is due to BCBSNC under this Services Appendix was timely paid unless otherwise agreed to in writing by BCBSNC;

The date that the Health and/or Dependent Care FSA related services, which are provided under this Services Appendix, have been terminated;

The date a termination of the Contract is effective;

Except as provided in Subsection C below, termination of this Services Appendix will not terminate the rights or obligations of either Party arising prior to the effective date of such termination. The indemnification, confidentiality and privacy related provisions of this Services Appendix will survive its termination.

B. Reporting and Return of Funds Following Termination. Within sixty (60) days after the date of termination or last claim, whichever is later, BCBSNC will prepare, complete and deliver the final accounting records and will report, as of the date of termination, the financial status of the Health and/or Dependent Care FSA to the Plan Sponsor. At the time of the final accounting BCBSNC will deliver any funds of the Health and/or Dependent Care FSA in its possession or control to the Plan Sponsor or its designee.

C. Run-out. BCBSNC will not be obligated to process and/or pay claims it receives after the date of termination, notwithstanding that such claims may have been incurred prior to termination of this Services Appendix, unless BCBSNC has otherwise expressly agreed in writing to provide run-out services under this Services Appendix. Claims run-out administrative services as mutually agreed to by BCBSNC and Plan Sponsor may be performed for an additional fee.

VI. GENERAL PROVISIONS

A. Audits. Plan Sponsor may perform no more than one audit of the records specifically related to performance of the parties under this Services Appendix each year, with at least 60 days prior written notice to BCBSNC. Audits must be performed during normal working hours. An agent of Plan Sponsor may perform audits provided such agent signs an acceptable confidentiality agreement. Each party agrees to provide reasonable assistance and information to the auditors. Plan Sponsor acknowledges and agrees that if it requests an audit, it will reimburse BCBSNC for BCBSNC's

reasonable expenses, including copying and labor costs, in assisting Plan Sponsor to perform the audit.

B. Use and Disclosure of Confidential Participant Information. The Parties' duties and responsibilities with respect to the protected health information of Participants are set forth in the attached Business Associate Addendum ("Exhibit A"). Plan Sponsor will indemnify and hold harmless BCBSNC for any loss, liability, damage, expense, settlement, cost or obligation (including reasonable attorneys' fees) in connection with the release or transfer of personal health information by BCBSNC to Plan Sponsor or a third party designated by Plan Sponsor, or the use or further disclosure of such information by Plan Sponsor or such third party.

C. Assignment. BCBSNC may assign this Agreement without Plan Sponsor's consent. Plan Sponsor may not assign its rights or obligations under this Agreement without prior written consent from BCBSNC.

D. Confidentiality. Each Party acknowledges that performance of the Agreement may involve access to and disclosure of data, rates, procedures, materials, lists, systems, and other information (collectively "Confidential Information") belonging to the other. The Parties further acknowledge and agree that BCBSNC operates in a highly regulated and competitive environment and that the unauthorized disclosure or use of Confidential Information will cause irreparable harm and significant injury to BCBSNC which will be difficult to measure with certainty or to compensate through monetary damage. Accordingly, the Parties agree that injunctive or other equitable relief will be appropriate in the event of any breach by Plan Sponsor of any part or parts of the Agreement, in addition to such other remedies as may be available to BCBSNC by law. No Confidential Information will be disclosed to any third party other than representatives of such party who have a need to know such Confidential Information, provided that such representatives are informed of the confidentiality provisions hereof and agree to abide by them. All such Confidential Information must be maintained in strict confidence. In addition, each Party will maintain the confidentiality of Member information as required by law. Upon termination of the Agreement, each Party upon the request of the other, will return or destroy all copies of all the other's Confidential Information in its possession or control except to the extent that such Information must be retained pursuant to applicable law, provided however that BCBSNC may retain copies of any such Confidential Information it deems necessary for the defense of litigation concerning the services it provided under the Agreement. Plan Sponsor agrees that BCBSNC may make lawful references to Plan Sponsor in its marketing activities and in informing health care providers as to the organizations and plans for which services are to be provided. Each Party will execute and cause its employees and agents to execute any documents the other reasonably requires in connection with this confidentiality provision.

E. Proprietary Rights. Each Party reserves the right to control the use of symbols, trademarks, computer programs and/or service marks owned or licensed by such Party either currently existing or hereafter established. The Parties agree that they will not use such computer programs, work, symbols, trademarks, service marks and/or other devices of the other in advertising, promotional materials or otherwise, and will not advertise or display such devices without the prior written consent of the other Party. In addition, the Parties further agree that any such signs, displays, literature, computer programs, or other material furnished by one Party to the other will remain the property of the Party furnishing the material and will be returned upon demand upon the termination of this Agreement.

F. Force Majeure. Neither Party will be responsible for the failure to fulfill its obligations under this Agreement to the extent that a natural disaster, war, act of terrorism, riot, civil insurrection, epidemic, complete or partial destruction of facilities, atomic explosion or other release of nuclear energy, disability of any third party that has entered into a contract to provide services to BCBSNC or Members pursuant to this Agreement or similar events, not within the control of the Parties results in the facilities, personnel, or financial resources of BCBSNC not being available to provide or arrange for services or benefits under this Agreement, each Party's obligation to provide such services or benefits will be limited to the requirements that the Party make a good faith effort to provide or arrange for the provision of such services or benefits within the resulting limitations on the availability of its facilities, personnel, or resources.

G. Entire Agreement. This Agreement, including the exhibits hereto, supersedes any and all other agreements, either oral or in writing, between the Parties with respect to the subject matter hereof, and contains all of the covenants and agreements between the Parties with respect to such matters.

H. Applicable Law. This Agreement is made and entered into in North Carolina. It will be governed by and construed in accordance with federal law, and to the extent not preempted, by the laws of the State of North Carolina.

I. Waiver of Breach. Waiver of a breach of any provision of this Agreement will not be deemed a waiver of any other breach of the same or a different provision.

J. Severability. In the event any portion of this Agreement is rendered invalid or unenforceable, the remainder of the provisions of this Agreement will remain in full force and effect.

K. Headings. The headings of articles and sections contained in this Agreement are for reference purposes only and will not affect in any way the meaning or interpretation of this Agreement.

L. Notices. Any notice required to be given pursuant to the terms and provisions hereof will be in writing and will be effective upon hand-delivery, electronic notice as described below, or upon deposit with the United States Postal Service by first-class mail or by certified mail, return receipt requested. Mailed notices will be addressed to the parties at the address of record, or as given below. Certain notices may be provided electronically. Acceptable electronic means of notice are electronic mail (e-mail) and/or confirmed facsimile (fax). Termination notices may not be provided electronically.

To: Blue Cross and Blue Shield of North Carolina
Post Office Box 2291
Durham, North Carolina 27702
Attention: Senior Vice President, Sales and Marketing

To: Plan Sponsor
130 S Queen St
Kinston NC 28501-4941
Attention: JOEY BRYAN

M. Scope of Undertaking. BCBSNC is an entity independent from Plan Sponsor. Nothing in this Agreement will be construed or be deemed to create a relationship of joint venturers, principal and agent (except as specifically provided in this Agreement), or of employer and employee between them. BCBSNC's only obligation under this Agreement is to the Plan Sponsor and nothing under this Agreement will be deemed to confer any responsibility on BCBSNC to any Member. Plan Sponsor acknowledges that BCBSNC is not an accounting or law firm and no services provided by BCBSNC in accordance with this Agreement will be construed as tax or legal advice as a result of providing such services.

N. Third Party Beneficiaries. Nothing express or implied in this Agreement is intended to confer, nor will anything herein confer, upon any person other than Plan Sponsor, BCBSNC and their respective successors or assigns, any rights, remedies or obligations whatsoever.

O. Blue Cross Association. The Parties expressly acknowledge that this Agreement constitutes a contract solely among the Plan Sponsor and BCBSNC, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the "Association") permitting BCBSNC to use the Blue Cross and/or Blue Shield Service Marks in the State of North Carolina, and that BCBSNC is not contracting as an agent of the Association. Plan Sponsor further acknowledge and agree that they have not entered into this Agreement based upon representations by any other person other than BCBSNC and that no person, entity or organization other than BCBSNC will be held accountable or liable to the Employer for any of BCBSNC's obligations to the Plan Sponsor created under this Agreement. This paragraph will not create any additional obligations whatsoever on the part of BCBSNC other than those obligations created under other provisions of this Agreement. The Plan Sponsor acknowledge that BCBSNC provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims liability.

P. Counterparts. This Agreement may be executed in two or more counterparts each of which will be deemed an original, and all of which taken together will constitute one and the same instrument.

EXHIBIT A

BUSINESS ASSOCIATE ADDENDUM

This Business Associate Addendum ("Addendum") is effective as of July 1, 2018 and amends and is made part of the Flexible Spending Arrangement Services Appendix ("Service Appendix") made by and between the Plan Sponsor, on behalf of the Group Health Plan ("Covered Entity"), and Blue Cross and Blue Shield of North Carolina ("Business Associate" or "BCBSNC"), an independent licensee of the Blue Cross and Blue Shield Association. (Collectively, Covered Entity and BCBSNC are referred to as the "Parties.") The effective date of this Addendum ("Effective Date") is the effective date of the Service Appendix.

In the performance of services pursuant to the Service Appendix, and in order for BCBSNC to receive, create, Use or Disclose certain information in connection with its provision of the services under the Service Appendix, some of which may constitute Protected Health Information ("PHI"), as that term is defined by the Health Insurance Portability and Accountability Act of 1996 and its implementing Administrative Simplification regulations (45 Code of Federal Regulations (C.F.R.) Parts 160 and 164) ("HIPAA"), BCBSNC is a Business Associate of the Covered Entity. Accordingly, the Parties mutually agree to execute this BAA to comply with the requirements of HIPAA and its implementing privacy and security regulations at 45 C.F.R. Parts 160-164 ("HIPAA Privacy Rule" and "HIPAA Security Rule"), and the requirements of the Health Information Technology for Economic and Clinical Health Act, as incorporated in the American Recovery and Reinvestment Act of 2009 (the "HITECH Act"), that are applicable to a business associate, along with any guidance and/or regulations issued thereunder by the Secretary of the U.S. Department of Health and Human Services ("Secretary").

A. Definitions. Capitalized terms which are not defined in this BAA shall have the meaning set forth in HIPAA or the HITECH Act, or any accompanying regulations, as amended from time to time.

B Privacy of Protected Health Information.

1. Permitted Uses and Disclosures. Business Associate agrees to Use or Disclose PHI that it creates or receives for or from Covered Entity only as follows:

   a. Functions and Activities on Covered Entity's Behalf. Business Associate is permitted to Use and Disclose PHI it creates or receives for or from Covered Entity or on behalf of Covered Entity, to perform the functions described under the Service Appendix.

   b. Business Associate's Operations - Use of PHI. Business Associate is permitted by this BAA to Use PHI it creates or receives for or from Covered Entity, or on behalf of Covered Entity, if such Use is necessary for Business Associate's proper management and administration, or is necessary to carry out Business Associate's legal responsibilities.

   c. Business Associate's Operations - Disclosure of PHI. Business Associate is permitted by this BAA to Disclose PHI it creates or receives for or from Covered Entity if such Disclosure is necessary for Business Associate's proper management and administration, or is necessary to carry out Business Associate's legal responsibilities only if the following conditions are met:

      i) The Disclosure is Required by Law; or

ii) Business Associate obtains reasonable assurances from any person or organization to which Business Associate will Disclose such PHI that the person or organization will hold such PHI as confidential, and will only Use or further Disclose such PHI as Required by Law, or for the purpose for which the Business Associate Disclosed such PHI to the person or organization. The person or organization shall promptly notify the Business Associate (who shall in turn promptly notify Covered Entity) of any instance of which the person or organization becomes aware in which the confidentiality of such PHI has been Breached.

d. Data Aggregation Services. In its reasonable discretion, Business Associate is permitted to use PHI to perform Data Aggregation services relating to the Health Care Operations of the Covered Entity, subject to any limitations imposed by this BAA or the Service Appendix.

e. Minimum Necessary Standard and Limited Data Set. In performing the functions and activities on Covered Entity's behalf, Business Associate's Use, Disclosure or request of PHI shall utilize a Limited Data Set, if practicable. Otherwise, Business Associate agrees to Use, Disclose or request only the Minimum Necessary PHI to accomplish the purpose of the Use, Disclosure or request.

C. Information Safeguards.

1. General.

Business Associate will implement, maintain and use appropriate Administrative, Technical and Physical Safeguards to preserve the integrity and confidentiality of and to prevent non-permitted Use or Disclosure of PHI created or received for or from Covered Entity.

