Summary Plan Description

for

BlueOptions®

Standard Plan

Coverage Option Under

Belk Stores Services LLC. Health & Welfare Plan

BlueCross BlueShield of North Carolina

An Independent Licensee of the Blue Cross and Blue Shield Association

BENEFIT BOOKLET

This benefit booklet describes the Standard Plan coverage under the Belk Stores Services, LLC health and welfare plan (the PLAN). Blue Cross and Blue Shield of North Carolina provides administrative claims and payment services only and does not assume any financial risk or obligation with respect to claims.

Please read this benefit booklet carefully.

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

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

Amendment and/or Termination of the PLAN

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

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Recent Changes

This section lists recent changes, which may include additions, deletions or revisions to your benefit booklet. These changes supersede language that appears elsewhere in your benefit booklet.

Benefit booklet changes due to recent legislation can be viewed at:
www.bluecrossnc.com/2022-recent-changes-aso.

GETTING STARTED WITH BLUE OPTIONS STANDARD PLAN

IMPORTANT INFORMATION REGARDING THE PLAN:

In accordance with applicable federal law, the PLAN will not discriminate against any health care PROVIDER acting within the scope of their license or certification, or against any person who has received a break on their premium, or taken any other action to endorse his or her right under applicable federal law. Further, the PLAN shall not impose eligibility rules or variations in premiums based on any specified health status-related factors unless specifically permitted by law. Blue Cross NC is a third-party administrator; the EMPLOYER is solely responsible for paying the benefits under the PLAN from its general assets.

- This document is intended to serve as the Summary Plan Description (SPD) for the Standard Plan which is a component program under the Plan. In the event of any conflict between this SPD and the PLAN document, the PLAN document will control.
- The Company intends to continue the Plan, including the Standard Plan component program, but reserves the right, in its sole discretion, to modify, change, revise, amend or terminate the PLAN, or the Standard Plan component program at any time, for any reason, unless required by law, and without prior notice.
- This SPD is not to be construed as a contract of or for employment.

There are separate SPD's that describe other medical and dental component programs under the PLAN.

Getting Started

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

Notes on Words

As you read this benefit booklet, keep in mind that any word you see in "small capital letters (SMALL CAPITAL LETTERS)" is a defined term and appears in the "Glossary" at the end of this benefit booklet.

This Booklet

This booklet tells you about:

- Your COVERED SERVICES and exclusions or services that are not covered
- How the PLAN works
- How we share expenses for COVERED SERVICES

- Who is eligible to be covered under the PLAN and when this coverage starts and ends
- Our UTILIZATION MANAGEMENT programs and the right to appeal the decision
- Any Special Programs that may come with the PLAN.

PRIOR REVIEW and CERTIFICATION

Certain services require PRIOR REVIEW and CERTIFICATION in order for you to avoid a penalty. General categories of services requiring PRIOR REVIEW and CERTIFICATION are noted in "COVERED SERVICES." To determine if a specific service requires PRIOR REVIEW and CERTIFICATION, visit **www.BlueCrossNC.com** for the PRIOR REVIEW list, which is updated when new services are added or when services are removed. You can also call Blue Cross NC Customer Service. See "PRIOR REVIEW (Pre-Service)" in "UTILIZATION MANAGEMENT" for information about the review process.

Exclusions and Limitations

Exclusions and limitations apply to your coverage. Service-specific exclusions are stated along with the benefit description in "COVERED SERVICES." Exclusions that apply to many services are listed in "What Is Not Covered?" To understand the exclusions and limitations that apply to each service, read "COVERED SERVICES," "Summary of Benefits" and "What Is Not Covered?"

No Assignment of Benefits

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

More Information upon Request

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

GETTING STARTED WITH BLUE OPTIONS STANDARD PLAN

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Medical and Reimbursement Policies

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

Reduced or Waived Payments

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

Common Insurance Terms

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

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

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

For Help in Reading this Benefit Booklet

Blue Cross NC provides consumer assistance tools and services for individuals living with disabilities (including accessible websites and the provision of auxiliary aids and services at no cost to the individual) in accordance with the Americans with Disabilities Act and section 504 of the Rehabilitation Act. Blue Cross NC also provides language services at no cost to the individual, including oral interpretation and written translations. To access these services and more, call 1-888-206-4697. For TTY and TDD, call 1-800-442-7028.

WHO TO CONTACT?

Toll-Free Phone Numbers, Website and Addresses

Blue Cross NC Website: www.BlueCrossNC.com	Find IN-NETWORK PROVIDERS and get information about top-performing facilities and news about Blue Cross NC.
Blue Connect Website: www.BlueConnectNC.com	Use our secure MEMBER website to look at your plan, check benefits, eligibility, and claims status, download forms, manage your account, ask for new ID CARDS, get helpful wellness information and more.
Blue Cross NC Customer Service: 1-800-422-2717 TTY/TDD: 1-800-442-7028	For questions about your benefits, claims, new ID CARD requests or to voice a complaint.
PRIOR REVIEW and CERTIFICATION: To request, MEMBERS call: 1-800-422-2717 PROVIDERS call: 1-800-672-7897	Some services need PRIOR REVIEW and CERTIFICATION from Blue Cross NC. Up-to-date information about which services may need PRIOR REVIEW can be found online at **www.BlueConnectNC.com.**
Behavioral Health: 1-800-359-2422	For questions about your mental health and substance use disorder benefits and claims.
Out of North Carolina Care: 1-800-810-BLUE (2583)	For help in obtaining care outside of North Carolina or the U.S., call this number or visit **www.bcbsglobalcore.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.
Nurse Support: 1-888-229-8510	Talk to a Nurse Advocate about receiving support for managing asthma, diabetes, congestive heart failure, coronary artery disease (CAD) and chronic obstructive pulmonary disease (COPD), or hypertension.
My Pregnancy: www.BCBSNC.com/mypregnancy	The maternity program will provide you with support for managing your pregnancy.
Wellness Coaching: 1-888-292-5444	Wellness coaches provide behavioral support to help you manage lifestyle issues. Wellness support is available by phone, as well as by e-mail and live chat.
Teladoc Telehealth:	For access to a DOCTOR regarding nonEMERGENCY medical issues, call or visit the website to ask for a

WHO TO CONTACT? *(cont.)*

(800) 835-2362 and www.Teladoc.com	consultation. DOCTORS will be able to diagnose and suggest a treatment that's appropriate.
Medical Claims Filing: Blue Cross NC Claims Department PO Box 35 Durham, NC 27702-0035	Mail completed medical claims to this address.
COBRA Administrator Connect Your Care (877) 292-4040	For questions about your COBRA benefits.
Livongo 150 W. Evelyn Ave. Suite 150 Mountain View, CA 94041 1-800-945-4355	For information on your diabetes or hypertension program. Blue Cross NC does not administer this benefit.

Value-Added Programs

Not all locations have these Value-Added programs. These programs are not covered benefits and are outside of the PLAN. Blue Cross NC does not accept claims or reimburse for these goods or services and MEMBERS are responsible for paying all bills. The PLAN ADMINISTRATOR and Blue Cross NC may change or discontinue these programs at any time.

Blue365™

Keep your body – and budget – healthy

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

Get deals, discounts & more:

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

Join and save

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

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

SUMMARY OF BENEFITS

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

- Coinsurance percentages shown in this section are the part that you pay for COVERED SERVICES
- Amounts applied to deductible and coinsurance are based on the ALLOWED AMOUNT
- Amounts applied to the deductible also count toward any visit or day maximums for those services
- Benefits may differ depending on where the service is performed and if the service is received with any other service or associated with a surgical procedure.
- If your benefit level for services includes deductible or coinsurance, your PROVIDER may collect an estimated amount of these at the time you receive services.
- To receive IN-NETWORK benefits, you must receive care from a Blue Options IN-NETWORK PROVIDER. However, in an EMERGENCY, you may receive care from an IN-NETWORK or OUT-OF-NETWORK PROVIDER. Please see "EMERGENCY and Ambulance Services" in "COVERED SERVICES" for additional information on EMERGENCY care.

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

BENEFIT PERIOD—01/01/2022 through 12/31/2022

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

Benefits	IN-NETWORK	OUT-OF-NETWORK
Deductibles, OUT-OF-POCKET LIMITS and Benefit Maximums		
The following deductibles and maximums apply to the services listed below in the "Summary of Benefits" unless otherwise noted.		
Deductible		
EMPLOYEE, per BENEFIT PERIOD	$2,800	$5,000
Family MEMBER, per BENEFIT PERIOD	$5,600	$10,000
Family, per BENEFIT PERIOD	$5,600	$10,000
The PLAN has 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, no MEMBER in your family will have to pay more than the family MEMBER deductible listed above. Once the family deductible is reached, it is met for all covered family MEMBERS. IN-NETWORK services are credited to your IN-NETWORK deductible and OUT-OF-NETWORK services are credited to your OUT-OF-NETWORK deductible.		
OUT-OF-POCKET LIMIT		
Individual, per BENEFIT PERIOD	$5,600	$100,000
Family, per BENEFIT PERIOD	$11,200	$100,000
The PLAN has an embedded individual OUT-OF-POCKET LIMIT and if DEPENDENTS are covered, you also have a combined family OUT-OF-POCKET LIMIT. Once a MEMBER meets their individual OUT-OF-POCKET LIMIT the PLAN will pay 100% of the ALLOWED AMOUNT for COVERED SERVICES for that individual. Once the family OUT-OF-POCKET LIMIT is met, it is met for all MEMBERS. Charges for IN-NETWORK services apply to your IN-NETWORK OUT-OF-POCKET LIMIT and charges for OUT-OF-NETWORK services apply to your OUT-OF-NETWORK OUT-OF-POCKET LIMIT.		

LIFETIME MAXIMUMS Per MEMBER	**Unlimited**
Unlimited for all services unless otherwise noted below. Maximums are combined IN- and OUT-OF-NETWORK, unless otherwise noted. 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.	
Orthotic Devices for POSITIONAL PLAGIOCEPHALY	One device
Vein Treatment	Endovenous or microfoam-sclerotherapy procedures—one procedure per limb. Liquid-sclerotherapy tributary 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. All day and visit limits are for IN- and OUT-OF-NETWORK benefits combined.	
ADAPTIVE BEHAVIOR TREATMENT	Unlimited
Bereavement Counseling	15 visits per family. Counseling must be received within 6 months after the patient is deceased.
Dialysis Treatment	Three (3) hemodialysis treatments per week, more hemodialysis treatments are available if MEDICALLY NECESSARY
Evaluation and Treatment of Obesity	Four visits, applies to office and outpatient setting. These visits are separate from any nutritional counseling visits, if applicable.
Hearing Aids	$5,000
Home Health Care	50 days
REHABILITATIVE THERAPY and HABILITATIVE SERVICES (applies to home, office and outpatient setting)	40 visits per benefit period for physical/occupational therapy 20 visits for chiropractic services. 20 visits per benefit period for speech therapy
SKILLED NURSING FACILITY	120 days

PREVENTIVE CARE

Available in an office-based, outpatient, ambulatory surgical setting, or URGENT CARE center. This benefit is only for services that indicate a primary diagnosis of preventive or wellness. See "PREVENTIVE CARE" in "COVERED SERVICES." Please visit Blue Cross NC's website at **www.BlueCrossNC.com/preventive** for the most up-to-date information on PREVENTIVE CARE covered under federal law.

Screenings	No Charge	40% after deductible

Includes: gynecological exams, cervical cancer screening, ovarian cancer screening, screening mammograms, colorectal screening, bone mass measurement, prostate-specific antigen tests, and newborn hearing screening.

Other PREVENTIVE CARE (federally mandated)	No Charge	Benefits not available

For a list of PREVENTIVE CARE services that are covered under federal law, including PRESCRIPTION contraceptives and certain preventive over-the-counter medications for individuals who qualify, see Blue Cross NC's website at **www.BlueCrossNC.com/preventive** or call Blue Cross NC Customer Service at the number in "Who to Contact?"

Please note that the following services are also covered at no charge IN-NETWORK: nutritional counseling visits, regardless of diagnosis (are also available OUT-OF-NETWORK at 40% after deductible).

PROVIDER'S Office

OFFICE VISIT Services

PRIMARY CARE PROVIDER or SPECIALIST	20% after deductible	40% after deductible

Includes all OFFICE VISITS for medical, mental health, substance use disorder, INFERTILITY (diagnosis only), pre-natal/post-delivery care (not included in the global maternity delivery fee), office SURGERY, x-rays, diagnostic imaging and lab tests.

Teladoc Telehealth	20% after deductible	Not Applicable

Telehealth services are also available from a local IN-NETWORK or OUT-OF-NETWORK PROVIDER, see "Office Services" in "COVERED SERVICES."

Near Site Clinic

(where available in North Carolina)

Non preventive	$30 copayment after deductible	**Benefits not available**

Benefits	IN-NETWORK	OUT-OF-NETWORK
Preventive	No Charge	**Benefits not available**
Therapy Services		
REHABILITATIVE THERAPY and HABILITATIVE SERVICES	20% after deductible	40% after deductible
OTHER THERAPIES	20% after deductible	40% after deductible
Includes chemotherapy, dialysis and cardiac rehabilitation provided in the office. See Outpatient Services for OTHER THERAPIES provided in an outpatient setting.		
Emergency and Ambulance Services		
Emergency Room Visit	20% after deductible	20% after deductible
Ambulance Services	20% after deductible	20% after deductible
URGENT CARE Center		
URGENT CARE	20% after deductible	40% after deductible
AMBULATORY SURGICAL CENTER		
Ambulatory Surgical Services	20% after deductible	40% after deductible
Outpatient		
Outpatient Services	20% after deductible	40% after deductible
Includes physician services, HOSPITAL and HOSPITAL-based services, HOSPITAL-based or OUTPATIENT CLINIC services, outpatient diagnostic services, mental health and substance use disorder services, and therapy services including REHABILITATIVE THERAPY and HABILITATIVE SERVICES and OTHER THERAPIES including dialysis. See Benefit Maximums for visit maximums.		
Outpatient diagnostic Mammography (physician and HOSPITAL-based services)	20% after deductible	40% after deductible
See PREVENTIVE CARE for coverage of screening mammograms.		
Inpatient		
Inpatient Services	20% after deductible	40% after deductible
Includes inpatient HOSPITAL services, including but not limited to medical, mental health, substance use disorder, INFERTILITY (diagnosis only), therapies, transplants, maternity		

Benefits	IN-NETWORK	OUT-OF-NETWORK
delivery, and surgeries. If you are in a HOSPITAL as an inpatient at the time you begin a new BENEFIT PERIOD, you may have to meet a new deductible for COVERED SERVICES from DOCTORS or OTHER PROFESSIONAL PROVIDERS.		
SKILLED NURSING FACILITY		
SKILLED NURSING FACILITY	20% after deductible	40% after deductible
Other Services		
Home Health care	20% after deductible	40% after deductible
HOSPICE, bereavement counseling and private duty nursing	20% after deductible	40% after deductible
DURABLE MEDICAL EQUIPMENT, MEDICAL SUPPLIES, orthotic devices, PROSTHETIC APPLIANCES	20% after deductible	40% after deductible
CT Scans, MRIs, MRAs and PET scans in any location, including a physician's office	20% after deductible	40% after deductible
Hearing Aids and Related Services	0% after deductible	40% after deductible
Cochlear Implants	0% after deductible	40% after deductible
CERTIFICATION Requirements		
Certain services require PRIOR REVIEW and CERTIFICATION by the PLAN in order to receive benefits. See "COVERED SERVICES" and "PRIOR REVIEW (Pre-Service)" in "UTILIZATION MANAGEMENT" for additional information. Blue Cross NC delegates PRIOR REVIEW and CERTIFICATION for particular benefits to other companies not associated with Blue Cross NC. Please see **https://www.BlueCrossNC.com/content/services/medical-policy/index.htm** for a detailed list of these companies and benefits. While some benefits have been identified under "COVERED SERVICES," the list of benefits and/or companies may change from time to time; for the most up-to-date information visit **https://www.BlueCrossNC.com/content/services/medical-policy/index.htm.**		

HOW Blue Options STANDARD PLAN WORKS

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

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

Most Cost-Effective Benefit Level

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

You and your DEPENDENTS will need to make the decision whether to receive treatment, services or supplies and whether such treatment, services or supplies should be provided by an IN-NETWORK PROVIDER or OUT-OF-NETWORK PROVIDER. Blue Cross NC and the EMPLOYER are not responsible for your treatment decisions.

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

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

	IN-NETWORK	OUT-OF-NETWORK
	provided, 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 Blue Cross NC's website at **www.BlueCrossNC.com**, or call Blue Cross NC Customer Service at the number listed in "Who to Contact?"	
ALLOWED AMOUNT vs. Billed Amount	If the billed amount for COVERED SERVICES is greater than the ALLOWED AMOUNT, you are not responsible for the difference. You only pay any applicable deductible, coinsurance, and non-covered expenses. (See Filing Claims below for additional information.)	You may be responsible for paying any charges over the ALLOWED AMOUNT in addition to any applicable deductible, coinsurance, and non-covered expenses.
Referrals	Blue Cross NC does not require you to obtain any referrals.	
After-hours Care	If you need nonEMERGENCY services after your PROVIDER'S office has closed, please call your PROVIDER'S office for their recorded instructions.	
Care Outside of North Carolina	Your ID CARD gives you access to participating PROVIDERS outside the state of North Carolina through the BlueCard® program, and benefits are provided at the IN-NETWORK benefit level.	If you are in an area that has participating PROVIDERS and you choose a PROVIDER outside the network, you will receive the lower OUT-OF-NETWORK benefit. Also see

		"OUT-OF-NETWORK Benefit Exceptions."
PRIOR REVIEW	All IN-NETWORK PROVIDERS in North Carolina and some outside of North Carolina are responsible for requesting PRIOR REVIEW when necessary. See "COVERED SERVICES" and "PRIOR REVIEW (Pre-Service)" in "UTILIZATION MANAGEMENT" for additional information about those services which require PRIOR REVIEW and CERTIFICATION.	OUT-OF-NETWORK PROVIDERS are not obligated by contract to request PRIOR REVIEW by Blue Cross NC. **You are responsible for ensuring that you or your OUT-OF-NETWORK PROVIDER requests PRIOR REVIEW by Blue Cross NC.** Failure to request PRIOR REVIEW and obtain CERTIFICATION will result in a penalty. However, PRIOR REVIEW is not required for 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 Blue Cross NC. Claims not received within 18 months from the service date will not be covered, except in the absence of legal capacity of the MEMBER.	You may have to pay the OUT-OF-NETWORK PROVIDER in full and submit your own claim to Blue Cross NC. Mail claims in time to be received within 18 months of the date the service was provided. Claims not received within 18 months from the service date will not be covered, except in the absence of legal capacity of the MEMBER.

Additional Providers that are Available Outside of North Carolina

Florida:

The PLAN also uses the Network Blue network which provides MEMBERS with access to a select group of high-quality, cost-effective PROVIDERS. You do not have to get a referral to see your DOCTOR and you will have easy access to SPECIALISTS. To get the most from your health care benefits, visit an IN-NETWORK PROVIDER. However, you also have the freedom to choose health care PROVIDERS who do not participate in the Network Blue network—the main

difference will be the cost to you. Benefits are available for services from an IN- and OUT-OF-NETWORK PROVIDER that is recognized by Blue Cross and Blue Shield as eligible. For a list of eligible PROVIDERS, please visit the Blue Cross and Blue Shield Provider Directory at **https://www.bcbs.com/find-a-doctor**, or call Blue Cross NC Customer Service at the number listed in "Who to Contact?"

Tennessee:

The PLAN also uses the Network S network which provides MEMBERS with access to a select group of high-quality, cost-effective PROVIDERS. You do not have to get a referral to see your DOCTOR and you will have easy access to SPECIALISTS. To get the most from your health care benefits, visit an IN-NETWORK PROVIDER. However, you also have the freedom to choose health care PROVIDERS who do not participate in the Network S network—the main difference will be the cost to you. Benefits are available for services from an IN- and OUT-OF-NETWORK PROVIDER that is recognized by Blue Cross and Blue Shield as eligible. For a list of eligible PROVIDERS, please visit the Blue Cross and Blue Shield Provider Directory at **https://www.bcbs.com/find-a-doctor**, or call Blue Cross NC Customer Service at the number listed in "Who to Contact?"

Washington / Maryland:

The PLAN also uses the Blue Choice Adv Open Access network which provides MEMBERS with access to a select group of high-quality, cost-effective PROVIDERS. You do not have to get a referral to see your DOCTOR and you will have easy access to SPECIALISTS. To get the most from your health care benefits, visit an IN-NETWORK PROVIDER. However, you also have the freedom to choose health care PROVIDERS who do not participate in the Blue Choice Adv Open Access network—the main difference will be the cost to you. Benefits are available for services from an IN- and OUT-OF-NETWORK PROVIDER that is recognized by Blue Cross and Blue Shield as eligible. For a list of eligible PROVIDERS, please visit the Blue Cross and Blue Shield Provider Directory at **https://www.bcbs.com/find-a-doctor**, or call Blue Cross NC Customer Service at the number listed in "Who to Contact?"

Georgia:

The PLAN also uses the Blue Open Access POS network which provides MEMBERS with access to a select group of high-quality, cost-effective PROVIDERS. You do not have to get a referral to see your DOCTOR and you will have easy access to SPECIALISTS. To get the most from your health care benefits, visit an IN-NETWORK PROVIDER. However, you also have the freedom to choose health care PROVIDERS who do not participate in the Blue Open Access POS network—the main difference will be the cost to you. Benefits are available for services from an IN- and OUT-OF-NETWORK PROVIDER that is recognized by Blue Cross and Blue Shield as eligible. For a list of eligible PROVIDERS, please visit the Blue Cross and Blue Shield Provider Directory at **https://www.bcbs.com/find-a-doctor**, or call Blue Cross NC Customer Service at the number listed in "Who to Contact?"

OUT-OF-NETWORK Benefit Exceptions

In an EMERGENCY, in situations where IN-NETWORK PROVIDERS are not reasonably available as determined by Blue Cross NC's access to care standards, or in continuity of care situations, OUT-OF-NETWORK benefits will be paid at your 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 Blue Cross NC.

> For more information, see one of the following sections: "EMERGENCY and Ambulance Services" in "COVERED SERVICES," or "Continuity of Care" in "UTILIZATION MANAGEMENT." For information about Blue Cross NC's access to care standards, visit Blue Cross NC's website at **www.BlueCrossNC.com** and type "access to care" in the search bar. If you believe an IN-NETWORK PROVIDER is not reasonably available, you can help assure that benefits are paid at the correct benefit level by calling Blue Cross NC before receiving care from an OUT-OF-NETWORK PROVIDER.

Bundled Care and Payments Program

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

Carry Your IDENTIFICATION CARD

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

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

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

Blue Cross NC is strongly committed to continuously improving your quality of care and reducing the cost of using health care services. Maintaining a relationship with a PCP, who will help you manage your health and make decisions about your health care needs is an important step towards ensuring you receive the highest quality of care.

If you change PCPs, be sure to have your medical records transferred, especially immunization records, to provide your new PROVIDER with your medical history. You should participate actively in all decisions related to your health care and discuss all treatment options with your health care PROVIDER regardless of cost or benefit coverage. PCPs are trained to deal with a broad range of health care issues and can help you to determine when you need a SPECIALIST. PROVIDERS from medical specialties such as family practice, internal medicine, and pediatrics, may participate as PCPs.

Please visit Blue Cross NC's website at **www.BlueCrossNC.com** or call Blue Cross NC Customer Service to confirm that the PROVIDER is in the network before receiving care.

If your PCP or SPECIALIST leaves the Blue Cross NC PROVIDER network and they are currently treating you for an ongoing special condition, see "Continuity of Care" in "UTILIZATION MANAGEMENT."

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

To make this request, or if you would like the professional qualifications of your PCP or IN-NETWORK SPECIALIST, you may call Blue Cross NC Customer Service at the number listed in "Who to Contact?"

COVERED SERVICES

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

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

Office Services

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

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

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

Telehealth services from a local PROVIDER: You can also check with your local PROVIDER to see if telehealth services are available. Telehealth services are available from IN-NETWORK and OUT-OF-NETWORK PROVIDERS and are separate from your telehealth benefit with Teladoc. Telehealth services include, but are not limited to, evaluation, management, and consultative services for medical, counseling, and care management issues with a PROVIDER via an

interactive audio/video or other telecommunication system. It is important to understand that your benefit will vary depending upon the type of PROVIDER you see for these services.