2. Safeguards for Securing Electronic Protected Health Information.

Business Associate agrees to:

i. Implement Administrative, Technical, and Physical Safeguards ("Safeguards") consistent with (and as required by) the Security Standards and by the HITECH Act, that reasonably and appropriately protect the Confidentiality, Integrity and Availability of the Electronic Protected Health Information ("ePHI") that Business Associate creates, receives, maintains or transmits on behalf of Covered Entity;

ii. Require its agents and subcontractors to which Business Associate Discloses ePHI created or received by Business Associate on behalf of Covered Entity, to implement reasonable and appropriate Safeguards to protect the ePHI;

iii. Promptly report to Covered Entity any unauthorized Use or Disclosure of PHI or any Security Incident of which Business Associate becomes aware that results in the successful non-permitted access, Use, Disclosure, modification, or destruction of Covered Entity's ePHI, or that interferes with Business Associate's information systems. Additionally, Business Associate agrees to

mitigate, to the extent practicable, any harmful effect that is known to it resulting from a Use or Disclosure of PHI by Business Associate that is in violation of the requirements of this BAA;

iv. Develop and implement policies and procedures and meet the Security Rule documentation requirements as required by the HITECH Act.

v. Agree to the termination of this BAA and the Service Appendix in accordance with Section H.2 if Covered Entity determines that Business Associate has violated a material term of this BAA.

D. Sub-Contractors and Agents. Business Associate will require any of its subcontractors and agents to which Business Associate is permitted by this BAA (or is otherwise given Covered Entity's prior written approval) to Disclose any of the PHI Business Associate creates or receives for or from Covered Entity, to implement reasonable and appropriate safeguards to protect such PHI and to provide reasonable assurances that subcontractor or agent will comply with the same restrictions and conditions that apply to the Business Associate under the terms and conditions of this BAA with respect to such PHI.

E. Compliance with Standard Transactions.

1. If Business Associate conducts in whole or part Standard Transactions for or on behalf of Covered Entity, Business Associate will comply, and will require any subcontractor or agent involved with the conduct of such Standard Transactions to comply, with each applicable requirement of 45 C.F.R. Part 162. Business Associate will not enter into, or permit its subcontractors or agents to enter into any trading partner agreement in connection with the conduct of Standard Transactions for or on behalf of Covered Entity that:

   a. Changes the definition, data condition, or use of a data element or segment in a Standard Transaction;

   b. Adds any data element or segment to the maximum defined data set;

   c. Uses any code or data element that is marked "not used" in the Standard Transaction's implementation specification or is not in the Standard Transaction's implementation specification; or

   d. Changes the meaning or intent of the Standard Transaction's implementation specification.

5. Specific Communications. The Parties recognize and agree that communications between the Parties that are required to meet the Standards for Electronic Transactions will meet the Standards set by that Regulation. Communications between Plan Sponsor and BCBSNC, or between Plan Sponsor and the Group Health Plan, do not need to comply with the Standards for Electronic Transactions. Accordingly, unless agreed otherwise by the Parties in writing, all communications (if any) for purposes of "enrollment" as that term is defined in 45 C.F.R. Part 162, Subpart O and "Health Plan Premium Payment Data," as that term is defined in 45 C.F.R. Part 162, Subpart Q, shall be conducted between Plan Sponsor and either BCBSNC or the Group Health Plan. For all such communications

(and any other communications between Plan Sponsor and BCBSNC, Plan Sponsor shall use such forms, tape formats or electronic formats as BCBSNC may approve. The Plan Sponsor will include all information reasonably required by BCBSNC to effect such data exchanges or notifications.

6. Communications Between BCBSNC and the Group Health Plan. All communications between BCBSNC and the Group Health Plan that are required to meet the Standards for Electronic Transactions shall do so. For any other communications between BCBSNC and the Group Health Plan, the Group Health Plan shall use such forms, tape formats or electronic formats as BCBSNC may approve. The Group Health Plan will include all information reasonably required by BCBSNC to effect such data exchanges or notifications.

F. Protected Health Information Access, Amendment and Disclosure Accounting.

1. Access. So that the Covered Entity may meet its obligations as required by 45 C.F.R. § 164.524, and where applicable the HITECH Act, upon request of the Covered Entity, an Individual or an Individual's Personal Representative, Business Associate will provide timely access to the Individual's PHI maintained in a Designated Record Set. Business Associate shall make such information available in an electronic format where directed by Covered Entity. All fees related to this access, as determined by Business Associate, shall be borne by the Individual seeking access to PHI. Business Associate's provision of access to the PHI will not relieve the Covered Entity of any additional and independent obligations to provide access where requested by an Individual.

2. Amendment. So that Covered Entity may meet its amendment obligations under 45 C.F.R. §164.526, upon the reasonable request of the Covered Entity, an Individual or an Individual's Personal Representative, Business Associate will timely amend, or permit an Individual or the Individual's Personal Representative to amend, the PHI maintained in Business Associate's Designated Record Set which Business Associate created or received for or from Covered Entity. Business Associate's amendment will not relieve the Covered Entity of any additional and independent obligations to amend PHI where requested by an Individual.

3. Restrictions on the Use or Disclosure of PHI and Confidential Communications. So that the Covered Entity may meet its obligations to evaluate an Individual's request for restrictions on the Use or Disclosure of PHI and comply with an Individual's reasonable request to receive communications by an alternative means or at an alternative location, as set forth under 45 C.F.R. §164.522, Business Associate agrees to receive and evaluate such requests wherever feasible and to the extent that such communications are within the control of Business Associate. Such evaluation by Business Associate will not relieve the Covered Entity of any additional and independent obligations to evaluate restrictions or implement confidential communications where requested by an Individual.

4. Disclosure Accounting.

   a. Disclosure Accounting. Business Associate will make available to Covered Entity or to an Individual, or the Individual's Personal Representative, the information required to provide an accounting of disclosures in accordance with 45 C.F.R. §164.528 ("Disclosure Information"). Business Associate further shall provide any additional information to the extent required by the HITECH Act and any accompanying regulations. Such provision of accounting of Disclosure Information will not relieve the Covered Entity of any additional and independent obligations to provide disclosure accounting where requested by an Individual.

b. Disclosure Tracking Time Periods. Unless otherwise provided under the HITECH Act, Business Associate shall have available the Disclosure Information required for the 6 years preceding the Individual's request for the disclosure information (except Business Associate need have no Disclosure Information for disclosures occurring before the effective date of the Service Appendix).

c. Direct Disclosure. In addition, where Business Associate is contacted directly by an Individual or an Individual's Personal Representative, and where so required by the HITECH Act and/or any accompanying regulations, Business Associate shall make such Disclosure Information available directly to the Individual or to the Individual's Personal Representative.

G. Inspection of Books and Records. Business Associate will make its internal practices, books, and records, relating to its Use and Disclosure of the PHI it creates or receives for or from Covered Entity, available to the Secretary to determine Covered Entity's compliance with 45 C.F.R. Parts 160-164.

H. Breach of Privacy or Security Obligations.

1. Reporting. Within a reasonable period of time after discovery, and in no event later than 60 days, Business Associate will report to Covered Entity any (i) acquisition, Access, Use or Disclosure of PHI that is neither permitted by this BAA nor given prior written approval by Covered Entity; and (ii) any Breach of Unsecured PHI, as defined under the HITECH Act. Business Associate will perform a risk assessment to determine whether the Breach compromises the security or privacy of the Unsecured PHI. Business Associate's report will contain the information necessary to comply with the applicable requirements of the HITECH Act.

2. Termination of BAA and Service Appendix.

a. Right to Terminate for Breach. Either party may terminate this BAA and the Service Appendix if it reasonably determines that the other party ("Breaching Party") has engaged in a pattern of activity or practice that violates any material provision of this BAA and the Breaching Party fails to cure the breach within sixty (60) days ("Cure Period") after receipt of notice. The non-breaching party may exercise the right to terminate this BAA and the Service Appendix by providing the Breaching Party written notice of termination after the Cure Period ("Written Notice") and stating the failure to cure the breach of this BAA that provides the basis for the termination. Any such termination will be effective upon ninety (90) days from Written Notice.

b. Obligations Upon Termination.

i. Return or Destruction. Upon termination, cancellation, expiration or other conclusion of this BAA and the Service Appendix, Business Associate will, if feasible, return to Covered Entity or destroy all PHI and, in whatever form or medium (including in any electronic medium under Business Associate's custody or control), that Business Associate created or received for or from Covered Entity, including all copies of and any data or compilations derived from and allowing identification of any individual who is a subject of the PHI. Business Associate will complete such return or destruction as promptly as possible after the effective date of the termination, cancellation, expiration or other conclusion of this BAA or Service Appendix. Business Associate will identify any PHI that Business Associate created or received for or from Covered Entity that cannot feasibly be returned to Covered Entity or

destroyed, and will limit its further Use or Disclosure of that PHI to those purposes that make return or destruction of that PHI infeasible. Upon reasonable request by the Covered Entity, Business Associate will deliver to Covered Entity the identification of the PHI for which return or destruction is infeasible and, for that PHI, will attest that it will only Use or Disclose such PHI for those purposes that make return or destruction infeasible. Covered Entity will reimburse Business Associate's reasonable costs incurred in returning or destroying the PHI.

ii. Continuing Privacy and Security Obligations. Business Associate's obligation to protect the privacy of the PHI and the security of the ePHI that Business Associate created or received for or from Covered Entity will be continuous and survive termination, cancellation, expiration or other conclusion of this BAA and the Service Appendix.

I. General Provisions.

1. Amendment. Upon the effective date of any final regulation or amendment to final regulations promulgated by the Secretary with respect to PHI, including, but not limited to the HIPAA Privacy and Security Regulations, this BAA will automatically amend such that the obligations they impose on Covered Entity and Business Associate remain in compliance with such regulations, unless Business Associate elects to terminate this BAA and the Service Appendix by providing notice of termination at least thirty (30) days before the effective date of such final regulation or amendment to final regulations; or (2) Business Associate notifies the Covered Entity of its objections to any such amendment. In the event of such an objection, Covered Entity and Business Associate will negotiate in good faith in connection with such changes or amendment to the relevant final regulation.

2. Rights of Third Parties. This BAA is between Covered Entity, Plan Sponsor and Business Associate and shall not be construed, interpreted, or deemed to confer any rights whatsoever to any third party or parties.

3. Indemnification. The Parties agree that if the Service Appendix provides for indemnification under specified terms and conditions, then such indemnification shall extend to the same terms and conditions with reference to the duties and obligations set forth in this BAA.

4. More Restrictive Confidentiality Terms. The Parties agree that if any provisions of the Service Appendix that relate to the Use or Disclosure of PHI are more restrictive than the provisions of this BAA, meaning that the terms provide greater privacy protections for the PHI at issue, then the provisions of the more restrictive document shall control. The Parties further agree that if any of the terms and conditions set forth in this BAA are more restrictive than the provisions of the Service Appendix, then the provisions of this BAA shall control.

5. Governing Law. This BAA shall be governed by the laws of the State of North Carolina, without regard to the North Carolina conflict of laws provisions, and the Parties hereto each specifically consent to jurisdiction in the appropriate state and federal courts within the State of North Carolina.

6. Notices. All notices and notifications under this BAA shall be sent in accordance with the notices provision in the Service Appendix.

7. Expenses. Unless otherwise stated in this BAA or the Service Appendix, each party shall bear its own costs and expenses related to compliance with the above provisions. Any additional expenses incurred by BCBSNC in connection with services to be provided pursuant to this BAA shall be included in the Service Appendix.

IMPORTANT NOTICE FOR PLAN SPONSORS WHO HAVE DECLINED HEALTHEQUITY SERVICES:

The following two sections do not apply to this contract if the Plan Sponsor has declined the services of BCBSNC's preferred HSA administrator, HealthEquity. If the Plan Sponsor has declined these services then please disregard the following sections, "HealthEquity Terms of Services for Employers", "Statement of Work"; and contact your chosen HSA administrator for information about their terms and conditions.

Version April 25, 2014
HSA-T&C-WEB-001

HEALTHEQUITY TERMS OF SERVICES FOR EMPLOYERS

The Terms and Conditions contained in here is between you (the "Employer") and HealthEquity (also may be referred to as we) as the service provider. By using HealthEquity services, you agree to these terms and conditions. This document is intended as a contractual agreement under the E-SIGN Act and UETA and is binding on both parties.