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

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

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

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

PREVENTIVE CARE

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

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

Please visit Blue Cross NC's website at **www.BlueCrossNC.com/preventive** or call Blue Cross NC Customer Service at the number in "Who to Contact?" for the most up-to-date information on PREVENTIVE CARE that is covered under federal law, including any limitations that may apply.

Some services are only available IN-NETWORK as indicated below.

PREVENTIVE CARE COVERED SERVICES include:

Routine Physical Examinations and Screenings

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

This benefit is only available IN-NETWORK.

Well-Baby and Well-Child Care

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

This benefit is only available IN-NETWORK.

Well-Woman Care

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

Contraceptive Methods

Contraceptive methods and procedures requiring a prescription and approved by the U.S. Food and Drug Administration are covered for each female MEMBER with reproductive capacity. This includes intrauterine devices, diaphragms and caps, injectable or transdermal contraceptives, NuvaRing®, implanted hormonal contraceptives, certain EMERGENCY contraceptives and GENERIC oral contraceptives. Some of these contraceptive services may be covered under a separate prescription drug plan. Contact your Plan Administrator to request additional information.

This benefit is only available IN-NETWORK.

Immunizations

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

This benefit is only available IN-NETWORK, except for meningococcal vaccine which is also available OUT-OF-NETWORK.

Tobacco Cessation

This PLAN provides benefits for some tobacco cessation over-the-counter nicotine replacement therapy (NRT) products, including patches, lozenges or gum. Please check with your Pharmacy Benefit Manager about FDA-approved PRESCRIPTION cessation medications that may be available.

Please log on to Blue Cross NC's website at **www.BlueCrossNC.com/preventive** or call Blue Cross NC at 1-877-275-9787 for the most up-to-date information on tobacco cessation benefits.

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

Bone Mass Measurement Services

The PLAN covers one scientifically proven and approved bone mass measurement for the diagnosis and evaluation of osteoporosis or low bone mass during any 23-month period for certain qualified individuals only. Additional follow-up bone mass measurement tests will be covered if MEDICALLY NECESSARY. Please note that bone mass measurement tests will be covered under your diagnostic benefit (not your PREVENTIVE CARE benefit) if the claim for these services indicates a primary diagnosis of something other than preventive or wellness. Your diagnostic benefit will be subject to the benefit level for the location where services are received.

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

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

Colorectal Screening

Colorectal cancer examinations and laboratory tests for cancer are covered for any 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.

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. Additional PSA tests will be covered if recommended by a DOCTOR.

Screening Mammograms

The PLAN provides coverage for one baseline mammogram for any female MEMBER between the ages of 35 and 39. Beginning at age 40, one screening mammogram will be covered per female MEMBER per BENEFIT PERIOD, along with a DOCTOR'S interpretation of the results. More frequent or earlier mammograms will be covered as recommended by a DOCTOR when a female MEMBER is considered at risk for breast cancer.

A female MEMBER is "at risk" if she:

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

PREVENTIVE CARE Exclusions

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

EMERGENCY and Ambulance Services

EMERGENCY SERVICES

The PLAN provides benefits for EMERGENCY SERVICES.

An EMERGENCY is the sudden and unexpected onset of a 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 Health Line Blue, and a Health Line 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 copayment or coinsurance level and based on the billed amount. You may be responsible for charges billed separately, which are not eligible for additional reimbursement and you may be required to pay the entire bill at the time of service and file a claim. PRIOR REVIEW and CERTIFICATION are not required.

You are held for observation.	Outpatient benefits apply to all COVERED SERVICES received in the emergency room and during the observation.
You are admitted to the HOSPITAL from the ER following EMERGENCY SERVICES.	Inpatient HOSPITAL benefits apply for all COVERED SERVICES received in the emergency room and during hospitalization. PRIOR REVIEW and CERTIFICATION are required for inpatient hospitalization and other selected services following EMERGENCY SERVICES (including screening and stabilization) in order to avoid a penalty. You may need to transfer to an IN-NETWORK HOSPITAL once your condition 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.

Ambulance Services

The PLAN covers services in a ground ambulance traveling:

- From a MEMBER'S home or scene of an accident or EMERGENCY to a HOSPITAL
- Between HOSPITALS
- Between a HOSPITAL and a SKILLED NURSING FACILITY

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

The PLAN covers services in an air ambulance 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 (Ground or Air)

- Services provided primarily for the convenience of travel of the MEMBER or caregiver.
- Transportation to or from a DOCTOR'S office or dialysis center

– Transportation for the purpose of receiving services that are not considered COVERED SERVICES, even if the destination is an appropriate facility.

URGENT CARE

The PLAN also provides benefits for URGENT CARE services. When you need URGENT CARE, call your PCP, a SPECIALIST or go to an URGENT CARE PROVIDER. If you are not sure if your condition requires URGENT CARE, you can call Health Line Blue.

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

HOSPITAL (Inpatient) and Other Facility Care

Benefits are provided for:

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

  PRIOR REVIEW must be requested and CERTIFICATION must be obtained in advance from Blue Cross NC for inpatient admissions, except for maternity deliveries and EMERGENCIES. See "Maternity Care," if applicable, and "EMERGENCY and Ambulance Services". If PRIOR REVIEW is not requested and CERTIFICATION is not obtained for covered OUT-OF-NETWORK inpatient admissions, allowed charges will be reduced by $500, then deductible and coinsurance will be applied. Also, Blue Cross NC requires notification for MEMBERS who have Medicare as their primary coverage and who are admitted to a Medicare-certified HOSPITAL or NONHOSPITAL FACILITY.

- Outpatient services received in a HOSPITAL, a HOSPITAL-based facility, NONHOSPITAL FACILITY or a HOSPITAL-based or OUTPATIENT CLINIC
- Surgical services received in an AMBULATORY SURGICAL CENTER
- COVERED SERVICES received in a licensed and accredited specialty care facility, such as a SKILLED NURSING FACILITY, or an acute inpatient rehabilitation facility or long-term acute care facility. SKILLED NURSING FACILITY services are limited to a day maximum per BENEFIT PERIOD. See "Summary of Benefits."

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

Alternatives to HOSPITAL Stays

Home Health Care

Home health care services are covered when ordered by your DOCTOR for a MEMBER who is HOMEBOUND due to illness or injury, or is actively receiving treatment for a cancer-related problem, and needs part-time or intermittent skilled nursing care from a REGISTERED NURSE (RN) or LICENSED PRACTICAL NURSE (LPN) and/or other skilled care services like REHABILITATIVE THERAPY and HABILITATIVE SERVICES. Usually, a HOME HEALTH AGENCY coordinates the services your DOCTOR orders for you. Services from a home health aide may be eligible for coverage only when the care provided supports a skilled service being delivered in the home.

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

See "Summary of Benefits" for home health day limits.

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

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

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

Family Planning

Maternity Care

Maternity care benefits, including prenatal care, admission to labor and delivery, management of labor including fetal monitoring, delivery, and uncomplicated post-delivery care until six weeks postpartum, are available to all female MEMBERS and

are covered. Together these make up the global maternity delivery fee. See the chart below for additional information.

Also visit **www.BlueCrossNC.com/preventive** for the most up-to-date federally-mandated PREVENTIVE CARE services, including those available for DEPENDENT CHILDREN.

	Mother	Newborn	Payment
Prenatal care	Care related to the pregnancy before birth		Coinsurance and any applicable deductible apply.
Labor & delivery services	No PRIOR REVIEW required for inpatient HOSPITAL stay for 48 hours after a vaginal delivery or 96 hours after a cesarean section. Mothers choosing a shorter stay are eligible for a home health visit for post-delivery follow-up care if received within 72 hours of discharge.	No PRIOR REVIEW required for inpatient well-baby care for 48 hours after a vaginal delivery or 96 hours after a cesarean section. Benefits include newborn hearing screening ordered by a DOCTOR to determine the presence of permanent hearing loss. (Please see PREVENTIVE CARE in "Summary of Benefits.")	Deductible and coinsurance apply. If adding the baby changes your policy from individual to family 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. In order to avoid a penalty, PRIOR REVIEW and CERTIFICATION are required for inpatient stays extending beyond 48/96 hours	After the first 48/96 hours, whether inpatient (sick baby) or outpatient (well baby), the newborn must be enrolled for coverage as a DEPENDENT CHILD, according to the rules in "When Coverage Begins and Ends." For inpatient services following the first 48/96 hours, PRIOR REVIEW and	

	Mother	Newborn	Payment
		CERTIFICATION are required in order to avoid a penalty.	

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

Termination of Pregnancy (Abortion)

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

COMPLICATIONS OF PREGNANCY

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

INFERTILITY Services

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

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

Sterilization

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

Contraceptive Devices

This benefit is available for all MEMBERS. Coverage includes the insertion or removal of and any MEDICALLY NECESSARY examination associated with the use of intrauterine devices, diaphragms, injectable contraceptives and implanted hormonal contraceptives. Certain FDA-approved contraceptive methods for female MEMBERS are covered under your PREVENTIVE CARE benefit. See **www.BlueCrossNC.com/preventive** or call Blue Cross NC

Customer Service for information about procedures that are covered according to federal regulations and any limitations that may apply.

Family Planning Exclusions

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

Specific Therapies and Tests

Therapy services are covered when provided for an illness, disease or injury when ordered by a DOCTOR or OTHER PROFESSIONAL PROVIDER.

Home Infusion Therapy Services

Home infusion therapy is covered for the administration of prescription drugs directly into a body organ or cavity or via intravenous, intraspinal, intramuscular, subcutaneous or epidural routes, under a plan prescribed by a DOCTOR. These services must be provided under the supervision of a licensed, registered, or certified healthcare professional acting within the scope of their practice.

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

REHABILITATIVE THERAPY and HABILITATIVE SERVICES

The following therapies are covered:

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

- Speech therapy

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

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

ADAPTIVE BEHAVIOR TREATMENT

This benefit is a non-essential health benefit. PRIOR REVIEW must be requested and CERTIFICATION must be obtained in advance for ADAPTIVE BEHAVIOR TREATMENT or services will not be covered. Coverage includes assessments and treatment, which must be MEDICALLY NECESSARY, and ordered by a licensed physician or licensed psychologist. ADAPTIVE BEHAVIOR TREATMENT must be provided or supervised by the following professionals who are licensed and/or board-certified* to provide this treatment:

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

*If received outside North Carolina, ADAPTIVE BEHAVIOR TREATMENT may be provided or supervised by a licensed and/or board-certified behavior analyst if such license and/or board certification exists in the state. PRIOR REVIEW and CERTIFICATION requirements still apply, and the appropriate licensing and/or board certification requirements of the state in which the services are received must be met in order for these services to be covered.

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

OTHER COVERED THERAPIES

The PLAN covers:

- Cardiac rehabilitation therapy
- Pulmonary and respiratory therapy
- Dialysis treatment
- Radiation therapy
- Chemotherapy, including intravenous chemotherapy.

Chemotherapy benefits are based on where services are received. For chemotherapy received in conjunction with bone marrow or peripheral blood stem cell transplants, follow transplant guidelines described in "Transplants."

Diagnostic Services

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

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

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

Diagnostic Services Exclusions

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

Other Services

Autism Spectrum Disorder Services

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

- ADAPTIVE BEHAVIOR TREATMENT (see "Specific Therapies and Tests" for additional information)
- Psychiatric care
- Psychological care

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

Autism Spectrum Disorder Exclusion

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

Blood

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

Blood Exclusion

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

Certain Drugs Covered under Your Medical Benefit

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

Gene and Cellular Therapy

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

PRIOR REVIEW and CERTIFICATION may be required for gene and cellular therapies covered under your medical benefit or services will not be covered.

Clinical Trials

The PLAN provides benefits for participation in clinical trials phases I, II, III, and IV. Coverage is also provided for CMS Investigational Device Exemption (IDE) Category B

device trials. Coverage is provided only for MEDICALLY NECESSARY costs of health care services associated with the trials, and only to the extent such costs have not been or are not funded by other resources. The MEMBER must meet all protocol requirements and provide informed consent in order to participate. The trial must involve the treatment of cancer or a life-threatening medical condition with services that are medically indicated and preferable for that MEMBER compared to non-investigational alternatives. In addition, the trial must:

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

Clinical Trials Exclusions

- Early feasibility/safety/pilot stages of device trials
- CMS IDE Category A device trials
- Non-health care services, such as services provided for data collection and analysis
- INVESTIGATIONAL drugs and devices and services that are not for the direct clinical management of the patient.