HEALTH SAVINGS ACCOUNTS

1. HealthEquity administers health savings account (HSA) in accordance to our understanding of the rules contained in the Section 223 of Internal Revenue Code (26 USC 223) and other documents issued by the government. None of our services, and none of our communication to you or your employees, should be considered legal or tax advice. You and your employees should consult professional advisors on these matters. We do not administer HSA that are subject to the Employee Retirement Income Security Act of 1974 (ERISA).

2. There is no specific term of this agreement. Services shall be provided only if the appropriate fees are paid. Please refer to the fee schedule on your employer welcome site referenced in the employer welcome communication. Each party may terminate the services with 60-days' notice.

3. Our Services are described in the Statement of Work (SOW) that immediately follows these Terms of Services. Your duties are also listed there. If we change the SOW, we will notify you.

4. Unless specified in the SOW, you agree that all communication between us will be electronic, and no physical mail will be used.

5. If you are responsible to pay HealthEquity monthly administrative fees, fees are due 30 days from invoice. HealthEquity may assess interest on outstanding fee payments not received within a 15 day grace period after the invoice due date. Outstanding fees shall bear interest at the rate equal to the lesser of (i) one and one-half percent per month or (ii) the maximum interest rate permitted by applicable law from the invoice due date until the date when such unpaid fees are paid in full. We may also terminate services if the outstanding fees have not been paid for two billing cycles.

6. If you, or you delegate (such as payroll or health plans) is sending us data, you agree that the data provided to us is complete, accurate, and timely. You agree to hold us harmless and indemnify us against any claims and costs for any erroneous data that you or your delegate sent us, including but not limited to any card reissuance fees, costs of making corrective distributions, costs of reissuing government forms (e.g., Form 1099-SA or 5498-SA).

7. Except for damages incurred arising out of or due to gross negligence or willful misconduct, the aggregate liability of HealthEquity be limited to the fees you paid. IN NO EVENT SHALL HEALTHEQUITY BE LIABLE FOR SPECIAL, INCIDENTAL, INDIRECT, CONSEQUENTIAL, OR SIMILAR DAMAGES EVEN IF YOU HAVE BEEN ADVISED OF THE POSSIBILITY OF SUCH DAMAGES. EXCEPT AS SPECIFIED HEREIN, THERE ARE NO EXPRESSED OR IMPLIED WARRANTIES.

8. Miscellaneous.

   If any provision of this Agreement is held invalid or otherwise unenforceable, the enforceability of the remaining provisions shall not be impaired.

   The failure to exercise any right in this Agreement shall not be deemed to be a waiver of that right.

   This document and any exhibits contains the entire understanding of the parties. It may not be modified or amended by you unilaterally, for example, by your purchase orders, payment advice, or wiring/ACH instructions.

   This Agreement is governed by and shall be construed in accordance with the laws of the State of Utah without giving effect to principles regarding conflict of laws.

STATEMENT OF WORK
EXHIBIT 2A—HSA SERVICES

HealthEquity shall perform the following:

A. Enrollment

1. Upon receipt of timely, accurate and complete eligibility – either online from Company or via electronic file from partner health plan, HealthEquity shall:

   a. enroll the individuals as members in the HealthEquity system,
   b. verify the identity of the eligible employee to comply with "know your customer" requirements under the USA Patriot Act, and
   c. once verified, mail by USPS the welcome kit, which contains the debit card, custodial agreement, fee and interest rate schedule, cardholder agreement, privacy policy and informational trifold.

B. Contributions

HealthEquity shall:

1. Accept electronic contributions files from Company via secure transmission mechanism (e.g., PPD/ direct deposit, or allocated by employee listing (or file upload) to HealthEquity employer portal). Company shall send contribution dollars electronically (EFT or ACH) on the date they wish funds to be posted to employee accounts. Payments made via check will be processed within two business days of receipt and made available after another two business days .

2. Allow members to directly contribute to their HSA by personal check or electronic funds transfer drawn on a US-based bank account.

C. Individual Account Management/Members Services

1. HealthEquity shall host a member accessible website to help members manage their HSA online where they can, among other activities:

   a. access their account balance, distribution history, and transaction activities;
   b. review, enter and pay claims;
   c. update their email preferences; and
   d. download account servicing (e.g., distribution request) forms.

   The website shall be made available 24/7 except for routine maintenance. Members must have a computing device that is capable of using secure HTTP (HTTPS) to use the members-only area of the website.

2. HealthEquity shall make available to members a 24/7 toll-free number (in the US) to access HealthEquity Member Services Specialists.

3. HealthEquity shall make available monthly statements to members to view and download from the website. There shall be a small charge to members for paper statements (refer to fee schedule).

4. HealthEquity shall make available for download the requisite IRS forms (1099-SA, 5498-SA) for download from the website. Member will be issued paper IRS forms mailed for no additional charge unless they have elected to only receive them electronically.

D. Investments

HealthEquity shall provide members the ability to invest HSA funds directly on the website under the following conditions:

1. a member's HSA balance exceeds the threshold set for the product offered
2. the member has provided a verified email address, and
3. the member has reviewed the terms and conditions, and the risks relating to investing, and agreed to the terms and conditions on the website.

E. Distribution and Use of Account Funds

1. HealthEquity shall mail to members debit cards to access HSA funds at merchants offering medical-related (including pharmacy, dental, and vision) products and services. Whether the debit card would be accepted at any particular merchant depends on the merchant's coding under the debit card processing system.
2. HealthEquity shall make available a directed payment mechanism on the website whereby members can direct their funds to be paid to one or more service providers.
3. Members may request distribution of their funds by either making a request via their online portal or completing a distribution request form. Members shall receive distribution via electronic means at no cost to the members. Members who request paper checks will be charged a small fee per check.

F. Member Education

HealthEquity shall make information available to help members save and spend their account balances. This may include Company specific educational programs and e-mail based messaging (based on having email address).

G. Reports to Company

HealthEquity shall provide real time reporting options for enrolled employees, contributions and past payments via the employer portal real time reporting options via their employer portal related to enrolled employees, contributions and payments.

H. Company Duties

Company shall:

1. Designate at least one employee as the primary contact who has familiarity with the Company's HSA offering.
2. Ensure that all eligibility and contribution data provided to HealthEquity are timely, accurate, complete, and free of errors. Company shall pay HealthEquity for any costs due to any inaccurate, incomplete or erroneous data. For example, if Company enrolled individuals who are not eligible to participate in an HSA, Company shall pay HealthEquity for time and materials to make corrective distributions (if legally permitted); notifications to affected individuals; corrective reporting to the government agencies; debit card cancellation fees; and the monthly fees for such individuals are (a) still payable if not already paid, or (b) if paid, are not refundable or creditable against future invoices.

Benefit Booklet
For Employees of
Lenoir County Government
for

Blue OPTIONS HSA℠

An Independent Licensee of the Blue Cross and Blue Shield Association

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.

Attest:

President

Secretary

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

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GETTING STARTED WITH BLUE OPTIONS HSA

IMPORTANT INFORMATION REGARDING THIS HEALTH BENEFIT PLAN:

In accordance with applicable federal law, BCBSNC 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, BCBSNC 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 booklet, keep in mind that any word you see in small caps is a defined term and appears in the "Glossary" at the end of the benefit booklet. The terms "we," "us," and "BCBSNC" 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 bcbsnc.com for the PRIOR REVIEW list, which is updated each quarter (January, April, July and October) with new service codes or service codes that are no longer effective. You can also call BCBSNC **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?"

More Information upon Request

You may receive, upon request, information about Blue Options HSA, 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 BCBSNC medical and reimbursement policies, which are updated throughout the plan year. These policies lay out the procedure and criteria to determine whether a procedure, treatment, facility, equipment, drug or device is MEDICALLY NECESSARY and eligible for coverage, INVESTIGATIONAL or EXPERIMENTAL, COSMETIC, a convenience item, or requires PRIOR REVIEW and CERTIFICATION by BCBSNC. The most up-to-date medical and reimbursement policies are available at **bcbsnc.com**, or call BCBSNC 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 BCBSNC criteria.

Common Insurance Terms

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

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 BCBSNC 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 BCBSNC 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 BCBSNC 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, please refer to "Summary of Benefits" for your benefits.

Please note: The Blue Options HSA plan is intended to be a high deductible health plan ("HDHP") that qualifies its MEMBERS to contribute to a Health Savings Account (HSA), unless its MEMBERS are otherwise ineligible under applicable federal requirements. Please consult a qualified tax advisor if you are unsure about whether or not you are ineligible. In addition, the deductible and OUT-OF-POCKET LIMIT amounts listed in the "Summary of Benefits" may be revised each year in accordance with Internal Revenue Service (IRS) rulings.

Using Informational Graphics

Graphic symbols are used throughout this benefit booklet to call your attention to certain information and requirements.

Definitions
This symbol calls attention to definitions of important terms throughout this benefit booklet. Additional terms are in the "Glossary" at the end of this benefit booklet. If you are unsure of the meaning of a term, please check "Glossary."

Cross-Reference
Throughout this benefit booklet, cross-references direct you to read other sections of the benefit booklet when necessary.

Call for PRIOR REVIEW and CERTIFICATION Required
This symbol calls attention to medical/surgical and mental health and substance abuse services which require PRIOR REVIEW and CERTIFICATION in order to avoid a full denial of benefits.

Limitations and Exclusions
Each subsection in "COVERED SERVICES" describes not only what is covered, but may also list some limitations and exclusions that specifically relate to a particular type of service. Limitations and exclusions that apply to all services are listed in "What Is Not Covered?"

Toll-Free Phone Numbers, Website and Addresses

BCBSNC **Website: bcbsnc.com**	Find IN-NETWORK PROVIDERS (includes pharmacies), and get information about top-performing facilities, PRESCRIPTION DRUG information, and news about BCBSNC.
Blue Connect Website: **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.
BCBSNC 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	You may visit our website or call BCBSNC 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.bcbsnc.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 BCBSNC. Up to date information about which services may need PRIOR REVIEW can be found online at BlueConnectNC.com.
Magellan Behavioral Health: 1-800-359-2422	BCBSNC delegates the administration of mental health and substance abuse benefits by contract to Magellan Behavioral Health, which is not associated with BCBSNC. See "Delegated UTILIZATION MANAGEMENT" for more information.
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 **bcbs.com**.
HealthLine Blue℠: 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.
MDLIVE **Telemedicine:** 1-888-910-9722 or MDLIVE.BCBSNC.COM	For access to a DOCTOR regarding nonemergency medical issues, call or visit the website to ask for a consultation. DOCTORS will be able to diagnose and suggest a treatment that's appropriate.

Toll-Free Phone Numbers, Website and Addresses (*cont.*)

Condition Care: 1-800-260-0091	Talk to a Condition Care Coach for information about programs and support for handling specific health conditions, such as asthma, diabetes, heart failure, coronary artery disease and COPD. 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.
Healthy Outcomes Customer Service: 1-877-719-9004	Talk with a representative to get help with any technical issues with the website as well as questions about the Healthy Outcomes program. Please talk to your GROUP ADMINISTRATOR to see if this program is available to you.
Medical Claims Filing: BCBSNC 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 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. BCBSNC does not accept claims or reimburse for these goods or services, and MEMBERS are responsible for paying all bills. BCBSNC 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 BCBSNC 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
- 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.bcbsnc.com/blue365**

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

SUMMARY OF BENEFITS

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

- Coinsurance percentages shown in this section are the 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
- If applicable, multiple OFFICE VISITS or emergency room visits on the same day may result in multiple copayments
- Benefits may differ depending on where the service is performed and if the service is received with any other service or associated with a surgical procedure.
- If your benefit level for services includes deductible or coinsurance, your PROVIDER may collect an estimated amount of these at the time you receive services.
- If a MEMBER uses Health Savings Account (HSA) funds to pay their PROVIDER and the PROVIDER refunds money to the MEMBER as a result of an overestimation of the MEMBER'S deductible or coinsurance, the MEMBER must return this money to the HSA in order to avoid any tax impacts.

Please Note: The list of IN-NETWORK PROVIDERS may change from time to time, so please verify that the PROVIDER is still in the Blue Options HSA network before receiving care. Find a PROVIDER on our website at **bcbsnc.com** or call BCBSNC 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 - July 1, 2018 through June 30, 2019

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.		
Aggregate Deductible		
EMPLOYEE, per BENEFIT PERIOD	$2,000	$4,000
Family Member, per BENEFIT PERIOD	$4,000	$8,000
Family, per BENEFIT PERIOD	$4,000	$8,000
You have an aggregate deductible which means the deductible corresponds to the type of coverage you have chosen. The EMPLOYEE deductible applies if you selected EMPLOYEE-only coverage; otherwise the family deductible applies. All covered family MEMBERS contribute to the same family deductible, however any individual family MEMBER who reaches his or her Family MEMBER deductible will have the benefit level apply to them only, and not the entire family. The Family deductible must be met before the benefit level is payable for all family MEMBERS, regardless of whether each individual family MEMBER'S deductible has been met. IN-NETWORK services are credited to your IN-NETWORK deductible and OUT-OF-NETWORK services are credited to your OUT-OF-NETWORK deductible.		
Aggregate TOTAL OUT-OF-POCKET LIMIT		
EMPLOYEE, per BENEFIT PERIOD	$2,000	$5,250
Family Member, per BENEFIT PERIOD	$4,000	$9,250
Family, per BENEFIT PERIOD	$4,000	$11,750
You have an aggregate TOTAL OUT-OF-POCKET LIMIT which means your TOTAL OUT-OF-POCKET LIMIT is determined by your type of coverage. The EMPLOYEE TOTAL OUT-OF-POCKET LIMIT applies if you selected EMPLOYEE-only coverage; otherwise, the family TOTAL OUT-OF-POCKET LIMIT applies. All covered family MEMBERS contribute to the same family TOTAL OUT-OF-pocket LIMIT, however any individual family MEMBER who reaches his or her Family MEMBER TOTAL OUT-OF-POCKET LIMIT will have the benefit level apply to them only, and not the entire family. The Family TOTAL OUT-OF-POCKET LIMIT must be met before the benefit level is payable for all family MEMBERS, regardless of whether each individual family MEMBER'S TOTAL OUT-OF-pocket LIMIT has been met. 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.		
INFERTILITY PRESCRIPTION DRUGS	Quantity limits apply, see **https://www.bcbsnc.com/content/services/formulary/rxnotes.htm**; 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)	

Benefits	IN-NETWORK	OUT-OF-NETWORK
INFERTILITY Services (in any place of service)	Three ovulation induction cycles, with or without insemination	
Orthotic Devices for POSITIONAL PLAGIOCEPHALY	One device	
Vein Treatment	Endovenous procedures—one procedure per limb Sclerotherapy vein treatment—three procedures per limb	
Benefit Maximums per MEMBER Maximums are per BENEFIT PERIOD and combined IN- and OUT-OF-NETWORK, unless noted otherwise. Any services in excess of these benefit maximums are not COVERED SERVICES.		
ADAPTIVE BEHAVIOR TREATMENT	Limited to $40,000 for MEMBERS up to age 19	
Dialysis Treatment	Three hemodialysis treatments per week, more hemodialysis treatments are available if MEDICALLY NECESSARY	
Evaluation and Treatment of Obesity	Four OFFICE VISITS	
Hearing Aids	When covered, one hearing aid per hearing-impaired ear every 36 months for MEMBERS under age 22.	
REHABILITATIVE and HABILITATIVE THERAPIES (applies to home, office and outpatient setting)	30 for physical/occupational therapy, including chiropractic services	
	30 for speech therapy	
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 BCBSNC. Also see "PREVENTIVE CARE" in "COVERED SERVICES."		
Federally-mandated PREVENTIVE CARE Services	No Charge	30% after deductible
Available in an office-based, outpatient, 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.bcbsnc.com/preventive** or call BCBSNC Customer Service at the number in "Who To Contact?" Routine eye exams are covered IN-NETWORK and OUT-OF-NETWORK as non-mandated PREVENTIVE CARE. This is a non-essential health benefit.		
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.		

Benefits	IN-NETWORK	OUT-OF-NETWORK
PROVIDER'S Office		
OFFICE VISIT Services		
PRIMARY CARE PROVIDER	0% after deductible	30% after deductible
SPECIALIST	0% after deductible	
Telemedicine	0% after deductible	30% after deductible
Includes: all OFFICE VISITS for medical, mental health, substance abuse, INFERTILITY, therapy services, pre-natal/post-delivery care (not included in the global maternity delivery fee), office SURGERY, x-rays, diagnostic imaging, and lab tests.		
URGENT CARE Centers, Emergency Room, and Ambulance		
URGENT CARE Centers	0% after deductible	0% after deductible
Emergency Room Visit	0% after deductible	0% after deductible
Ambulance Services	0% after deductible	0% after deductible
AMBULATORY SURGICAL CENTER		
Ambulatory Surgical Services	0% after deductible	30% after deductible
Outpatient		
Outpatient Services	0% after deductible	30% after deductible
Includes physician services, HOSPITAL and HOSPITAL-based services, HOSPITAL-based or OUTPATIENT CLINIC services, outpatient diagnostic services, and therapy services, including REHABILITATIVE and HABILITATIVE THERAPIES, and OTHER THERAPIES including dialysis. 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	0% after deductible	30% after deductible
Includes physician services, HOSPITAL and HOSPITAL-based services, including, but not limited to medical, mental health, substance abuse, INFERTILITY, therapies, 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		

Benefits	IN-NETWORK	OUT-OF-NETWORK
	0% after deductible	30% after deductible
Other Services		
Home Health care, HOSPICE services, private duty nursing	0% after deductible	30% after deductible
DURABLE MEDICAL EQUIPMENT, MEDICAL SUPPLIES, orthotic devices, PROSTHETIC APPLIANCES	0% after deductible	30% after deductible
CT Scans, MRIs, MRAs and PET scans in any location, including a physician's office	0% after deductible	30% after deductible
CERTIFICATION Requirements		
Certain services, regardless of the location, require PRIOR REVIEW and CERTIFICATION by BCBSNC 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 BCBSNC. BCBSNC delegates PRIOR REVIEW and CERTIFICATION for particular benefits to other companies not associated with BCBSNC. Please see https://www.bcbsnc.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.bcbsnc.com/content/services/medical-policy/index.htm. BCBSNC delegates administration of your mental health and substance abuse benefits to Magellan Behavioral Health. Magellan Behavioral Health is not associated with BCBSNC. **Failure to request PRIOR REVIEW and receive CERTIFICATION will result in a full denial of benefits. See "COVERED SERVICES" and "PRIOR REVIEW (Pre-Service)" in "UTILIZATION MANAGEMENT" for additional information.** To request PRIOR REVIEW, please see the numbers in "Who to Contact?"		
PRESCRIPTION DRUGS		
PRESCRIPTION DRUGS	0% after deductible	0% after deductible
Designated Preventive PRESCRIPTION DRUGS	0%	0%
Diabetic Supplies **Spacers and Peak Flow Meters**	0% after deductible	0% after deductible
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 is not considered preventive if it is being prescribed to treat an existing symptomatic illness, injury, or condition. You may visit our website at **bcbsnc.com** or call BCBSNC 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. Limits apply to INFERTILITY drugs, see "PRESCRIPTION DRUG Benefits" for a detailed description. Also see Enhanced 4 Tier C FORMULARY at http://www.bcbsnc.com/enhanced4tierC.		
Preventive over-the-counter medications and PRESCRIPTION contraceptive drugs and devices as listed at www.bcbsnc.com/preventive*	No Charge	No Charge**

Benefits	IN-NETWORK	OUT-OF-NETWORK
* Please visit the BCBSNC website at **www.bcbsnc.com/preventive** or call BCBSNC Customer Service for guidelines on which preventive over-the-counter medications are covered and individuals who may qualify, as well as more information and any limitations that apply for contraceptives. PRESCRIPTION contraceptive drugs and devices that are not covered at the PREVENTIVE CARE benefit level will be covered according to your regular PRESCRIPTION DRUG benefits. Also see "PREVENTIVE CARE" in "COVERED SERVICES." ** No Charge indicates no obligation for MEMBERS to pay any portion of the ALLOWED AMOUNT. For OUT-OF-NETWORK benefits, you may be required to pay for charges over the ALLOWED AMOUNT, the difference between the ALLOWED AMOUNT and the billed charge.		

HOW BLUE OPTIONS HSA WORKS

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

Table of Contents:

Key Words:

- ALLOWED AMOUNT vs. Billed Amount
- PRIOR REVIEW
- PRIMARY CARE PROVIDER
- SPECIALIST

As a MEMBER of the Blue Options HSA 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 HSA 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 BCBSNC as eligible. For a list of eligible PROVIDERS, please visit our website at **bcbsnc.com** or call BCBSNC 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 BCBSNC, or a PROVIDER participating in the BlueCard® program. ANCILLARY PROVIDERS outside North Carolina are considered IN-NETWORK only if they contract directly with the Blue Cross or Blue Shield plan in the state where services are received, even if they participate in the BlueCard® program. See “Glossary” for a description of ANCILLARY PROVIDERS and the criteria for determining where services are received. The list of IN-NETWORK PROVIDERS may change from time to time. IN-NETWORK PROVIDERS are listed on our website at **bcbsnc.com**, or call BCBSNC Customer Service at the number listed in "Who to Contact?"	OUT-OF-NETWORK PROVIDERS are not designated as a Blue Options HSA PROVIDER by BCBSNC. Also see "OUT-OF-NETWORK Benefit Exceptions."
ALLOWED AMOUNT vs. Billed Amount	If the billed amount for COVERED SERVICES is greater than the ALLOWED AMOUNT, you are not responsible for the difference. You only pay any applicable copayment, deductible, coinsurance, and 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, URGENT CARE and Ambulance Services” for additional information.

	IN-NETWORK	OUT-OF-NETWORK
Referrals	BCBSNC does not require you to obtain any referrals.	
After-hours Care	If you need nonemergency services after your PROVIDER'S office has closed, please call your PROVIDER'S office for their recorded instructions.	
Care Outside of North Carolina	Your ID CARD gives you access to participating PROVIDERS outside the state of North Carolina through the BlueCard® Program, and benefits are provided at the IN-NETWORK benefit level.	If you are in an area that has participating PROVIDERS and you choose a PROVIDER outside the network, you will receive the lower OUT-OF-NETWORK benefit. Also see "OUT-OF-NETWORK Benefit Exceptions."
PRIOR REVIEW	IN-NETWORK PROVIDERS in North Carolina are responsible for requesting PRIOR REVIEW when necessary. IN-NETWORK PROVIDERS outside of North Carolina, except for Veterans' Affairs (VA) and military PROVIDERS, are responsible for requesting PRIOR REVIEW for inpatient FACILITY SERVICES. For all other COVERED SERVICES received outside of North Carolina, **you** are responsible for ensuring that you or your PROVIDER requests PRIOR REVIEW by BCBSNC 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 abuse services and all other medical services. PRIOR REVIEW is not required for an EMERGENCY or for an inpatient HOSPITAL stay for 48 hours after a vaginal delivery or 96 hours after a Cesarean section.	OUT-OF-NETWORK PROVIDERS are not obligated by contract to request PRIOR REVIEW by BCBSNC. **You are responsible for ensuring that you or your OUT-OF-NETWORK PROVIDER requests PRIOR REVIEW by** BCBSNC. Failure to request PRIOR REVIEW and obtain CERTIFICATION will result in a full denial of benefits. However, PRIOR REVIEW is not required for an EMERGENCY or for an inpatient HOSPITAL stay for 48 hours after a vaginal delivery or 96 hours after a Cesarean section.
Filing Claims	IN-NETWORK PROVIDERS in North Carolina are responsible for filing claims directly with BCBSNC. However, you will have to file a claim if you do not show your ID CARD when you obtain a PRESCRIPTION from an IN-NETWORK pharmacy, or the IN-NETWORK pharmacy's records do not show as eligible for coverage. In order to recover the full cost of the PRESCRIPTION minus any applicable copayment or coinsurance you owe, return to the IN-NETWORK pharmacy within 14 days of receiving your PRESCRIPTION so that it can be reprocessed with your correct eligibility information and the pharmacy will	You may have to pay the OUT-OF-NETWORK PROVIDER in full and submit your own claim to BCBSNC. Mail claims in time to be received within 18 months of the date the service was provided. Claims not received within 18 months from the service date will not be covered, except in the absence of legal capacity of the MEMBER.

	IN-NETWORK	OUT-OF-NETWORK
	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.	

OUT-OF-NETWORK Benefit Exceptions

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

For more information, see one of the following sections: "EMERGENCY, URGENT Care and Ambulance Services" in "COVERED SERVICES" or "Continuity of Care" in "UTILIZATION MANAGEMENT." For information about BCBSNC's access to care standards, see our website at **bcbsnc.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 BCBSNC before receiving care from an OUT-OF-NETWORK PROVIDER.

Carry Your ID CARD

Your ID CARD identifies you as a Blue Options HSA 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 **BlueConnectNC.com** or call BCBSNC Customer Service at the number listed in "Who to Contact?"