Dental Treatment Covered Under Your Medical Benefit

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

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

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

Benefits are also provided for extractions, root canal therapy, crowns, bridges, and dentures necessary for treatment of accidental injury or for reconstruction for the

conditions listed above. In addition, benefits may be provided for dentures and orthodontic braces if used to treat CONGENITAL deformity including cleft lip and cleft palate.

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

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

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

In addition, benefits will be provided if a MEMBER is treated in a HOSPITAL following an accidental injury, and COVERED SERVICES such as oral SURGERY or reconstructive procedures are required at the same time as treatment for the bodily injury.

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

Dental Treatment Excluded Under Your Medical Benefit

Treatment for the following conditions:

- Injury related to chewing or biting
- Preventive dental care, diagnosis or treatment of or related to the teeth or gums
- Periodontal disease or cavities and disease due to infection or tumor
- COSMETIC procedures, except as specifically covered by the PLAN.

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

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

Temporomandibular Joint (TMJ) Services

The PLAN provides benefits for services provided by a duly licensed DOCTOR, DOCTOR of dental SURGERY, or DOCTOR of dental medicine for diagnostic, therapeutic or surgical procedures, including oral SURGERY involving bones or joints of the jaw, face or head when the procedure is related to TMJ disease. Therapeutic benefits for TMJ disease include splinting and use of intra-oral PROSTHETIC APPLIANCES to reposition the bones. Surgical benefits for TMJ disease are limited to SURGERY performed on the temporomandibular joint.

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

If TMJ is caused by malocclusion, benefits are provided for surgical correction of malocclusion when surgical management of the TMJ is MEDICALLY NECESSARY. Please have your PROVIDER contact Blue Cross NC before receiving surgical treatment for TMJ.

Diabetes-Related Services

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

Equipment and Supplies

DURABLE MEDICAL EQUIPMENT

Benefits are provided for DURABLE MEDICAL EQUIPMENT and supplies required for operation of equipment when prescribed by a PROVIDER. Equipment may be purchased or rented at the discretion of the PLAN. The PLAN provides benefits for repair or replacement of the covered equipment. Benefits will end when it is determined that the equipment is no longer MEDICALLY NECESSARY.

Certain DURABLE MEDICAL EQUIPMENT requires PRIOR REVIEW and CERTIFICATION or services will not be covered.

DURABLE MEDICAL EQUIPMENT Exclusions

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

Hearing Aids

The PLAN provides coverage for MEDICALLY NECESSARY hearing aids, including implantable bone-anchored hearing aids (BAHA), and related services that are ordered by a DOCTOR or a licensed audiologist. Benefits are also provided for the evaluation, fitting, and adjustments of hearing aids or replacement of hearing aids, and for supplies, including ear molds.

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

Lymphedema-Related Services

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

Lymphedema-Related Services Exclusion

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

MEDICAL SUPPLIES

Coverage is provided for MEDICAL SUPPLIES.

> To obtain MEDICAL SUPPLIES and equipment, please find a PROVIDER on Blue Cross NC's website at **www.BlueCrossNC.com** or call Blue Cross NC Customer Service.

Orthotic Devices

Orthotic devices, which are rigid or semi-rigid supportive devices that restrict or eliminate motion of a weak or diseased body part, are covered if MEDICALLY NECESSARY and prescribed by a PROVIDER. Foot orthotics may be covered only when custom molded to the patient.

Orthotic Devices Exclusions

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

PROSTHETIC APPLIANCES

The PLAN provides benefits for the purchase, fitting, adjustments, repairs, and replacement of PROSTHETIC APPLIANCES. The PROSTHETIC APPLIANCES must replace all or part of a body part or its function. The type of PROSTHETIC APPLIANCE will be based on the functional level of the MEMBER. Therapeutic contact lenses may be covered when used as a corneal bandage for a medical condition. Benefits include a one-time replacement of eyeglass or contact lenses due to a PRESCRIPTION change after cataract SURGERY.

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

PROSTHETIC APPLIANCES Exclusions

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

Surgical Benefits

Surgical services by a professional or facility PROVIDER on an inpatient or outpatient basis, including pre-operative and post-operative care and care of complications, are covered.

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

To understand more fully your responsibility, please refer to "Medical and Reimbursement Policy" in the "Getting Started with BLUE OPTIONS" section.

Surgical benefits include, but are not limited to:

- Diagnostic SURGERY such as biopsies, and reconstructive SURGERY performed to correct CONGENITAL defects that result in functional impairment of newborn, adoptive children, and FOSTER CHILDREN
- Surgical treatment for morbid obesity (bariatric SURGERY)
- Surgical, endovenous or microfoam-sclerotherapy procedures used to support the normal function of your major (truncal) veins. Coverage is also provided for liquid-sclerotherapy tributary vein treatment associated with a covered truncal vein procedure.
- Mastectomy SURGERY, including:
  - Reconstruction of the breast on which the mastectomy has been performed
  - SURGERY and reconstruction of the non-diseased breast to produce a symmetrical appearance, without regard to the lapse of time between the mastectomy and the reconstructive SURGERY
  - Prostheses and physical complications of all stages of the mastectomy, including lymphedemas.

  See “Federal Notices” for more information about mastectomy benefits.
- Joint replacement SURGERY

If you have more than one surgical procedure performed on the same date of service, those procedures may not be eligible for separate reimbursement.

For information about coverage of multiple surgical procedures, please refer to Blue Cross NC’s reimbursement policies, which are on Blue Cross NC's website at **www.BlueCrossNC.com,** or call Blue Cross NC Customer Service at the number listed in “Who to Contact?"

Anesthesia

Your anesthesia benefit includes coverage for general, spinal block or monitored regional anesthesia ordered by the attending DOCTOR and administered by or under the supervision of a DOCTOR other than the attending surgeon or assistant at SURGERY.

Benefits are not available for charges billed separately by the PROVIDER which are not eligible for additional reimbursement. Also, your coverage does not provide additional benefits for local anesthetics, which are covered as part of your surgical benefit.

Gender Affirmation Surgery

This PLAN provides coverage for non-essential health benefits for hormone therapy and gender affirmation surgery. PRIOR REVIEW and CERTIFICATION are required or services will not be covered.

The following male to female gender affirmation SURGERY services are covered:

- Breast augmentation (mammoplasty)
- Feminizing genitoplasty
- Vaginoplasty
- Intersex SURGERY male to female

The following female to male gender affirmation surgery services are covered:

- Intersex surgery female to male
- Subcutaneous mastectomy (chest masculinization)
- Masculinizing genitoplasty
- Metaidoioplasty (post-testosterone stimulation of external genitals) performed under general anesthesia
- Testicular implants, placed six months after above surgery
- Phalloplasty (functional male organs constructed in a two or three stage procedure)
- Hysterectomy and bilateral salpingo-oophorectomy.

Gender Affirmation SURGERY Exclusions

- Services and procedures that are considered COSMETIC and unrelated to the covered gender affirmation SURGERY benefits:
  - COSMETIC services that may be used to make a person look more feminine including but not limited to procedures such as: plastic SURGERY of the nose; face lift; neck lift; malar implants, lip enhancement; facial bone reduction; plastic SURGERY of the eyelids; liposuction of the waist; reduction of the thyroid cartilage; hair removal; hair transplants; and SURGERY of the larynx, including shortening or tightening of the vocal cords
  - COSMETIC services that may be used to make a person look more masculine including but not limited to procedures such as: chin implants; nose implants; and lip reduction

- Speech therapy
- Sperm banking and embryonic freezing
- Restylane injections
- Any services performed to reverse gender affirmation SURGERY.

Transplants

The PLAN provides benefits for transplants, including HOSPITAL and professional services for covered transplant procedures. The PLAN provides care management for transplant services and will help you find a HOSPITAL or Blue Distinction Centers for Transplants that provides the transplant services required. Travel and lodging expenses may be reimbursed up to a $10,000 maximum per transplant based on Blue Cross NC guidelines that are available upon request from a transplant coordinator.

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

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

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

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

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

Transplants Exclusions

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

Blue Distinction® Centers

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

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

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

Mental Health and Substance Use Disorder Services

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

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

How to Access Mental Health and Substance Use Disorder Services

PRIOR REVIEW is not required for any OFFICE VISIT services or in EMERGENCY situations; however, please notify Blue Cross NC of an EMERGENCY inpatient admission as soon as reasonably possible.

PRIOR REVIEW and CERTIFICATION are required for inpatient (including RESIDENTIAL TREATMENT FACILITY services) or certain outpatient services by Blue Cross NC, failure to request PRIOR REVIEW and receive CERTIFICATION may result in allowed charges being reduced by $500. See PRIOR REVIEW and CERTIFICATION number listed in "Who to Contact?" Information about which services require PRIOR REVIEW as well as a list of IN-NETWORK PROVIDERS can be found online at **https://www.BlueCrossNC.com/content/services/medical-policy/index.htm** or you can call Blue Cross NC Customer Service or the mental health phone number on the back of your ID

CARD. See "PRIOR REVIEW (Pre-Service)" in "UTILIZATION MANAGEMENT" for additional information.

Mental Health and Substance Use Disorder Services Exclusion

- Counseling with relatives about a patient.

WHAT IS NOT COVERED?

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

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

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

A

Acupuncture and acupressure

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

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

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

B

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

C

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

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

COSMETIC services: the removal of excess skin from any area of the body (except panniculectomy), skin tag excisions, cryotherapy, dermabrasion and/or chemical exfoliation for acne and acne scarring, injection of dermal fillers, removal of wrinkles (facelift), services for hair transplants, skin tone enhancements, electrolysis, liposuction/lipectomy from head, neck, trunk/buttocks, and SURGERY for psychological or emotional reasons, except as specifically covered by the PLAN.

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

Custodial care designed essentially to assist an individual with activities of daily living, with or without routine nursing care and the supervisory care of a DOCTOR. While some skilled services may be provided, the patient does not require continuing skilled services 24 hours daily. The individual is not under specific medical, surgical, or psychiatric treatment to reduce a physical or mental disability to the extent necessary to enable the patient to live outside either the institution or the home setting with substantial assistance and supervision, nor is there reasonable likelihood that the disability will be reduced to that level even with treatment. Custodial care includes, but is not limited to, help in walking, bathing, dressing, feeding, preparation of special diets and supervision over medications that could otherwise be self-administered. Such services and supplies are custodial as determined by Blue Cross NC without regard to the place of service or the PROVIDER prescribing or providing the services.

D

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

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

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

Evaluation and treatment of **DEVELOPMENTAL DYSFUNCTION** and/or learning differences

The following **drugs**:

- PRESCRIPTION DRUGS except as specifically covered in the PLAN

E

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

The following **equipment:**

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

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

F

ROUTINE **FOOT CARE** that is 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

Certain **home health care** services, including, but not limited to: homemaker services, such as cooking, and housekeeping; dietitian services or meals; services that are provided by a close relative or a member of your household.

Hypnosis except when used for control of acute or chronic pain

I

Inpatient admissions primarily for the purpose of receiving diagnostic services or a physical examination. Inpatient admissions primarily for the purpose of receiving therapy services,

except when the admission is a continuation of treatment following care at an inpatient facility for an illness or accident requiring therapy.

Inpatient confinements that are primarily intended as a change of environment

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

M

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

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

N

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

O

The following **obesity** services:

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

P

Body **piercing**

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

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

R

The following **residential care** services:

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

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

S

Services or supplies that are:

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

SEXUAL DYSFUNCTION not due to organic disease

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

T

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

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

The following types of **therapy:**

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

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

V

The following **vision** services:

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

Vitamins, food supplements or replacements, nutritional or dietary supplements, formulas or special foods of any kind, including medical foods with a PRESCRIPTION, or certain over-the-counter medications that may be available under your PREVENTIVE CARE benefits for certain individuals.