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

BCBSNC does not require that you designate a PCP to manage your health care. However, it is important for you to maintain a relationship with a PCP, who will help you manage your health and make decisions about your health care needs. If you change PCPs, be sure to have your medical records transferred, especially immunization records, to provide your new DOCTOR with your medical history. You should participate actively in all decisions related to your health care and discuss all treatment options with your health care PROVIDER regardless of cost or benefit coverage. PCPs are trained to deal with a broad range of health care issues and can help you 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 **bcbsnc.com** and click on Find a Doctor or call BCBSNC 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 BCBSNC, a SPECIALIST treating a MEMBER for a serious or chronic disabling or life-threatening condition can act as the MEMBER'S PCP. The selected SPECIALIST would be responsible for providing and coordinating the MEMBER'S primary and specialty care. The selection of a SPECIALIST under these circumstances shall be made under a treatment plan approved by the SPECIALIST and BCBSNC, with notice to the PCP if applicable. A request may be denied where it is determined that the SPECIALIST cannot appropriately coordinate the MEMBER'S primary and specialty care.

To make this request or if you would like the professional qualifications of your PCP or IN-NETWORK SPECIALIST, you may call BCBSNC Customer Service at the number listed in "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 HSA 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, URGENT CARE, and Ambulance Services - HOSPITAL and Other Facility Care - Alternatives to HOSPITAL Stays - Family Planning - Specific Therapies and Tests - Other Services - Surgical Benefits - Mental Health/Substance Abuse Services - PRESCRIPTION DRUG Benefits	- OFFICE VISIT - Outpatient Clinic - PREVENTIVE CARE - IN-NETWORK - OUT-OF-NETWORK - REHABILITATIVE/HABILITATIVE THERAPIES - 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
- telemedicine services which include evaluation, management and consultation services for nonemergency medical issues with a PROVIDER via an interactive audio/video telecommunications system. See MDLIVE in "Who to Contact?" to access a DOCTOR who can diagnose and recommend treatment. Telemedicine services from MDLIVE will be subject to your PCP copayment and/or coinsurance and any applicable deductible. You can also check with your PROVIDER to see if telemedicine services are available; your benefit will depend on the type of PROVIDER supplying these services.

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 BCBSNC Customer Service at the number listed in "Who to Contact?" for this information.

PREVENTIVE CARE

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

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

Federally-Mandated PREVENTIVE CARE Services

Under federal law, you can receive certain covered PREVENTIVE CARE services from an IN-NETWORK PROVIDER in an office-based, outpatient, or ambulatory surgical setting, or URGENT CARE center at no cost to you. Please log on to our website at **www.bcbsnc.com/preventive** or call BCBSNC Customer Service at the number in "Who to Contact?" for the most up-to-date information on PREVENTIVE CARE that is covered under federal law, including general preventive services and screenings, immunizations, well-baby/well-child care, women's preventive care, nutritional counseling

visits, and certain over-the-counter medications. These 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; 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, BCBSNC 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 if the criteria mentioned above are met. Visit **www.bcbsnc.com/preventive** or call BCBSNC 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 procedure, such as a Vitamin D serum test.	The Vitamin D test will not be covered as a 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.

State-Mandated PREVENTIVE CARE Services:

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

The PROVIDER search on our website at **bcbsnc.com** can help you find office-based PROVIDERS or you can call BCBSNC 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.

Non-Mandated PREVENTIVE CARE Services

Routine Eye Exams

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

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

PREVENTIVE CARE Exclusions

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

The health benefit plan provides benefits for EMERGENCY SERVICES.

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

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

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

What to Do in an EMERGENCY

In an EMERGENCY, you should seek care immediately from an emergency room or other similar facility. If necessary and available, call 911 or use other community EMERGENCY resources to obtain assistance in handling life-threatening EMERGENCIES. If you are unsure if your condition is an EMERGENCY, you can call HealthLine Blue and a HealthLine Blue nurse will provide information and support that may save you an unnecessary trip to the emergency room.

Benefits for services in the emergency room

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

URGENT CARE

The 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. If you are not sure if your condition requires URGENT CARE, you can call HealthLine Blue.

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.

The health benefit plan covers services in an air ambulance only when: (i) ground transportation is not medically appropriate due to the severity of the illness or the pick-up point is inaccessible by land, and (ii) traveling from the site of an EMERGENCY to a HOSPITAL when such a facility is the closest one that can provide COVERED SERVICES appropriate to your condition.

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

Ambulance Service Exclusions

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

HOSPITAL (Inpatient) and Other Facility Care

Benefits are provided for:

- Inpatient services received in a HOSPITAL or NONHOSPITAL FACILITY. You are considered an inpatient if you are admitted to the HOSPITAL or NONHOSPITAL FACILITY as a registered bed patient for whom a room and board charge is made. Your IN-NETWORK PROVIDER is required to use the PPO network HOSPITAL where he/she practices, unless that HOSPITAL cannot provide the services you need. If you are admitted before the EFFECTIVE DATE, benefits will not be available for services received prior to the EFFECTIVE DATE. 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 BCBSNC for inpatient admissions, except for maternity deliveries and EMERGENCIES. See "Maternity Care," if applicable, and "EMERGENCY, URGENT CARE 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, BCBSNC 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 SKILLED NURSING FACILITY.

  PRIOR REVIEW must be requested and CERTIFICATION must be obtained in advance from BCBSNC or services will not be covered. However, CERTIFICATION is not required for MEMBERS who have Medicare as their primary coverage and who are admitted to a Medicare-certified SKILLED NURSING FACILITY.

Alternatives to HOSPITAL Stays (home health care, HOSPICE, private duty nursing)

Home Health Care

Home health care services are covered when ordered by your DOCTOR for a MEMBER who is HOMEBOUND due to illness or injury, 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 and HABILITATIVE THERAPIES. Usually, a HOME HEALTH AGENCY coordinates the services your DOCTOR orders for you. Services from a HOME HEALTH aide may be eligible for coverage only when the care provided supports a skilled service being delivered in the home.

Home health 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.

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 care management. Private duty nursing provides more individual and continuous skilled care than can be provided in a skilled nursing visit through a HOME HEALTH AGENCY.

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

See "Care Management."

Family Planning

Maternity Care

Maternity care benefits, including prenatal care, admission to labor and delivery, management of labor including fetal monitoring, delivery and uncomplicated post-delivery care until six weeks postpartum, are available to all female MEMBERS and are covered. Together these make up the global maternity delivery fee. See the chart below for additional information. However, maternity benefits for DEPENDENT CHILDREN cover only treatment for COMPLICATIONS OF PREGNANCY. Also visit **www.bcbsnc.com/preventive** for the most up-to-date federally-mandated PREVENTIVE CARE services, including those available for DEPENDENT CHILDREN. 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 benefits.
Labor & delivery services	No PRIOR REVIEW required for inpatient HOSPITAL stay for 48 hours after a vaginal delivery or 96 hours after a cesarean section. Mothers choosing a shorter stay are eligible for a home health visit for post-delivery follow-up care if received within 72 hours of discharge.	No PRIOR REVIEW required for inpatient well baby care for 48 hours after a vaginal delivery or 96 hours after a cesarean section. Benefits include newborn hearing screening ordered by a DOCTOR to determine the presence of permanent hearing loss. (Please see	Deductible and coinsurance apply. If adding the baby changes your policy from EMPLOYEE to family

		PREVENTIVE CARE in "Summary of Benefits.")	coverage, the family BENEFIT PERIOD deductible applies.
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.	

For information on CERTIFICATION, contact BCBSNC Customer Service at the number listed in "Who to Contact?".

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 and reversal of sterilization includes female tubal occlusion and male vasectomy. Reversal of sterilization is available for all MEMBERS. Certain sterilization procedures for female MEMBERS are covered under your PREVENTIVE CARE benefit. See **www.bcbsnc.com/preventive** or call BCBSNC 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.bcbsnc.com/preventive** or call BCBSNC 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 (GIFT) and associated services
- Oocyte and sperm donation
- Cryopreservation of oocytes, sperm, or embryos
- Surrogate mothers
- Care or treatment of the following:
  - maternity for DEPENDENT CHILDREN, except as specifically covered by this health benefit plan
  - elective termination of pregnancy (abortion) for DEPENDENT CHILDREN
  - elective termination of pregnancy (abortion), except within the first 16 weeks of pregnancy for female SUBSCRIBERS and enrolled spouses of the SUBSCRIBERS when the life of the mother 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

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 an RN or LPN.

PRIOR REVIEW and CERTIFICATION are required for certain home infusion therapy services or services will not be covered.

REHABILITATIVE and HABILITATIVE THERAPIES

The following therapies are covered:

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

ADAPTIVE BEHAVIOR TREATMENT

This benefit is a non-essential health benefit. Benefits are provided for ADAPTIVE BEHAVIOR TREATMENT for MEMBERS up to age 19 and are subject to a combined IN- and OUT-OF-NETWORK maximum of $40,000 per BENEFIT PERIOD per MEMBER. Charges for ADAPTIVE BEHAVIOR TREATMENT from an inpatient or outpatient facility do not apply to the dollar limit. Coverage includes assessments and treatment, which must be MEDICALLY NECESSARY, and ordered by a licensed physician or licensed psychologist. ADAPTIVE BEHAVIOR TREATMENT must be provided or supervised by the following professionals who are 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 professional counselor
- Licensed marriage and family therapist

PRIOR REVIEW must be requested and CERTIFICATION must be obtained in advance for ADAPTIVE BEHAVIOR TREATMENT or services will not be covered. Call Magellan Behavioral Health at the number listed in "Who to Contact?" Visit our website at **bcbsnc.com** or call BCBSNC Customer Service at the number listed in "Who to Contact?" for a list of PROVIDERS.

OTHER COVERED THERAPIES

- Cardiac rehabilitation therapy
- Pulmonary and respiratory therapy
- Dialysis treatment (three hemodialysis treatments per week, more treatments are available if MEDICALLY NECESSARY)
- Radiation therapy
- Chemotherapy, including intravenous chemotherapy.

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. BCBSNC may delegate UTILIZATION MANAGEMENT of sleep studies to another company not associated with BCBSNC. 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 BCBSNC.

Diagnostic Services Exclusions

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

Other Services

Autism Spectrum Disorder Services

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 (see "Tests and Specific Therapies" for additional information)
- Pharmacy care
- Psychiatric care
- Psychological care

- Therapeutic care (services provided by the following licensed professionals: speech therapist, occupational therapist, physical therapist, clinical social worker, professional counselor or marriage and family therapist)

Autism Spectrum Disorder Exclusion

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

Blood

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 **bcbsnc.com**.

Clinical Trials

This health benefit plan provides benefits for participation in clinical trials phases I, II, III, and IV. Coverage is provided only for MEDICALLY NECESSARY costs of health care services associated with the trials, 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 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
- Be conducted in a setting and by personnel of high expertise based on training, experience and patient volume.

Clinical Trials Exclusions

- 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 the 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

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 these services will not be covered, unless treatment is for an EMERGENCY.

If TMJ is caused by malocclusion, benefits are provided for surgical correction of malocclusion when surgical management of the TMJ is MEDICALLY NECESSARY. Please have your PROVIDER contact BCBSNC 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 BCBSNC. BCBSNC 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
- Repair or replacement of equipment due to abuse or desire for new equipment.

Hearing Aids

The 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 for each MEMBER under the age of 22. Benefits are also provided for the evaluation, fitting, and adjustments of hearing aids or replacement of hearing aids, and for supplies, including ear molds.

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.

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.

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 gender confirmation 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
- surgical treatment for morbid obesity (bariatric surgery) if you have received 12 months for medical management of this condition prior to the surgical procedure, supervised by your DOCTOR or OTHER PROFESSIONAL PROVIDER.
- endovenous procedures used to support the normal functions of your veins, and sclerotherapy vein treatment

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 BCBSNC's reimbursement policies, which are on our website at **bcbsnc.com,** or call BCBSNC 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. BCBSNC provides care management for transplant services and will help you find a HOSPITAL or Blue Distinction Centers for Transplants that provides the transplant services required. Travel and lodging expenses and charges related to a search for a donor may be reimbursed based on BCBSNC guidelines that are available upon request from a transplant coordinator.

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

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

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

Some transplant services are INVESTIGATIONAL and 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 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
- complex and rare cancers
- knee or hip replacement
- transplants
- spine surgery

Visit **https://www.bcbs.com/blue-distinction-center-finder** to find a Blue Distinction Center near you.