W

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

WHEN COVERAGE BEGINS AND ENDS

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

Table of Contents:	**Key Words:**
• Enrolling in the PLAN • Adding or Removing a DEPENDENT • Qualified Medical Child Support Order • Type(s) of coverage • Reporting Changes • Continuing Coverage • Termination of MEMBER coverage	• EMPLOYEE • DEPENDENTS • PLAN ADMINISTRATOR

- You are eligible to enroll in the Standard Plan if you are classified as a full-time associate of the employer who is reasonably expected to work on average 30 hours or more per week. You are eligible for coverage as of your date of hire. You have 31 days to enroll for coverage from your date of hire. If you are an associate who is initially classified as part-time, variable, or seasonal, you are generally not eligible to enroll in the Standard Plan. However, but you may become eligible if the employer determines that your average work schedule over a 11 month initial or 12 month standard period (whichever is applicable) is 30 or more hours per week. You will retain your eligibility for a limited period (generally, through the calendar year) after you change from full time to part time employment provided you pay the associate contribution. If you want to cancel this limited period of coverage, you will need to contact HR Shared Services. When your coverage ends because of the change from full time to part time, you will also be offered the right to elect up to 18 months of COBRA continuation coverage under the Standard Plan at the COBRA cost.
- The employer keeps track of your hours and determines your eligibility in accordance with rules under the Affordable Care Act. If you have questions about your eligibility or your weekly average hours determination, please contact the HR Shared Services.
- Your spouse, as defined in the "Glossary," unless your SPOUSE is eligible for medical coverage through his or her employer
- Your domestic partner, so long as you and your domestic partner have attested to the PLAN ADMINISTRATOR, in writing to the following:
    1. That you and your domestic partner are both mentally competent
    2. That you and your domestic partner are both at least the age of consent for marriage in the state where you are a resident
    3. That you and your domestic partner are not related by blood to a degree of closeness that would prohibit legal marriage in the state where you are a resident

4. That you and your domestic partner are not married to anyone else under either statutory or common law.
5. That you and your domestic partner are mutually responsible for the cost of basic living expenses as evidenced by joint home ownership/lease of a residence, common investments, or some other similar evidence of financial interdependence
6. That you and your domestic partner live together and intend to do so permanently
7. That you do not currently have a domestic partner covered under the PLAN
8. That you have not been in an exclusive, committed relationship for at least 12 months before adding this domestic partner unless the previous domestic partnership was terminated by death.

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

- You or your spouse's or your domestic partner's DEPENDENT CHILD through the end of the month of their 26th birthday, including a natural child, stepchild, a legally adopted child, a child placed for foster care or adoption or a child for whom health coverage is required through a Qualified Medical Child Support Order or other court administrative order where you or your spouse are the court appointed legal.
- A DEPENDENT CHILD age 26 or over who is or becomes disabled and dependent upon you and who has been continuously disabled by a physical or mental condition that began before age 26.

You or your SPOUSE, domestic partner or dependent child must meet the definition of an eligible dependent to be covered under the applicable benefit Standard Plan. The employer reserves the right to collect documentation and have you to complete an affidavit regarding dependent status at least annually and as a new hire. Correct and accurate completion of the affidavit and document request is a condition of eligibility. Please understand that the Standard Plan is relying on your representation of eligibility in accepting the enrollment of you and your Dependents. Your failure to correctly complete these enrollment materials and to provide required evidence of eligibility is evidence of fraud and material misrepresentation and may result in retroactive disenrollment of an individual. Note: An eligible domestic partner must sign an Affidavit of Domestic Partnership, guaranteeing that your partnership meets all eligibility requirements. The Associate and domestic partner must jointly sign the Affidavit furnished documents to support financial interdependence for the plan year.

Proof of eligibility may include:

- copies of social security cards for spouse and dependents.
- marriage license, in the case of spousal coverage
- birth certificates and/or tax forms indicating the ages and dependent relationship to you, in the case of qualified dependents

To be eligible for coverage under the Standard Plan, a Dependent must reside within the United States. Note: Your Dependents may not enroll in the Standard Plan unless you are also enrolled. If you and your spouse are both covered under the Standard Plan, you may each be enrolled as a participant or be covered as a dependent of the other person, but not both. In addition, if you and your spouse are both covered under the Standard Plan, only one parent may enroll your child as a Dependent.

A Dependent also includes a child for whom health care coverage is required through a Qualified Medical Child Support Order or other court or administrative order.

How to Enroll

Visit HYPERLINK "http://www.mybelkbenefits.com" www.mybelkbenefits.com to enroll from home or work.

- Click on tab – New To Belk
- Click on Learn More
- Click on Enroll in Benefits and follow instructions

If you need help in enrolling, please talk to your HR representative or contact HR Shared Services at HYPERLINK " mail to: HRsharedservices@belk.com" HRsharedservices@belk.com or 1-800-588-3700.

If you do not enroll within 31 days, you will need to wait until the next annual Open Enrollment to make your benefit elections.

Each year during annual Open Enrollment, you will have the opportunity to review and change your medical election. Any changes you make during Open Enrollment will become effective the following January 1.

Adding or Removing a DEPENDENT

Do you want to add or remove a DEPENDENT? You can add or remove a DEPENDENT by logging into your Workday account and following the instructions or contact HR Shared Services for assistance.

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

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

DEPENDENTS may be removed from coverage by logging into your Workday account and by completing the proper form or contacting HR Shared Services for assistance. 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 remove a DEPENDENT could result in loss of eligibility for continuation of coverage.

Qualified Medical Child Support Order

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

Types of Coverage

These are the types of coverage available:

- Associate-only coverage—The Standard Plan covers only you
- Associate-spouse coverage—The Standard Plan covers you and your spouse or domestic partner
- Associate-children coverage—The Standard Plan covers you and your or your domestic partner's DEPENDENT CHILD(REN)
- Associate Family coverage—The Standard Plan covers you, your spouse or domestic partner's child(ren) and your DEPENDENT CHILDREN.

Cost of Coverage

You and the EMPLOYER share in the cost of the Standard Plan. Your contribution amount depends on the family members you choose to enroll.

Your contributions are deducted from your paychecks on a before-tax basis. Premiums for coverage of domestic partners and/or partner's child(ren) are After-Tax and are also subject to imputed income. Before-tax dollars come out of your pay before federal income and Social Security taxes are withheld--and in most states, before state and local taxes are withheld. This gives your contributions a special tax advantage and lowers the actual cost to you.

Your contributions are subject to review and the EMPLOYER reserves the right to change your contribution amount from time to time.

You can obtain current contribution rates by calling HR Shared Services.

Reporting Changes

Have you moved, added or changed other health coverage, changed your name or phone number? If so, log into your Workday account and complete the proper form or contact HR Shared Services for assistance. It will help assure better service if Blue Cross NC is kept informed of these changes.

Continuing Coverage

Under certain circumstances, your eligibility for coverage under this PLAN may end.

You may have certain options such as enrolling in Medicare or continuing health insurance under this PLAN. Coverage available during a leave of absence varies depending on the type of leave you take and your EMPLOYER'S leave of absence policy. Contact your Human Resources department for more information.

Medicare

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

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

Continuation Under Federal Law

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

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

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

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

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

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

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

You or your DEPENDENTS must notify the PLAN ADMINISTRATOR within 60 days of the following qualifying life event (QLE):

- Divorce
- Ineligibility of a DEPENDENT CHILD.

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

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

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

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

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

Certificate of CREDITABLE COVERAGE

The PLAN ADMINISTRATOR or its designee will supply a Certificate of CREDITABLE COVERAGE when your or your DEPENDENT'S coverage under the PLAN ends or you exhaust continuation of coverage. Keep the Certificate of CREDITABLE COVERAGE in a safe place.

You may request a Certificate of CREDITABLE COVERAGE from Blue Cross NC Customer Service while you are still covered under the PLAN and up to 24 months following your termination.

You may call Blue Cross NC Customer Service at 1-800-422-2717 (toll-free), or visit Blue Cross NC's website at **www.BlueCrossNC.com.**

Termination of MEMBER Coverage

Blue Cross NC will terminate coverage under the PLAN in accordance with eligibility information provided by the EMPLOYER. A MEMBER'S termination shall be effective at 11:59 p.m. on the date that eligibility ends. See the beginning of "When Coverage Begins and Ends" section.

Termination for Cause

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

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

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

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

- Fraud or intentional misrepresentation of a material fact by a MEMBER or DEPENDENT. However, if such termination is made retroactively, including back to the EFFECTIVE DATE of your policy (called a rescission), you will be given 30 days advance written notice of this rescission and may submit an appeal; see "Need to Appeal a Decision?" If your policy is rescinded, any premiums paid will be returned unless Blue Cross NC deducts the amount for any claims paid.
- A MEMBER has been convicted of (or a restraining order has been issued for) communicating threats of harm to Blue Cross NC personnel or property
- A MEMBER permits the use of his or her or any other MEMBER'S ID CARD by any other person not enrolled under this PLAN, or uses another person's ID CARD.

UTILIZATION MANAGEMENT

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

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

The UM program requires certain health care services to be reviewed and approved by Blue Cross NC in order to receive benefits. As part of this process, Blue Cross NC looks at whether health care services are MEDICALLY NECESSARY, given in the proper setting and for a reasonable length of time. Blue Cross NC will honor a CERTIFICATION to cover medical services or supplies under the PLAN unless the CERTIFICATION was based on:

- A material misrepresentation about your health condition
- You were not eligible for these services under the PLAN due to cancellation of coverage (including your voluntary termination of coverage)
- Nonpayment of premiums.

Rights and Responsibilities Under the UM Program

Your MEMBER Rights

Under the UM program, you have the right to:

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

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

Blue Cross NC's Responsibilities

As part of all UM decisions, Blue Cross NC will:

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

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

PRIOR REVIEW (Pre-Service)

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

IN-NETWORK PROVIDERS in North Carolina will request PRIOR REVIEW when necessary. IN-NETWORK inpatient facilities outside of North Carolina will also request PRIOR REVIEW for you, except for Veterans' Affairs (VA) and military PROVIDERS. If you go to any other PROVIDER outside of North Carolina or to an OUT-OF-NETWORK PROVIDER in North Carolina, you are responsible for ensuring that you or your PROVIDER requests PRIOR REVIEW by Blue Cross NC. Approval of a pre-service review for services to be provided by an OUT-OF-NETWORK PROVIDER does not guarantee payment of the OUT-OF-NETWORK PROVIDER'S billed charges. The PLAN pays the ALLOWED AMOUNT for COVERED SERVICES rendered by an OUT-OF-NETWORK PROVIDER. **Failure to request PRIOR REVIEW and receive CERTIFICATION will result in a penalty.**

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

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

General categories of services requiring PRIOR REVIEW and CERTIFICATION are noted in "COVERED SERVICES." To determine if a specific service requires PRIOR REVIEW and CERTIFICATION, visit Blue Cross NC's website at **www.BlueCrossNC.com** for the PRIOR REVIEW list, which is updated when new services are added or when

services are removed. You can also call Blue Cross NC Customer Service at the number listed in "Who to Contact?"

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

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

Urgent PRIOR REVIEW

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

If Blue Cross NC needs more information to process your urgent review, Blue Cross NC will let you and your PROVIDER know of the information needed as soon as possible but no later than 24 hours following the receipt of your request. You will then be given a reasonable amount of time, but not less than 48 hours, to provide the requested information. Blue Cross NC will make a decision on your request within a reasonable time but no later than 48 hours after receipt of requested information or within 48 hours after the time period given to the PROVIDER to submit necessary clinical information, whichever comes first.

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

Concurrent Reviews

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

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

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

Urgent Concurrent Review

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

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

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

Retrospective Reviews (Post-Service)

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

Blue Cross NC will make all retrospective review decisions and let you and your PROVIDER know of its decision within a reasonable time but no later than 30 calendar days from the date Blue Cross NC received the request for coverage. If more information is needed, before

the end of the initial 30-day period, Blue Cross NC will let you know of the information needed. You will then have 90 days to provide the requested information. As soon as Blue Cross NC gets the requested information, or at the end of the 90 days, whichever is earlier, Blue Cross NC will make a decision within 15 calendar days. Regardless if additional information is needed, in the event of a NONCERTIFICATION, Blue Cross NC will let you and your PROVIDER know in writing within five business days after making the NONCERTIFICATION.

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

Care Management

MEMBERS with complicated and/or chronic medical needs may be eligible for care management services.

Care management (case management as well as disease management) encourages MEMBERS with complicated or chronic medical needs, their PROVIDERS, and the PLAN to work together to meet the individual's health needs and promote quality outcomes.

To accomplish this, MEMBERS enrolled in or eligible for care management programs may be contacted by Blue Cross NC or by a representative of Blue Cross NC. The PLAN is not obligated to give the same benefits or services to a MEMBER at a later date or to any other MEMBER. Information about these services can be found by calling Blue Cross NC Customer Service. You may also want to talk with your PCP or SPECIALIST.