Mental Health and Substance Abuse Services

This health benefit plan provides benefits for the treatment of MENTAL ILLNESS and substance abuse by a HOSPITAL, RESIDENTIAL TREATMENT FACILITY, DOCTOR or OTHER PROVIDER and includes, but is not limited to:

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

How to Access Mental Health and Substance Abuse Services

Your coverage for inpatient and certain outpatient services is coordinated through Magellan Behavioral Health. PRIOR REVIEW by Magellan Behavioral Health is not required for any OFFICE VISIT services or in EMERGENCY situations; however, in EMERGENCY situations, please notify Magellan Behavioral Health of inpatient admission as soon as reasonably possible.

PRIOR REVIEW and CERTIFICATION are required for inpatient (including RESIDENTIAL TREATMENT FACILITY services) or certain outpatient services, such as partial hospitalization and intensive therapy or services will not be covered. To request PRIOR REVIEW, call a Magellan Behavioral Health customer service representative at the number listed in "Who to Contact?" The Magellan Behavioral Health customer service representative can help you find an appropriate IN-NETWORK PROVIDER and give you information about PRIOR REVIEW and CERTIFICATION requirements.

Mental Health and Substance Abuse Services Exclusion

- Counseling with relatives about a patient.

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 BCBSNC Customer Service for the most up-to-date list.
- PRESCRIPTION DRUGS related to treatment of SEXUAL DYSFUNCTION
- PRESCRIPTION DRUGS approved by the U.S. Food and Drug Administration (FDA) for short-term and long-term use in the treatment of clinical obesity
- 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 or URGENT CARE condition and went to an OUT-OF-NETWORK pharmacy, we recommend that you call BCBSNC 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 an open FORMULARY or list of PRESCRIPTION DRUGS, divided into categories or tiers. BCBSNC determines the tier placement of PRESCRIPTION DRUGS in the FORMULARY, and this determines the amount you pay. Tier placement of PRESCRIPTION DRUGS in the FORMULARY may be determined by the effectiveness and safety of the drug, the cost of the drug, and/or the classification of the drug by the U.S. Food and Drug Administration (FDA) or nationally-recognized drug databases (e.g., Medispan). The 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 is not considered preventive if it is being prescribed to treat an existing symptomatic illness, injury, or condition. You may visit BCBSNC's website at **bcbsnc.com** or call BCBSNC 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.” Certain combinations of compound drugs may require PRIOR REVIEW and CERTIFICATION. 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 **bcbsnc.com** for a listing of retail

Situation	Value
	pharmacies or mail-order service that can dispense an extended supply of your PRESCRIPTION. You cannot refill a PRESCRIPTION until: • three-fourths of the time period has passed that the 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.
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. 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.
PRIOR REVIEW Requirements	PRIOR REVIEW and CERTIFICATION by BCBSNC are required for some PRESCRIPTION DRUGS or services will not be covered. BCBSNC may change the list of these PRESCRIPTION DRUGS from time to time.
SPECIALTY DRUGS	BCBSNC 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 **bcbsnc.com**.

Situation	Value
RESTRICTED-ACCESS DRUGS and Devices	Coverage will be provided for a RESTRICTED-ACCESS DRUG or device to a MEMBER without requiring PRIOR REVIEW or CERTIFICATION or use of a nonrestricted FORMULARY drug if a MEMBER'S physician certifies in writing that the MEMBER has previously used an alternative nonrestricted-access drug or device and the alternative drug or device has been detrimental to the MEMBER'S health or has been ineffective in treating the same condition and, in the opinion of the prescribing physician, is likely to be detrimental to the MEMBER'S health or ineffective in treating the condition again.
Quantity Limitations	BCBSNC covers certain PRESCRIPTION DRUGS up to a set quantity based on criteria developed by BCBSNC to encourage the appropriate use of the drug. For these PRESCRIPTION DRUGS, PRIOR REVIEW and CERTIFICATION are required before excess quantities of these drugs will be covered. When excess quantities are approved, you may be required to pay an additional copayment, if applicable.
Benefit Limitations	Certain PRESCRIPTION DRUGS are subject to benefit limitations which may include: the amount dispensed per PRESCRIPTION, per day, or per defined time period; the amount dispensed per lifetime; per month's supply; or the amount dispensed per single copayment, if applicable. Note: excess quantities are not covered.

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
- 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.

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

A

Acupuncture and acupressure

Administrative charges billed by a PROVIDER, including charges for failure to keep a scheduled visit, completion of claim forms, obtaining medical records, late payments, and telephone charges

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 BCBSNC within 18 months of the date the charge was INCURRED, except in the absence of legal capacity of the MEMBER

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

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

COSMETIC services, which include the removal of excess skin from the abdomen, arms or thighs, skin tag excisions, cryotherapy or chemical exfoliation for active acne and acne scarring, superficial dermabrasion, injection of dermal fillers, services for hair transplants, skin tone enhancements, electrolysis, 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 BCBSNC 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 emergency or disaster
- A PRESCRIPTION DRUG that is any portion or refill which exceeds 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.

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
- 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 or COSMETIC

G

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

H

Routine **hearing** examinations and **hearing aids,** including implantable bone-anchored hearing aids (BAHA), or examinations for the fitting of hearing aids for MEMBERS over the age of 22

Home health care, care provided in the home, including, but not limited to: homemaker services, such as cooking, housekeeping, and food or meal preparation; 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

Services that would not be necessary if a **noncovered service** had not been received, except for EMERGENCY SERVICES in the case of an EMERGENCY. This includes any services, procedures or supplies associated with COSMETIC services, INVESTIGATIONAL services, services deemed not MEDICALLY NECESSARY, or elective termination of pregnancy if not specifically covered by this health benefit plan.

O

The following obesity services:

- Any cost associated with membership in weight management program or health club
- Any treatment or regimen, medical or surgical, for the purpose of reducing or controlling the weight of a MEMBER or for treatment of **obesity**, except for surgical treatment of morbid obesity, 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 BCBSNC 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 abuse 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.

SEXUAL DYSFUNCTION unrelated to organic disease

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

T

The following types of **Temporomandibular Joint (TMJ) Services**:
- Treatment for periodontal disease
- Dental implants or root canals
- Crowns and bridges
- Orthodontic braces
- Occlusal (bite) adjustments
- Extractions

The following types of **therapy**:
- Music therapy, recreational or activity therapy, and all types of animal therapy. Remedial reading and all forms of special education and supplies or equipment used similarly, except as specifically covered by this health benefit plan
- Massage therapy
- Cognitive therapy
- Group classes for pulmonary rehabilitation.

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

V

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

- Lenses for keratoconus or any other eye procedure except as specifically covered 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.bcbsnc.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 or your spouse'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 handicapped 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 handicap must be medically certified by the child's DOCTOR and may be verified annually by BCBSNC.

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 order such as a Qualified Medical Child Support Order (QMCSO) are not restricted to the annual enrollment period.

See also "Adding or Removing a DEPENDENT."

You may also apply for coverage and/or add DEPENDENTS within a 30-day period following any of the triggering/ qualifying events (hereafter referred to as “triggering events”) listed below unless otherwise noted. Coverage is effective no later than the first day of the first month following a completed request for enrollment. The following are considered triggering events:

- You or your DEPENDENTS become eligible for coverage under this health benefit plan
- You get married or obtain a DEPENDENT through birth, court 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 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 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 BCBSNC 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 BCBSNC; 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-spouse coverage - This health benefit plan covers you and your spouse
- 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
- Family coverage - This health benefit plan covers you, your spouse and your DEPENDENT CHILDREN.

Reporting Changes

Have you moved, added or changed other health coverage, changed your name or phone number? If so, contact your GROUP ADMINISTRATOR and fill out the proper form. It will help us give you better service if BCBSNC 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.

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 triggering events:

- Divorce
- Ineligibility of a DEPENDENT CHILD.

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

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

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

If you are covered by 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 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, BCBSNC 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. BCBSNC 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 BCBSNC 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

BCBSNC 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 BCBSNC Customer Service while you are still covered under this health benefit plan and up to 24 months following your termination. You may call BCBSNC Customer Service at 1-877-258-3334 (toll-free), Monday through Friday except holidays or visit our website at **mybcbsnc.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 BCBSNC
- A MEMBER exhibits disruptive, abusive, or fraudulent behavior toward an IN-NETWORK PROVIDER.

As an alternative to termination as stated above, BCBSNC, 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 BCBSNC 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 BCBSNC deducts the amount for any claims paid.

- A MEMBER has been convicted of (or a restraining order has been issued for) communicating threats of harm to BCBSNC personnel or property
- A MEMBER permits the use of his or her or any other MEMBER'S ID CARD by any other person not enrolled under this 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/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, BCBSNC has a UTILIZATION MANAGEMENT (UM) program. The UM program requires certain health care services to be reviewed and approved by BCBSNC in order to receive benefits. As part of this process, BCBSNC looks at whether health care services are MEDICALLY NECESSARY, given in the proper setting and for a reasonable length of time. BCBSNC 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 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 BCBSNC'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 BCBSNC 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.

BCBSNC's Responsibilities

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

PRIOR REVIEW (Pre-Service)

Certain services require PRIOR REVIEW as noted in "COVERED SERVICES." These types of reviews are called pre-service reviews. If PRIOR REVIEW is required by BCBSNC, 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 BCBSNC's website at **mybcbsnc.com** or call BCBSNC Customer Service at the number listed in "Who to Contact?"

If you fail to follow the procedures for filing a request, BCBSNC 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.

BCBSNC will make a decision on your request for CERTIFICATION within a reasonable amount of time taking into account the medical circumstances. The decision will be made and communicated to you and your PROVIDER within three business days after BCBSNC receives all necessary information. However, it will be no later than 15 calendar days from the date BCBSNC received the request. BCBSNC may extend this period one time for up to 15 days if additional information is required and BCBSNC 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 BCBSNC expects to make a decision. You will have 45 days to provide the requested information. As soon as BCBSNC receives all the requested information, or at the end of the 45 days, whichever is earlier, BCBSNC will make a decision within three business days. BCBSNC will 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. BCBSNC 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 BCBSNC needs more information to process your urgent review, BCBSNC 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. BCBSNC 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 BCBSNC Customer Service at the number given in "Who to Contact?"

Concurrent Reviews

BCBSNC 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, BCBSNC 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 BCBSNC receives the request. Written confirmation of the decision will also be sent to your home by U.S. mail. For concurrent reviews, BCBSNC 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 BCBSNC needs more information to process your urgent concurrent review, BCBSNC 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. BCBSNC will make a decision within 72 hours after receipt of the request.

Retrospective Reviews (Post-Service)

BCBSNC also reviews the coverage of health care services after you receive them (retrospective/post-service reviews). Retrospective review may include a review to see if services received in an EMERGENCY setting qualify as an EMERGENCY. BCBSNC 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 BCBSNC received the request.

In the event of an ADVERSE BENEFIT DETERMINATION, BCBSNC will let you and your PROVIDER know in writing within a reasonable time but no later than 30 calendar days from the date BCBSNC received the request. All decisions will be based on MEDICAL NECESSITY and whether the service received was a benefit under this health benefit plan. If more information is needed, before the end of the initial 30-day period, BCBSNC will let you know of the information needed. You will then have 90 days to provide the requested information.

As soon as BCBSNC gets the requested information, or at the end of the 90 days, whichever is earlier, BCBSNC will make a decision within 15 calendar days. Services that were approved in advance by BCBSNC will not be subject to denial for MEDICAL NECESSITY once the claim is received, unless the CERTIFICATION was based on a material misrepresentation about your health condition or you were not eligible for these services under 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 BCBSNC to work together to meet the individual's health needs and promote quality outcomes.

To accomplish this, MEMBERS enrolled in or eligible for care management programs may be contacted by BCBSNC or by a representative of BCBSNC. BCBSNC 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 contacting an IN-NETWORK PCP or IN-NETWORK SPECIALIST or by calling BCBSNCCustomer Service.

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 BCBSNC 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 PPO 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, BCBSNC will notify you in writing 30 days before the PROVIDER'S termination, as long as BCBSNC 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 BCBSNC's requirements for continuity of care.

An ongoing special condition means:

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

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

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

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

Delegated UTILIZATION MANAGEMENT

BCBSNC delegates UM and first level appeal for inpatient and outpatient mental health and substance abuse services to Magellan Behavioral Health. Magellan Behavioral Health is not associated with BCBSNC. Please see https://www.bcbsnc.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 bcbsnc.com and search for "Prior Review" for additional information, including those services subject to PRIOR REVIEW and CERTIFICATION. Claims determination and second level appeals, if eligible, are provided by BCBSNC.

NEED TO APPEAL OUR DECISION?