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

Continuity of Care

Continuity of care is a process that allows you to continue receiving care from an OUT-OF-NETWORK PROVIDER for ongoing special conditions at the IN-NETWORK benefit level when your PROVIDER is no longer in the Blue Options network. If your PCP or SPECIALIST leaves the Blue Cross NC PROVIDER network and they are currently treating you for an ongoing special condition that meets Blue Cross NC continuity of care criteria, Blue Cross NC will notify you 30 days before the PROVIDER'S termination, as long as Blue Cross NC receives timely notification from the PROVIDER. To be eligible for continuity of care, the MEMBER must be actively being seen by the OUT-OF-NETWORK PROVIDER for an ongoing special condition and the PROVIDER must agree to abide by the Blue Cross NC 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 60 days 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 Blue Cross NC within 60 days of the PROVIDER termination date. Continuity of care requests will be reviewed by a medical professional based on the information given about specific medical conditions. If your continuity of care request is denied, you may request a review through our appeals process (see "Need to Appeal a Decision?"). Claims for approved continuity of care services will be subject to the IN-NETWORK benefit. In these situations, benefits are based on the billed amount. However, you may be responsible for charges billed separately by the PROVIDER which are not eligible for additional reimbursement. Continuity of care will not be given when the PROVIDER'S contract was terminated for reasons relating to quality of care or fraud. Such a decision may not be reviewed on appeal.

Please call Blue Cross NC Customer Service at the number listed in "Who to Contact?" for more information.

Delegated UTILIZATION MANAGEMENT

Blue Cross NC delegates certain UM services for particular benefits to other companies not associated with Blue Cross NC. Please see **https://www.BlueCrossNC.com/content/services/medical-policy/index.htm** for a detailed list of these companies and benefits. While some benefits have been identified under "COVERED SERVICES," the list of benefits and/or companies may change from time to time; for the most up-to-date information visit **www.BlueCrossNC.com** and search for "PRIOR REVIEW" for additional information, including those services subject to PRIOR REVIEW and CERTIFICATION.

NEED TO APPEAL A DECISION?

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

Table of Contents:	**Key Words:**
• Steps to Follow • Internal Appeals • External Review	• ADVERSE BENEFIT DETERMINATION • GRIEVANCE • MEDICALLY NECESSARY

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

If you want to appeal an ADVERSE BENEFIT DETERMINATION or have a GRIEVANCE, you can request that Blue Cross NC review the decision or GRIEVANCE. The process may be requested by the MEMBER or an authorized representative acting on the MEMBER'S behalf with the MEMBER's written consent. In the event you name an authorized representative, "you" under this section means "you or your authorized representative." Your representative will also receive all notices and benefit determinations from the appeal.

You may also ask for, at no charge, reasonable access to, and copies of all documents, records and other information relevant to your claim for benefits. Additionally, you will be provided with, at no charge, any new or additional evidence that is relied upon or generated by the PLAN or Blue Cross NC in connection with the claim being appealed. Please see the end of this section for contact information. References to Blue Cross NC throughout this section refer to Blue Cross NC or the designee.

Steps to Follow in the Appeals Process

For each step in this process, there are set time frames for filing an appeal and for letting you or your PROVIDER know of the decision. The type of ADVERSE BENEFIT DETERMINATION or GRIEVANCE will determine the steps that you will need to follow in the appeals process. For all appeals, the review must be requested in writing, within 180 days of an ADVERSE BENEFIT DETERMINATION or by the date listed on your Explanation of Benefits.

Any request for review should include:

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

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

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

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

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

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

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

After a request for review, a staff member who works in a separate department from the staff members who denied your first request will look at your appeal. The appeals staff members have not reviewed your case or information before. The denial of the initial claim will not have an effect on the review. If a claims denial is based on medical judgment, including determinations about whether a certain treatment, drug or other item is EXPERIMENTAL, INVESTIGATIONAL, or not MEDICALLY NECESSARY or appropriate, Blue Cross NC shall seek advice from a health care professional with an appropriate level of training and expertise in the field of medicine involved (as determined by Blue Cross NC). The health care professionals have not reviewed your case or information before.

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

Timeline for Appeals

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

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

First Level Appeal

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

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

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

Quality of Care Complaints

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

Second Level Appeal

Second Level Appeal Timeline

Blue Cross NC Notifies You	Within 10 business days after receipt of request

Second Level Appeal Meeting	Occurs within 45 days after receipt of request
Notice of the Appeal Meeting	15 days before the appeal meeting
Notice of Decision	7 days after the appeal meeting

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

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

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

Notice of Decision

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

- The specific reason(s) for the denial
- Reference to the specific health benefit plan provisions on which the decision is based
- A statement that the MEMBER is entitled to receive reasonable access to, and copies of, all documents, records and other information relevant to the MEMBER'S claim for benefits upon request at no additional cost
- If applicable, a statement describing any voluntary appeals procedures and the MEMBER'S right to receive information about the procedures as well as the MEMBER'S

right to bring a civil action under Section 502(a) of ERISA following an adverse determination upon review

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

Expedited Appeals (Available only for NONCERTIFICATIONS)

You have the right to a more rapid or expedited review of a NONCERTIFICATION if a delay: (i) would reasonably appear to seriously jeopardize your or your DEPENDENT'S life, health or ability to regain maximum function; or (ii) in the opinion of your PROVIDER, would subject you or your DEPENDENT to severe pain that cannot be adequately managed without the requested care or treatment. You can request an expedited second level review even if you did not request that the initial review be expedited. To start the process of an expedited appeal, you can call Blue Cross NC Customer Service at the number given in "Who to Contact?" An expedited review will take place in consultation with a medical DOCTOR. All of the same conditions for a first level or second level appeal apply to an expedited review. Blue Cross NC will communicate the decision by phone to you and your PROVIDER as soon as possible, taking into account the medical circumstances. The decision will be communicated no later than 72 hours after receiving the request. A written decision will be communicated within four days after receiving the request for the expedited appeal. Information initially given by telephone must also be given in writing.

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

External Review

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

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

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

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

Expedited External Review

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

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

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

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

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

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

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

ADDITIONAL TERMS OF YOUR COVERAGE

This section provides information on:

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

Benefits to which MEMBERS are Entitled

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

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

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

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

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

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

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

Administrative Discretion

Blue Cross NC, the employer and for prescription drug purposes, Express Scripts, have the authority to use their sole discretion to make determinations in the administration of coverage. These determinations shall be final and binding on all persons. Blue Cross determinations include decisions regarding coverage of services, care, treatment or supplies, and reasonableness of charges. Blue Cross NC medical policies are guides considered when making coverage determinations. The EMPLOYER determinations made in the Employer's sole discretion include decisions on eligibility.

North Carolina PROVIDER Reimbursement

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

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

PROVIDERS may bill you directly. If you are billed, you will be responsible for paying the bill and filing a claim with Blue Cross NC.

Services Received Outside of North Carolina

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

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

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

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

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

This "negotiated price" can be:

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

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

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

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

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

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

Value-Based Programs: BlueCard® Program

If you receive COVERED SERVICES under a Value-Based Program inside a Host Blue's service area, you will not be responsible for paying any of the PROVIDER Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host

Blue passes these fees to Blue Cross NC through average pricing or fee schedule adjustments.

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

Blue Cross Blue Shield Global Core:

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

If you need medical assistance services (including locating a DOCTOR or HOSPITAL) outside the BlueCard service area, you should call the service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

Inpatient Services

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

Outpatient Services

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

Submitting a Blue Cross Blue Shield Global Core Claim

When you pay for COVERED SERVICES outside the BlueCard service area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a claim form and send the claim form with the PROVIDER'S itemized bill(s) to the service center (the address is on the form) to initiate claims processing. Following the

instructions on the claim form will help ensure timely processing of your claim. The claim form is available from Blue Cross NC, the service center or online at **www.BCBSglobalcore.com**. If you need assistance with your claim submission, you should call the service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week.

Right of Recovery Provision

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

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

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

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

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

In addition, if a MEMBER receives any payment from any potentially responsible party as a result of an injury, illness or condition, the PLAN has the right to recover from, and be reimbursed by, the MEMBER for all amounts the PLAN has paid and will pay as a result of that injury or illness, up to and including the full amount the MEMBER receives from all potentially

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

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

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

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

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

The MEMBER acknowledges that Blue Cross NC has been delegated authority by the PLAN ADMINISTRATOR to assert and pursue the right of subrogation and/or reimbursement on behalf of the PLAN. The MEMBER shall fully cooperate with Blue Cross NC's efforts to recover benefits paid by the PLAN. It is the duty of the MEMBER to notify Blue Cross NC in writing of

the MEMBER'S intent to pursue a claim against any potentially responsible party, within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of the intention to pursue or investigate a claim to recover damages or obtain compensation due to injuries or illness sustained by the MEMBER. The MEMBER and their agents agree to provide the PLAN or its representatives notice of any recovery the MEMBER or the MEMBER'S agents obtain prior to receipt of such recovery funds or within 5 days if no notice was given prior to receipt. Further, the MEMBER and the MEMBER'S agents shall provide notice prior to any disbursement of settlement or any other recovery funds obtained. The MEMBER shall provide all information requested by Blue Cross NC or its representative including, but not limited to, completing and submitting any applications or other forms or statements as Blue Cross NC may reasonably request and all documents related to or filed in personal injury litigation.

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

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

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

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

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

Recovery of Overpayment

If the amount of the payments made by Blue Cross NC is more than it should have paid under the PLAN, it may recover the excess from one or more of the persons it has paid or for whom it has paid, or any other person or organization that may be responsible for the

benefits or services provided for the MEMBER. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Notice of Claim

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

Notice of Benefit Determination

Blue Cross NC will provide an explanation of benefits determination to the MEMBER or the MEMBER'S authorized representative within 30 days of Blue Cross NC's receipt of a notice of claim if the MEMBER has financial liability on the claim other than a copayment or other services where payment was made at the point of service (unless the PLAN has chosen to provide an explanation of benefits for additional claims where the MEMBER does not have a financial liability other than a copayment).

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

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

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

Upon receipt of a denial of benefits, you have the right to file an appeal with Blue Cross NC. See "Need To Appeal a Decision?" for more information.

Limitation of Actions

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

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

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

Evaluating New Technology

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

Coordination of Benefits (Overlapping Coverage)

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

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

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

insurance plan that determines benefits first is called the primary insurance plan. The other insurance plan is called the secondary insurance plan.

Benefits paid by the secondary insurance plan may be reduced to avoid paying benefits between the two plans that are greater than the cost of the health care service. Most health insurance plans include a COB provision. Payment by Blue Cross NC under the PLAN takes into account whether or not the PROVIDER is a participating PROVIDER. If the PLAN is the secondary plan, and the MEMBER uses a participating PROVIDER, the PLAN will coordinate up to the ALLOWED AMOUNT. The participating PROVIDER has agreed to accept the ALLOWED AMOUNT as payment in full.

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

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

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

Important Information for MEMBERS Eligible for Medicare

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

you become eligible for Medicare and are unsure about how the PLAN will coordinate benefits with Medicare, please contact your PLAN ADMINISTRATOR for more information.

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

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

When a person is covered by 2 group health plans, and	Then	Primary	Secondary
have responsibility for the DEPENDENT CHILD's health care coverage; or 4) divorced/separated or not living together with no court decree for coverage for the DEPENDENT CHILD'S health care coverage and the person is age 18 or older	The plan of the parent whose birthday is later in the calendar year is		√
	Note: When the parents have the same birthday, the plan that covered the parent longer is *Exception: If DEPENDENT CHILD is age 18 or older the *birthday rule will be used to determine primary only if the parents are still married or living together.*	√	
The person is covered as a DEPENDENT CHILD under both plans and parents are divorced/separated or not living together with no court decree* for coverage	The custodial parent's plan is	√	
	The plan of the spouse of the custodial parent is		√
	Or, if the custodial parent covers the child through their spouse's plan, the plan of the spouse is	√	
	The non-custodial parent's plan is		√
	Note: The custodial parent is considered to be the parent awarded custody of a child by a court decree; or in the absence of a court decree, the parent with whom the child resides more than one half of the calendar year. Unless otherwise stated, a court decree is not applicable to a DEPENDENT CHILD age 18 years or older. If a court decree does specify coverage over the age of 18 the court decree will succeed any prior rule.*		
The person is covered as a DEPENDENT CHILD under both plans and parents are divorced/separated or not living together, and	The plan of the parent primarily responsible for health coverage under the court decree is	√	

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

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

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

FEDERAL NOTICES

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

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

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

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

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

Mastectomy Benefits

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

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

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

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

Important Notice of Special Enrollment

If you are declining enrollment for yourself or your DEPENDENTS (including your spouse) because of other health insurance (including Medicaid or Children's Health Insurance Program (CHIP)) or group health plan coverage, you may be able to enroll yourself and the DEPENDENTS in this PLAN if you or your DEPENDENTS lose eligibility for that other coverage (or

if the employer stops contributing towards your or your DEPENDENTS' other coverage). However, you must request enrollment within 30 days after your or your DEPENDENTS' other coverage ends (other than Medicaid or CHIP) or if the employer stops contributing towards your or your DEPENDENTS' other coverage and within 60 days after the loss of Medicaid or CHIP eligibility.

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

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

Programs Outside Your Regular Benefits

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

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

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

Health and Wellness Programs

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

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

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

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

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

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

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

Health Information Services

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

GLOSSARY

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

ADAPTIVE BEHAVIOR TREATMENT

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

ADVERSE BENEFIT DETERMINATION

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

ALLOWED AMOUNT

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

AMBULATORY INFUSION SUITE

An Ambulatory Infusion Suite is a free-standing facility that solely provides infusion services under the supervision of a nurse or medical director.

AMBULATORY SURGICAL CENTER

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

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

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

c) Does not provide inpatient accommodations

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

ANCILLARY PROVIDER

Independent clinical laboratories, durable/home medical equipment and supply PROVIDERS. 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.

BENEFIT PERIOD

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

BENEFIT PERIOD MAXIMUM

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

CERTIFICATION

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

COMPLICATIONS OF PREGNANCY

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

CONGENITAL

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

COSMETIC

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

COVERED SERVICE(S)

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

CREDITABLE COVERAGE

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

DENTAL SERVICE(S)

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

DENTIST

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

DEPENDENT

Your eligible Dependents may also participate in the Standard Plan. An eligible Dependent is considered to be:

- Your Spouse, as defined in the Glossary, unless your Spouse is eligible for medical coverage through his or her employer
- Your or your Spouse's child who is under age 26, including a natural child, stepchild, a legally adopted child, a child placed for foster care or adoption or a child for whom health coverage is required through a Qualified Medical Child Support Order or other court administrative order you or your Spouse are the court appointed legal.
- A child age 26 or over who is or becomes disabled and dependent upon you and who has been continuously disabled by a physical or mental condition that began before age 26.

DEPENDENT CHILD(REN)

A child, until the end of the month of their 26th birthday, who is either: 1) the EMPLOYEE'S biological child, stepchild, legally adopted child (or child placed with the EMPLOYEE and/or spouse or domestic partner for adoption), FOSTER CHILD, or 2) a child for whom legal guardianship has been awarded to the EMPLOYEE and/or spouse or domestic partner, or 3) a child for whom the EMPLOYEE and/or spouse or domestic partner is required by court or administrative order to provide coverage. The spouse or children of a dependent child are not considered DEPENDENTS.

DEVELOPMENTAL DYSFUNCTION

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

teach a member the activities of daily living, to use small muscle skills or balance or to assist with behavior or achievement in the learning setting.

DOCTOR

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

DURABLE MEDICAL EQUIPMENT

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

EDUCATIONAL TREATMENT

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

EFFECTIVE DATE

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

EMERGENCY(IES)

A medical condition manifesting itself by acute symptoms of sufficient severity, including, but not limited to, severe pain, or by acute symptoms developing from a chronic medical condition that would lead a prudent layperson, possessing an average knowledge of health and medicine, to reasonably expect the absence of immediate medical attention to result in any of the following:

a) placing the health of an individual, or with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy,

b) serious impairment to bodily functions,

c) serious dysfunction of any bodily organ or part.

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

EMERGENCY SERVICES

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

EMPLOYEE

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

EMPLOYER

Belk Stores Services, LLC.

ERISA

The Employee Retirement Income Security Act of 1974, as amended.

ESSENTIAL HEALTH BENEFITS

The core set of services as defined by federal law that includes the following ten categories: (1) ambulatory patient services, (2) EMERGENCY SERVICES, (3) hospitalization, (4) maternity and newborn care, (5) mental health and substance use disorder services, including behavioral health treatment, (6) REHABILITATIVE THERAPY and HABILITATIVE SERVICES and devices, (7) laboratory services, (8) preventive and wellness services and chronic disease management, and (9) pediatric services, including oral and vision care. No annual or lifetime dollar limits can apply to essential health benefits.

EXPERIMENTAL

See INVESTIGATIONAL.

FACILITY SERVICES

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

FOSTER CHILD(REN)

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

GRIEVANCE

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

HABILITATIVE SERVICES

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

HOMEBOUND

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

HOME HEALTH AGENCY

A NONHOSPITAL FACILITY which is primarily engaged in providing home health care services, medical or therapeutic in nature, and which:

a) Provides skilled nursing and other services on a visiting basis in the MEMBER'S home,

b) Is responsible for supervising the delivery of such services under a plan prescribed by a DOCTOR,

c) Is accredited and licensed or certified in the state where located,

d) Is certified for participation in the Medicare program, and

e) Is acceptable to Blue Cross NC.

HOSPICE

A NONHOSPITAL FACILITY that provides medically related services to persons who are terminally ill, and which:

a) Is accredited, licensed or certified in the state where located,

b) Is certified for participation in the Medicare program, and

c) Is acceptable to Blue Cross NC.

HOSPITAL

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

IDENTIFICATION CARD (ID CARD)

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

INCURRED

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

INFERTILITY

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

IN-NETWORK

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

IN-NETWORK PROVIDER

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

INVESTIGATIONAL (EXPERIMENTAL)

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

a) Services or supplies requiring federal or other governmental body approval, such as drugs and devices that do not have unrestricted market approval from the U.S. Food and Drug Administration (FDA) or final approval from any other governmental regulatory body for use in treatment of a specified condition. Any approval that is granted as an interim step in the regulatory process is not a substitute for final or unrestricted market approval.

b) There is insufficient or inconclusive scientific evidence in peer-reviewed medical literature to permit Blue Cross NC's evaluation of the therapeutic value of the service or supply

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

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

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

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

LICENSED PRACTICAL NURSE (LPN)

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

LIFETIME MAXIMUM

The benefit maximum of certain COVERED SERVICES that will be reimbursed on behalf of a MEMBER while covered under the PLAN. Services in excess of any lifetime maximum are not COVERED SERVICES, and MEMBERS may be responsible for the entire amount of the PROVIDER'S billed charge. See "Summary of Benefits" for any limits that may apply.

MEDICAL SUPPLIES

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

MEDICALLY NECESSARY (or MEDICAL NECESSITY)

Those COVERED SERVICES or supplies that are:

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

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

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

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

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

MEMBER

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

MENTAL ILLNESS

(1) When applied to an adult MEMBER, an illness which so lessens the capacity of the individual to use self-control, judgment, and discretion in the conduct of his/her affairs and social relations as to make it necessary or advisable for him/her to be under treatment, care, supervision, guidance, or control; and (2) when applied to a DEPENDENT CHILD, in accordance with North Carolina law, a mental condition, other than intellectual disability alone, that so impairs the DEPENDENT CHILD'S capacity to exercise age adequate self-control or judgment in the conduct of his/her activities and social relationships so that he/she is in need of treatment; and a mental disorder defined in the current edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, Washington, DC ("DSM-V"). Those mental disorders coded in the DSM-V as autism spectrum disorder, substance-related disorders, SEXUAL DYSFUNCTION, and those coded as "V" codes are not included in the definition of mental illness.

NONCERTIFICATION

An ADVERSE BENEFIT DETERMINATION by Blue Cross NC that a service covered under the PLAN has been reviewed and does not meet Blue Cross NC's requirements for MEDICAL NECESSITY, appropriateness, health care setting, level of care or effectiveness or the prudent layperson standard for coverage of EMERGENCY SERVICES and, as a result, the requested service is denied, reduced or terminated. The determination that a requested service is EXPERIMENTAL, INVESTIGATIONAL or COSMETIC is considered a noncertification. A noncertification is not a decision based solely on the fact that the requested service is specifically excluded under your benefits.

NONHOSPITAL FACILITY

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

OFFICE VISIT

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

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

OTHER PROFESSIONAL PROVIDER

A person or entity other than a DOCTOR who is accredited and licensed or certified in the state where located to provide COVERED SERVICES, and which is acceptable to Blue Cross NC.

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

OTHER PROVIDER

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

OTHER THERAPY(IES)

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

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

b) Chemotherapy (including intravenous chemotherapy)—the treatment of malignant disease by chemical or biological antineoplastic agents which have received full, unrestricted market approval from the U.S. Food and Drug Administration (FDA)

c) Dialysis treatments—the treatment of acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body to include hemodialysis or peritoneal dialysis

d) Pulmonary therapy—programs that combine exercise, training, psychological support and education in order to improve the patient's functioning and quality of life

e) Radiation therapy—the treatment of disease by x-ray, radium, or radioactive isotopes

f) Respiratory therapy—introduction of dry or moist gases into the lungs for treatment purposes.

OUT-OF-NETWORK

Not designated as participating in the Blue Options network, and not certified in advance by Blue Cross NC to be considered as IN-NETWORK. Payment for out-of-network COVERED SERVICES is described in this benefit booklet as out-of-network benefits or out-of-network benefit levels.

OUT-OF-NETWORK PROVIDER

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

OUT-OF-POCKET LIMIT

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

OUTPATIENT CLINIC(S)

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

PLAN

The health care component program of the Belk Stores Services, LLC. Health & Welfare Plan.

PLAN ADMINISTRATOR

Belk Stores Services, LLC.

PLAN SPONSOR

Belk Stores Services, LLC.

POSITIONAL PLAGIOCEPHALY

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

PREVENTIVE CARE

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

PRIMARY CARE PROVIDER (PCP)

An IN-NETWORK PROVIDER who has been designated by Blue Cross NC as a PCP.

PRIOR REVIEW

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

PROSTHETIC APPLIANCES

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

PROVIDER

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

PROVIDER-ADMINISTERED SPECIALTY DRUGS

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

REGISTERED NURSE (RN)

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

REHABILITATIVE THERAPY

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

a) Occupational therapy—treatment by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those required by the person's particular occupational role after such ability has been impaired by disease, injury or loss of a body part

b) Physical therapy—treatment by physical means, hydrotherapy, heat or similar modalities, physical agents, biomechanical and neurophysiological principles and devices to relieve pain, restore maximum function and prevent disability following disease, injury or loss of a body part

c) Speech therapy—treatment for the restoration of speech impaired by disease, SURGERY, or injury; certain significant physical CONGENITAL conditions such as cleft lip and palate; or swallowing disorders related to a specific illness or injury.

RESIDENTIAL TREATMENT FACILITY

A residential treatment facility is a facility that either: (1) offers treatment for patients that require close monitoring of their behavioral and clinical activities related to their chemical

dependency or addiction to drugs or alcohol, or (2) offers treatment for patients that require psychiatric services for the diagnosis and treatment of MENTAL ILLNESS. All services performed must be within the scope of license or certification to be eligible for reimbursement.

RESPITE CARE

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

ROUTINE FOOT CARE

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

SEXUAL DYSFUNCTION

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

SKILLED NURSING FACILITY

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

SPECIALIST

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

SPOUSE

The person to whom the Participant is legally married under applicable state law.

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 pre-operative and post-operative care

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

URGENT CARE

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

UTILIZATION MANAGEMENT (UM)

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

WAITING PERIOD

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

OTHER IMPORTANT PLAN INFORMATION

Summary Plan Description

The following information, together with the information contained in the benefit booklet furnished to EMPLOYEES by the PLAN ADMINISTRATOR, is intended to furnish the Summary Plan Description required by Section 102 of the Employee Retirement Income Security Act of 1974 (ERISA):

Name and Number of PLAN(S)

Plan Number 522 - Group Health Plan for EMPLOYEES of Belk Stores Services, LLC Health & Welfare Plan

Name, Address and Telephone Number of PLAN SPONSOR

Belk Stores Services, LLC
2801 W TYVOLA RD
CHARLOTTE, NC 28217
(980) 949-2251

Employer Identification Number of PLAN SPONSOR

56-0616731

Identification of PLAN ADMINISTRATOR

Belk Stores Services, LLC
2801 W. Tyvola Road
Charlotte, NC 28217

Benefits Provided by PLAN(S)

Medical Insurance—The specific coverages provided by the PLAN are set forth in your benefit booklet.

Type of PLAN Administration

The general administration of the PLAN is contract administration provided by the PLAN SPONSOR under Policy Number 14163723 issued to the PLAN SPONSOR by Blue Cross and Blue Shield of North Carolina for medical claims and under a contract with Express Scripts for pharmacy claims.