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

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

In addition to the UTILIZATION MANAGEMENT (UM) program, BCBSNC 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 BCBSNC 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. Mental Health and Substance Abuse as well as Dental appeals have been delegated to third party vendors. Please see the end of this section for contact information. References to BCBSNC throughout this section refer to BCBSNC 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 **BlueConnect.com** or call BCBSNC Customer Service at the number listed in "Who to Contact?"

All information related to a request for a review through BCBSNC's appeals process should be sent to:
BCBSNC
Appeals Department
PO Box 30055
Durham, NC 27702-3055

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

Health Insurance Smart NC
North Carolina Department of Insurance
1201 Mail Service Center
Raleigh, NC 27699-1201
Phone: (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, BCBSNC 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 BCBSNC). The health care professionals have not reviewed your case or information before.

You will have exhausted BCBSNC'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 BCBSNC's internal appeals process at any time it is determined that BCBSNC 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 BCBSNC's control). In the event you are deemed to have exhausted BCBSNC'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
BCBSNC Contacts You	Within 3 business days after receipt of request	Within 10 business days after receipt of request	N/A
Notice of Decision	30 days after receipt of request	7 days after the appeal meeting	72 hours after receipt of request-Oral 4 days after receipt of request - Written

First Level Appeal

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

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

If your appeal is due to a NONCERTIFICATION, your appeal will be 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 BCBSNC may use in making a decision so that you may have an opportunity to respond prior to the notice of an ADVERSE BENEFIT DETERMINATION.

BCBSNC 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 BCBSNC received the request. You may then request all information that was relevant to the review.

Second Level Appeal

Second Level Appeal Timeline

BCBSNC 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 BCBSNC receives your request for a second level appeal, BCBSNC 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 BCBSNC. The panel will include external physicians and/or benefit experts. This will be held within 45 days after BCBSNC receives a second level appeal. BCBSNC 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 BCBSNC 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. BCBSNC 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, BCBSNC 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. BCBSNC 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 BCBSNC 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 BCBSNC's internal appeals process as described below.

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

- completed BCBSNC's first and second level appeals and received a written second level determination from BCBSNC, 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 BCBSNC's written decision within 60 days of the date you can show that the appeal was filed with BCBSNC, or
- received written notification that BCBSNC has agreed to waive the requirement to exhaust the internal appeal and/or second level appeals process.
- determined that BCBSNC 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 BCBSNC'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 BCBSNC.

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

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 web-page:
http://www.ncdoi.com/smart
Tel (toll free): (855) 408-1212

(Web): www.ncdoi.com/smart 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 BCBSNC 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 BCBSNC 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 BCBSNC's receipt of the acceptance notice (or, for an expedited review, within the same business day), BCBSNC 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 BCBSNC at the same time and by the same means of communication (e.g., you must fax the information to BCBSNC if you faxed it to the IRO). When sending additional information to BCBSNC, send it to:

Blue Cross and Blue Shield of North Carolina
Appeals Department
PO Box 30055
Durham, NC 27702-3055

Please note that you may also give this additional information to the NCDOI within the seven-day deadline rather than sending it directly to the IRO and BCBSNC. The NCDOI will forward this information to the IRO and BCBSNC 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, BCBSNC 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 BCBSNC at the time BCBSNC receives notice of the IRO's decision to reverse the ADVERSE BENEFIT DETERMINATION, BCBSNC 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 BCBSNC 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.

Quality of Care Complaints

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

Delegated Appeals

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

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

Second level appeal, if eligible, is provided by BCBSNC.

ADDITIONAL TERMS OF YOUR COVERAGE

This section provides information on:

Table of Contents:	Key Words:
- Benefits to Which MEMBERS are Entitled - BCBSNC'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 BCBSNC and your EMPLOYER. The terms of your coverage cannot be changed or waived unless BCBSNC agrees in writing to the change.

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. PROVIDERS are not considered beneficiaries under this group health plan and do not have standing to sue under ERISA. BCBSNC may pay a PROVIDER directly. For example, BCBSNC 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 BCBSNC, and not through this health benefit plan. Under this health benefit plan, BCBSNC has the sole right to determine whether payment for services is made to the PROVIDER, to the SUBSCRIBER, or allocated among both. BCBSNC'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.

If a MEMBER resides with a custodial parent or legal guardian who is not the SUBSCRIBER, BCBSNC 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. BCBSNC 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 BCBSNC for noncovered services or that are in excess of the benefit provided under your Blue Options HSA coverage may be recovered by BCBSNC. BCBSNC 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 BCBSNC pays the PROVIDER amounts that are your responsibility, such as deductible, copayments or coinsurance, BCBSNC may collect such amounts directly from you.

BCBSNC 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 BCBSNC 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.

BCBSNC's Disclosure of Protected Health Information (PHI)

At BCBSNC, 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 **bcbsnc.com** or call BCBSNC Customer Service at the number listed in "Who to Contact?"

Administrative Discretion

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

Recovery of Overpayment

If a benefit payment is made by BCBSNC to or on your behalf, which exceeds the benefit amount that you are entitled to receive, BCBSNC 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 BCBSNC may have with respect to such overpayment. To the extent that BCBSNC is required to bring an action for recovery of an overpayment under this policy, BCBSNC 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 BCBSNC on your behalf to the extent you recover from another party.

North Carolina PROVIDER Reimbursement

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

Some OUT-OF-NETWORK PROVIDERS have other agreements with BCBSNC that affect their reimbursement for COVERED SERVICES provided to Blue Options HSA 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 HSA ALLOWED AMOUNT and the contracted amount. OUT-OF-NETWORK PROVIDERS may bill you directly. If you are billed, you will be responsible for paying the bill and filing a claim with BCBSNC.

Services Received Outside of North Carolina

BCBSNC has a variety of relationships with other Blue Cross and/or Blue Shield licensees, generally referred to as "Inter-Plan Arrangements." As a MEMBER of BCBSNC, you have access to PROVIDERS outside the state of North Carolina. Your ID CARD tells PROVIDERS that you are a MEMBER of BCBSNC. While BCBSNC 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 BCBSNC. 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 BCBSNC to provide the specific service or services.

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

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

- The billed charges for your COVERED SERVICES, or
- The negotiated price that the Host Blue passes on to 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 BCBSNC 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 negotiated price made available to BCBSNC 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, BCBSNC may use other payment bases, such as billed charges, to determine the amount BCBSNC will pay for COVERED SERVICES from a nonparticipating PROVIDER. In other exception cases, BCBSNC may pay such a claim based on the payment it would make if BCBSNC were paying a non-participating PROVIDER for the same covered healthcare services inside of BCBSNC's service area, where the Host Blue's corresponding payment would be more than BCBSNC's in-service area non-participating PROVIDER payment, or in BCBSNC's sole and absolute discretion, BCBSNC 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 BCBSNC 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 BCBSNC 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 BCBSNC has entered into a Negotiated National Account Arrangement with a Host Blue to provide Value-Based Programs to your EMPLOYER on your behalf, BCBSNC 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 the Blue Cross Blue Shield Global Core assists you with accessing a network of inpatient, outpatient and professional PROVIDERS, the network is not served by a Host Blue. As such, when you receive care from PROVIDERS outside the BlueCard service area, you will typically have to pay the PROVIDERS and submit the claims yourself to obtain reimbursement for these services.

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

- Inpatient Services

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

BCBSNC will not be liable for payment of benefits unless proper notice is furnished to BCBSNC that COVERED SERVICES have been provided to a MEMBER. If the MEMBER files the claim, written notice must be given to BCBSNC within 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 BCBSNC to determine benefits.

Notice of Benefit Determination

BCBSNC will provide an explanation of benefits determination to the MEMBER or the MEMBER'S authorized representative within 30 days of receipt of a notice of claim 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.

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

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

- The specific reason(s) for the denial of benefits
- Reference to the benefit booklet section on which the denial of benefits is based
- A description of any additional information needed for you to perfect the claim and an explanation of why such information is needed
- A description of the review procedures and the time limits applicable to such procedures, including the MEMBER'S right to bring a civil action under Section 502(a) of ERISA following a denial of benefits
- A copy of any internal rule, guideline, protocol or other similar criteria relied on, if any, in making the benefit determination or a statement that it will be provided without charge upon request

- If the denial of benefits is based on MEDICAL NECESSITY or EXPERIMENTAL treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying the terms of 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 BCBSNC. See "Need to Appeal Our Decision?" for more information.

Limitation of Actions

Since your health benefit plan is subject to ERISA, you must exhaust only the first level appeal process before bringing any legal action to recover benefits.

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

No legal action to recover benefits may be brought later than one year from the date your claim for benefits is denied at the end of the appeals process. If you choose to pursue a second level appeal, the one-year period for bringing a legal action will begin to run once that final second-level decision has been issued.

Evaluating New Technology

In an effort to allow for continuous quality improvement, BCBSNC has processes in place to evaluate new medical technology, procedures and equipment. These policies allow us to determine the best services and products to offer 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, BCBSNC 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 BCBSNC; 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, BCBSNC 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, **BCBSNC 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, BCBSNC 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	The plan of the parent whose birthday occurs earlier in the calendar year (known as the birthday rule) is	√	
	The plan of the parent whose birthday is later in the calendar year is		√
	Note: When the parents have the same birthday, the plan that covered the parent longer is	√	
The person is covered as a DEPENDENT CHILD under both plans and parents are divorced/separated or not living together with no court decree* for coverage	The custodial parent's plan is	√	
	The plan of the spouse of the custodial parent is		√
	Or, if the custodial parent covers the child through their spouse's plan, the plan of the spouse is	√	
	The non-custodial parent's plan is		√
	Note: The custodial parent is considered to be the parent awarded custody of a child by a court decree; or in the absence of a court decree, the parent with whom the child resides more than one half of the calendar year.*		
The person is covered as a DEPENDENT CHILD under both plans and parents are divorced/separated or not living together, and coverage is stipulated in a court decree*	The plan of the parent primarily responsible for health coverage under the court decree is	√	
	The plan of the other parent is		√
	Note: If there is a court decree that requires a parent to assume financial responsibility for the child's health care coverage, and BCBSNC has actual knowledge of those terms of the court decree, benefits under that parent's plan are	√	
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		

When a person is covered by 2 group health plans, and	Then	Primary	Secondary
The person is the participant in two active group health plans and none of the rules above apply	The plan that has been in effect longer is	√	
	The plan that has been in effect the shorter amount of time is		√

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

NOTE: If either the primary or the secondary plan covers a particular service, where BCBSNC is the secondary plan, BCBSNC 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. BCBSNC 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.

Statement of Rights Under the Newborns' and Mothers' Health Protection Act

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

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

In addition, a plan or issuer may not, under Federal law, require that a DOCTOR or other health care PROVIDER obtain CERTIFICATION for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain PROVIDERS or facilities, or to reduce your out-of-pocket costs, you may be required to obtain CERTIFICATION.

Mastectomy Benefits

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

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

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 **t**his health benefit plan.

Programs Outside Your Regular Benefits

BCBSNC 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
- 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 BCBSNC'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 BCBSNC.

BCBSNC 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. BCBSNC 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. BCBSNC is not liable for third party PROVIDERS' negligent provision of the gifts. BCBSNC may stop or change these programs at any time.

Health Information Services

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

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

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

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

BENEFIT PERIOD
The period of time, as stated in the "Summary of Benefits" and GROUP CONTRACT, during which charges for COVERED SERVICES provided to a MEMBER must be INCURRED in order to be eligible for payment by BCBSNC. A charge shall be considered INCURRED on the date the service or supply was provided to a MEMBER.

BENEFIT PERIOD MAXIMUM

The maximum amount of charges or number of visits in a BENEFIT PERIOD that will be covered on behalf of a MEMBER. Services in excess of a benefit period maximum are not COVERED SERVICES, and MEMBERS may be responsible for the entire amount of the PROVIDER'S billed charge.

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. BCBSNC 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 BCBSNC that an admission, availability of care, continued stay, or other services, supplies or drugs have been reviewed and, based on the information provided, satisfy 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, BCBSNC 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 BCBSNC coverage can be group health insurance, an employee welfare benefit plan to the extent that the plan provides medical care to employees and/or their dependents directly or through insurance, reimbursement, or otherwise, individual health insurance, short-term limited duration health insurance coverage, public health plan, Children's Health Insurance Program (CHIP), Medicare, Medicaid, and any other coverage defined as creditable coverage under state or federal law. Creditable coverage does not include coverage consisting solely of excepted benefits.

DENTAL SERVICE(S)
Dental care or treatment provided by a DENTIST or OTHER PROFESSIONAL PROVIDER in the DENTIST'S office to a covered MEMBER while the policy is in effect, provided such care or treatment is recognized by BCBSNC as a generally accepted form of care or treatment according to prevailing standards of dental practice.

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

DEPENDENT
A MEMBER other than the 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 for adoption), FOSTER CHILD, or
b) a child for whom legal guardianship has been awarded to the SUBSCRIBER and/or spouse, or
c) a child for whom the SUBSCRIBER and/or spouse has been court-ordered 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 BCBSNC which can withstand repeated use, are used primarily to serve a medical purpose, are not useful to a person in the absence of illness, injury or disease, and are appropriate for use in the patient's home.

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

EMERGENCY SERVICES

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

EMPLOYEE
The person who is eligible for coverage under this health benefit plan due to employment with the EMPLOYER and who is enrolled for coverage.

EMPLOYER
Lenoir County Government

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 abuse services, including behavioral health treatment, (6) PRESCRIPTION DRUGS, (7) REHABILITATIVE 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 order of a court with proper jurisdiction and who are residing with a person appointed as guardian or custodian for so long as the guardian or custodian has assumed the legal obligation for total or partial support of the children with the intent that the children reside with the guardian or custodian on more than a temporary or short-term basis.

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 BCBSNC 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 BCBSNC.

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 BCBSNC 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 BCBSNC.

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

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

IDENTIFICATION CARD (ID CARD)
The card issued to 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 PPO network. BCBSNC's payment for in-network COVERED SERVICES is described in this benefit booklet as in-network benefits or in-network benefit levels.

IN-NETWORK PROVIDER
A HOSPITAL, DOCTOR, other medical practitioner or PROVIDER of medical services and supplies that has been designated as a BLUE OPTIONS HSA PROVIDER by BCBSNC 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 BCBSNC does not recognize as standard medical care of the condition, disease, illness, or injury being treated. The following criteria are the basis for BCBSNCs 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 BCBSNC's evaluation of the therapeutic value of the service or supply
c) There is inconclusive evidence that the service or supply has a beneficial effect on health outcomes
d) The service or supply under consideration is not as beneficial as any established alternatives

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

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

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

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

MEMBER
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"). Those mental disorders coded in the DSM-V as autism spectrum disorder, substance-related disorders, SEXUAL DYSFUNCTION not due to organic disease, and those coded as “V” codes are not included in the definition of Mental Illness.

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

OFFICE VISIT

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

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

OTHER PROFESSIONAL PROVIDER

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

OTHER THERAPY(IES)

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

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

OUT-OF-NETWORK

Not designated as participating in the PPO network, and not certified in advance by BCBSNC 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 HSA PROVIDER by BCBSNC.

OUTPATIENT CLINIC(S)

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

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 BCBSNC as a PCP.

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

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

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

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

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

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

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

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

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

RESTRICTED-ACCESS DRUGS
Covered PRESCRIPTION DRUGS or devices for which reimbursement by BCBSNC is conditioned on: (1) BCBSNC'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.

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 BCBSNC as specializing in an area of medical practice.

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

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

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 BCBSNC.

TOTAL OUT-OF-POCKET LIMIT
The maximum amount listed in "Summary of Benefits" that is payable by the MEMBER in a BENEFIT PERIOD before BCBSNC 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

BCBSNC 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:

Case Management – 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.

Condition Care – provides support to MEMBERS 18 years of age and older who are at risk of or diagnosed with one of these chronic health conditions:

- Chronic obstructive pulmonary disease (COPD)
- Asthma
- Diabetes
- Congestive Heart Failure
- Coronary Artery Disease

MEMBERS enrolled in the program receive educational materials and can speak to a nurse by phone.

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 about the best solution at the lowest cost.

Check with your GROUP ADMINISTRATOR to find out which programs are available to you. Program information, including how to get started, is available by logging in at **bcbsnc.com**. Programs are available at the discretion of your EMPLOYER.

Certain aspects of the programs are only available to groups with 100 or more employees.

BCBSNC **MEMBER RIGHTS AND RESPONSIBILITIES**

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

- Receive information about your coverage and your rights and responsibilities as a MEMBER
- Receive, upon request, facts about your plan, including a list of DOCTORS and health care services covered
- Receive polite service and respect from BCBSNC
- Receive polite service and respect from the DOCTORS who are part of the BCBSNC networks
- Receive the reasons why BCBSNC denied a request for treatment or health care service, and the rules used to reach those results
- Receive, upon request, details on the rules used by BCBSNC to decide whether a procedure, treatment, site, equipment, drug or device needs prior approval
- Receive, upon request, a copy of BCBSNC'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 BCBSNC will take measures to keep your health information private and protect your health care records
- Voice complaints and expect a fair and quick appeals process for addressing any concerns you may have with BCBSNC
- Make recommendations regarding BCBSNC's MEMBER rights and responsibilities policies
- Receive information about BCBSNC, its services, its practitioners and PROVIDERS and MEMBERS' rights and responsibilities
- Be treated with respect and recognition of your dignity and right to privacy.

As a BCBSNC MEMBER, you should:

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

INFORMATION ABOUT YOUR HEALTH SAVINGS ACCOUNT (HSA)

The product offered by BCBSNC 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 BCBSNC. The HSA is administered separately, through a company that is not affiliated with BCBSNC. Your rights with respect to the HSA are governed by a separate agreement with the HSA custodian. While BCBSNC may forward certain materials to you on behalf of the HSA custodian, BCBSNC assumes no responsibility for the administration of the HSA. Termination of your HDHP with BCBSNC 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 BCBSNC collects information from you that may indicate your ineligibility to contribute to an HSA, or that may indicate your contribution limit, BCBSNC 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.

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 applied for your provider's services. If your provider collected too much from you, and you used your HSA funds, it is your responsibility to make sure you know the tax implications to you if you use your HSA funds for medical expenses that you did not have.

Some or all administrative fees for your HSA may be waived during your coverage under the HDHP. If this coverage with BCBSNC terminates and you elect to retain your HSA, the HSA custodian may then begin collecting all administrative fees directly from you under the terms and conditions established between you and the HSA custodian.

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 BCBSNC's name and marks may be included on the face of the debit card for your convenience, BCBSNC 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.

IMPORTANT NOTICE

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 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 becomes financially unable to meet its obligations. If this should happen, the guaranty association will assess its other member insurance 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
Post Office Box 10218
Raleigh, North Carolina, 27605

North Carolina Department of Insurance, Consumer Services Division
1201 Mail Service Center
Raleigh, NC 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 insurance 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. 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 an HMO, 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.

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 contract holder;
- 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 contract holders, 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.

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 the number of policies or types of policies issued by the insolvent company.
3. The guaranty association will pay a maximum of $500,000 with respect to basic hospital, medical and surgical insurance and major medical insurance.
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 with pay a maximum of $5,000,000 to any one unallocated annuity contract holder.

BlueCross BlueShield of North Carolina

Non-Discrimination and Accessibility Notice

Discrimination is Against the Law

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

  BCBSNC:

  - Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
  - Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages
- If you need these services, contact Customer Service **1-888-206-4697**, TTY and TDD, call **1-800-442-7028**.
- If you believe that BCBSNC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:
  - BCBSNC, PO Box 2291, Durham, NC 27702, Attention: Civil Rights Coordinator- Privacy, Ethics & Corporate Policy Office, Telephone **919-765-1663**, Fax **919-287-5613**, TTY **1-888-291-1783** civilrightscoordinator@bcbsnc.com
- You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Civil Rights Coordinator - Privacy, Ethics & Corporate Policy Office is available to help you.
- You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf,* or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 **1-800-368-1019, 800-537-7697** (TDD). Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.
- This Notice and/or attachments may have important information about your application or coverage through BCBSNC. Look for key dates. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call Customer Service **1-888-206-4697**.

BlueCross BlueShield of North Carolina

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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Lenoir County Government
082476 HSA1 07/01/18 062018

Blue OPTIONS HSA℠

Lenoir County Government

Group Effective Date:
July 1, 2018

BlueCross BlueShield of North Carolina

An Independent Licensee of the Blue Cross and Blue Shield Association

Decoupling Booklet END Page - Discard

Benefit Booklet
For Employees of
Lenoir County Government
for

Blue OPTIONS℠

BlueCross BlueShield of North Carolina

An Independent Licensee of the Blue Cross and Blue Shield Association

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.

Attest:

President

Secretary

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

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GETTING STARTED WITH BLUE OPTIONS

IMPORTANT INFORMATION REGARDING THIS HEALTH BENEFIT PLAN:

In accordance with applicable federal law, BCBSNC 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, BCBSNC 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 booklet, keep in mind that any word you see in small caps is a defined term and appears in the "Glossary" at the end of the benefit booklet. The terms "we," "us," and "BCBSNC" 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 bcbsnc.com for the PRIOR REVIEW list, which is updated each quarter (January, April, July and October) with new service codes or service codes that are no longer effective. You can also call BCBSNC **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?"

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 BCBSNC medical and reimbursement policies, which are updated throughout the plan year. These policies lay out the procedure and criteria to determine whether a procedure, treatment, facility, equipment, drug or device is MEDICALLY NECESSARY and eligible for coverage, INVESTIGATIONAL or EXPERIMENTAL, COSMETIC, a convenience item, or requires PRIOR REVIEW and CERTIFICATION by BCBSNC. The most up-to-date medical and reimbursement policies are available at **bcbsnc.com**, or call BCBSNC 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 BCBSNC criteria.

Common Insurance Terms

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

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 BCBSNC 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 BCBSNC 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 BCBSNC pays 100% of COVERED SERVICES. It includes ESSENTIAL HEALTH BENEFITS and non-essential health benefits. It does not include charges over the ALLOWED AMOUNT, including any charges over the allowable cost difference between GENERIC and BRAND-NAME drugs, 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	**$250**	**$500**
D. ALLOWED AMOUNT Minus Deductible (B-C)	$4,000	$3,750
E. Your Coinsurance Amount (x% times D)	**(20%) $800**	**(40%) $1,500**
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)	**$1,050**	**$2,750**

Deductible and coinsurance amounts are for example only, please refer to "Summary of Benefits" for your benefits.

Using Informational Graphics

Graphic symbols are used throughout this benefit booklet to call your attention to certain information and requirements.

Definitions
This symbol calls attention to definitions of important terms throughout this benefit booklet. Additional terms are in the "Glossary" at the end of this benefit booklet. If you are unsure of the meaning of a term, please check "Glossary."

Cross-Reference
Throughout this benefit booklet, cross-references direct you to read other sections of the benefit booklet when necessary.

Call for PRIOR REVIEW and CERTIFICATION Required
This symbol calls attention to medical/surgical and mental health and substance abuse services which require PRIOR REVIEW and CERTIFICATION in order to avoid a full denial of benefits.

Limitations and Exclusions
Each subsection in "COVERED SERVICES" describes not only what is covered, but may also list some limitations and exclusions that specifically relate to a particular type of service. Limitations and exclusions that apply to all services are listed in "What Is Not Covered?"

Toll-Free Phone Numbers, Website and Addresses

BCBSNC **Website: bcbsnc.com**	Find IN-NETWORK PROVIDERS (includes pharmacies), and get information about top-performing facilities, PRESCRIPTION DRUG information, and news about BCBSNC.
Blue Connect Website: **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.
BCBSNC 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	You may visit our website or call BCBSNC 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.bcbsnc.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 BCBSNC. Up to date information about which services may need PRIOR REVIEW can be found online at BlueConnectNC.com.
Magellan Behavioral Health: 1-800-359-2422	BCBSNC delegates the administration of mental health and substance abuse benefits by contract to Magellan Behavioral Health, which is not associated with BCBSNC. See "Delegated UTILIZATION MANAGEMENT" for more information.
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 **bcbs.com**.
HealthLine Blue℠: 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.
MDLIVE **Telemedicine:** 1-888-910-9722 or MDLIVE.BCBSNC.COM	For access to a DOCTOR regarding nonemergency medical issues, call or visit the website to ask for a consultation. DOCTORS will be able to diagnose and suggest a treatment that's appropriate.

Toll-Free Phone Numbers, Website and Addresses (*cont.*)

Condition Care: 1-800-260-0091	Talk to a Condition Care Coach for information about programs and support for handling specific health conditions, such as asthma, diabetes, heart failure, coronary artery disease and COPD. 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.
Healthy Outcomes Customer Service: 1-877-719-9004	Talk with a representative to get help with any technical issues with the website as well as questions about the Healthy Outcomes program. Please talk to your GROUP ADMINISTRATOR to see if this program is available to you.
Medical Claims Filing: BCBSNC 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 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. BCBSNC does not accept claims or reimburse for these goods or services, and MEMBERS are responsible for paying all bills. BCBSNC may change or discontinue these programs at any time.

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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.

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 **bcbsnc.com** or call BCBSNC 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.