Contributions to the Cost of the PLAN(S)

The cost of the medical plan is paid by the EMPLOYER and the EMPLOYEES.

Financial Records

The financial records of the PLAN(S) are kept on a PLAN year basis. Each PLAN year ends Dec 2022.

Agent for Service of Legal Process

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

ERISA Rights Statement

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

- Examine, without charge, at the PLAN ADMINISTRATOR'S office and at other specified locations, such as worksites, all PLAN documents, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the PLAN with the U.S. Department of Labor.
- Obtain, upon written request to the PLAN ADMINISTRATOR, copies of documents governing the operation of the PLAN, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Descriptions. The PLAN ADMINISTRATOR may make a reasonable charge for the copies.
- Receive a summary of the PLAN'S financial report. The PLAN ADMINISTRATOR is required by law to furnish each MEMBER with a copy of this summary annual report.
- Continue health care coverage for yourself, spouse or DEPENDENTS if there is a loss of coverage under the PLAN as a result of a QLE. You or your DEPENDENTS may have to pay for such coverage. Review this Summary Plan Description and the documents governing the PLAN on the rules governing your COBRA continuation coverage rights.

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

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

Other Information

In addition, federal law requires that the PLAN ADMINISTRATOR provide you certain administrative information about the PLAN. Please refer to the summary plan description for the Belk Stores, Services Health & Welfare Plan, which is provided in a separate document, for this information on the PLAN.

BLUE OPTIONS

Blue Cross NC MEMBER RIGHTS and RESPONSIBILITIES

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

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

As a Blue Cross NC MEMBER, you should:

- Present your Blue Cross NC ID CARD each time you receive a service
- Read your Blue Cross NC benefit booklet and all other Blue Cross NC MEMBER materials
- Call Blue Cross NC when you have a question or if the material given to you by Blue Cross NC is not clear

Blue Cross NC MEMBER RIGHTS and RESPONSIBILITIES (cont.)

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

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

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

Blue Cross NC does not administer these prescription drug benefits referenced in the schedule below. These benefits are separate from this plan.

ATTACHMENT I – EXPRESS SCRIPTS

Your prescription drug benefit program is administered by Express Scripts (Express Scripts)

All participants enrolled will receive an ID card from Express Scripts.

Important Contact Information for your Prescription Drug Plan

Prescription Drugs Home Delivery

EXPRESS SCRIPTS
PO BOX 747000
CINCINNATI, OH 45274-7000
Express Scripts Member Services: 1-800-797-2283
www.express-scripts.com/STARTHD
www.express-scripts.com

Prescription Claim Department

Express Scripts
ATTN: Commercial Claims
P.O. Box 14711
Lexington, KY 40512-4711

HOW THE PLAN WORKS

ELIGIBILITY AND PARTICIPATION

You are eligible for the prescription drug benefits described in this SPD if you are eligible for and enrolled in coverage under the Standard Plan coverage offered under the Plan. When you enroll in the Standard Plan in accordance with the Plan's procedures, you will automatically be enrolled in coverage for the prescription drug benefits described in this SPD.

Your prescription drug benefits coverage under the Plan will become effective on the same date your coverage under the Standard Plan begins, and your prescription drug benefits coverage under the Plan will end on the same date your coverage under the Standard Plan is terminated.

Generic versus Brand

A brand name drug is so called because the manufacturer that developed the drug and patented the drug has the right to "brand" the drug. Brand name drugs are expensive because the manufacturer wants to recover years of expense that go into the research and

development of the drug. The patent period varies, but can be as short as two years before generics of the drug can be manufactured.

A generic drug is a therapeutically equivalent copy of the brand name. Generics cannot be marketed until the brand name patent expires. Generics are much less expensive than brands because the manufacturer is not burdened with the high cost of research and development.

As an example, using over-the-counter medication to make the point, we've probably all seen Tylenol and Walmart acetaminophen side-by-side on the supermarket shelves. Tylenol is the "brand" and Walmart-packaged acetaminophen is the "generic." The generic is most often much less expensive than the brand, yet contains the same active ingredients. The same holds true for prescription drugs.

The brand name is the most recognized name. When your doctor writes a prescription, she or he writes the brand name on the prescription form because that is the familiar name your doctor knows. Your doctor may or may not be aware of therapeutically equivalent generic medications in the market, and usually will not know the names of all generics available in a specific therapeutic class. Your doctor permits or does not permit generic substitution when completing the prescription form. If your doctor wants you to have the brand name as written on the prescription form, she or he will indicate that so the pharmacist knows to dispense the brand name drug and not substitute any other product for it.

In situations where you have a choice, generics save you and the Company money. If you have a choice, but you do not choose the least expensive product, you will pay the difference between the brand and generic product plus the applicable brand copay. The HDHP Preventive drug list is a list of brand and generic drugs that have been approved by the Food and Drug Administration (FDA) to be used in the prevention of various medical conditions. Once implemented, brand drugs on the HDHP Preventive drug list will automatically bypass the deductible at the point-of-sale and process with the applicable copay or coinsurance. Generic preventive drugs are covered at 100%. The copay or coinsurance paid for all preventive drugs will accumulate toward the HDHP out of pocket limit.

Preferred Prescription Formulary

The Standard Plan uses a formulary or a list of commonly prescribed brand name and generic medications. These medications are selected because they can safely and effectively treat most medical conditions while helping to contain costs. The list of preferred medications is available online at www.express-scripts.com and is updated quarterly.

Your Choices

You can get your prescription drugs from a retail pharmacy or through the mail service program, depending on whether the prescription is a short-term or maintenance prescription.

The pharmacist will verify your eligibility electronically, review early refills, investigate drug-to-drug interaction and identify duplicate therapy.

When you need prescription drugs, you must use:

- A retail network pharmacy
- Express Scripts home delivery pharmacy, or
- Express Scripts Specialty Pharmacy

Retail Pharmacy Program

When You Use a Participating Pharmacy

When you present your ID card to a participating pharmacy, the pharmacy can fill your prescription for nonmaintenance medications – up to a 30-day supply. There are no claim forms for you to complete. The program pays the balance owed for your prescription, after you pay your copayment. You can get a list of participating pharmacies by calling Express Scripts at:

- **1-800-797-2283** or by accessing their Web site at **www.express-scripts.com**

The retail pharmacy program is typically for the purchase of short-term use medications that you need to purchase immediately, such as antibiotics or certain pain medications. You can receive up to a 30-day supply of medication at a time. You must present your ID card to the pharmacist when purchasing a prescription drug. The amount of your copayment depends on whether you purchase a generic or brand drug. Ask your doctor to consider prescribing an equivalent generic drug whenever possible, since you can get the same quality as a brand-name drug at a lower cost.

You have two ways to get up to a three-month supply of your long-term medications (those drugs you take regularly for ongoing conditions). You can conveniently fill those prescriptions either through home delivery from the Express Scripts Pharmacy or from any CVS pharmacy.

If you keep filling a one-month supply instead of a three-month supply, or if you're using a non-CVS pharmacy to fill your long-term medication, you'll pay the full cost for your medication.

When You Use a Non-Participating Pharmacy

When you visit a non-network pharmacy to get a prescription filled, you pay the full cost of your prescription drugs up front. Then, you must file a claim with Express Scripts for reimbursement. Once your claim is processed, you will receive reimbursement for the amount you paid minus the appropriate coinsurance.

Home Delivery through the Express Scripts Pharmacy

Prescription drugs that you use regularly are available by mail order for up to a 90-day supply. In general, you use the mail-order service for maintenance drugs – prescription medicines you take for extended periods or to treat or control a chronic condition. For example, you may take medicine daily to control high blood pressure, or relieve seasonal allergies.

To start using home delivery, you may do so by choosing between these easy options:

Call Express Scripts at the toll-free number on the back of your member ID card and let Express Scripts do all the work. For most medications, Express Scripts will be able to contact your doctor for you and arrange for your first mail-order supply.

Visit www.express-scripts.com/StartHD. After logging in, select "Transfer your retail prescriptions" to get started. The Express Scripts Pharmacy will contact your doctor for you to obtain a 90-day prescription.

Ask your doctor for a new prescription for up to a 90-day supply, plus refills for up to 1 year (if appropriate). Then, ask your doctor to electronically send the prescription to the Express Scripts Pharmacy.

To transfer any remaining maintenance medication refills from a retail pharmacy to home delivery, log in or register at Express-Scripts.com and look for "Transfer to Home Delivery" on the home page. Select the medications you'd like to transfer, click "Add to Cart" and checkout. Express Scripts does the rest.

Accredo Specialty Pharmacy

Specialty medications, are drugs that treat complex medical conditions and potentially have significant side effect profiles. Because of this, patients who take specialty medications require greater clinical oversight and attention. Medicines handled by a specialty pharmacy may be 1) injectable and infused, 2) high-cost, and 3) require special delivery and storage requirements (e.g., refrigeration). Prescriptions are limited to a 30-day supply.

Exclusive Specialty is in place for Express Scripts members because of the complexity associated with monitoring, handling and administrating specialty drugs for rare chronic conditions such as multiple sclerosis, rheumatoid arthritis, and cancer. Members are allowed to fill the first prescription of a specialty medication at retail, when available; however, all additional fills of the same medication must be purchased through the specialty mail pharmacy.

By filling specialty prescriptions through Accredo, you'll pay only your plan's copayment or coinsurance and receive a variety of specialized services – the kind that you may not get from your retail pharmacy.

- Safe, prompt delivery. Accredo will schedule and quickly ship all your specialty medications, including those that require special handling such as refrigeration.
- Personalized care. You'll have access to a team of specialty-trained pharmacists and nurses who are trained in your condition.
- Supplies. Most supplies, such as syringes, needles and sharps containers, will be provided with your medication.
- Support – 24/7. Specialty-trained pharmacists and nurses are available around the clock to answer your questions and will assist you in managing your condition.

- Refill reminders. Accredo will contact you regularly to schedule your next refill and see how your therapy is progressing. For convenience, some specialty medication refills can be ordered online, safely and securely, through Express-Scripts.com.
- Drug safety monitoring. As an Express Scripts pharmacy, Accredo can access your prescription information on file at all Express Scripts pharmacies to monitor for potential drug interactions and side effects of your medications.

UNDERSTANDING PRIOR AUTHORIZATION AND CLINICAL PROGRAMS

Managed Drug Limitation Program

In an effort to continue to offer a comprehensive prescription drug program, your benefit provider has put in place certain drug limits. In doing this, your benefit provider can better manage the high cost of certain drugs, yet not eliminate their coverage all together. Only when you have exceeded your benefit limit will you pay the full cost of your medication.

This program is used to assure an appropriate quantity is dispensed in keeping with the manufacturers and the FDA's recommendation and accepted medical practices. The limits on these drug classes only affect the amount your plan will pay for, not whether you can obtain greater quantities.

For certain drug classes, there is a limit on the quantity of that medication that the Plan will cover. However, if your physician determines that a greater quantity of a specific medication is appropriate for your treatment; your physician can call Express Scripts Prior Authorization at 1-800-753-2851.

If you have any further questions about these prescription drug management programs, please contact Express Scripts customer service at 1-800-797-2283.

Prior Authorization Required

Certain medications require prior authorization before they are covered by the Standard Plan to ensure they are used for appropriate situations and conditions. If your doctor prescribes a prescription drug that requires a prior authorization, your pharmacist will inform you to have your doctor contact the Express Scripts Prior Authorization Unit toll-free at 1-800-753-2851 prior to receiving your prescription. If you are notified that coverage for your prescription drug is approved, your pharmacist can fill the prescription. If the prescription drug is not approved, you can choose to have the prescription filled, but you will pay 100% of the pharmacy charge.

Please verify with an Express Scripts Member Services Representative to confirm the status and eligibility of the drug.

Step Therapy Required

Step therapy requires members to try alternative medicines for certain duration before the prescribed drug will be covered under the pharmacy benefit. The program helps ensure that

you receive clinically appropriate, cost-effective medicines based on your prescription history before the Plan will pay for higher-cost medicines.

Therapeutic Resource Centers

For patients with chronic and complex conditions, specialist pharmacists and nurses utilize their disease-specific experience to ensure safety, improve medication adherence, address omissions of essential therapy and close other gaps in care.

Therapeutic Resource Center reviews identify members who have a clinical gap in care, including those related to adherence, safety, and financial savings opportunities. When counseling patients, specialist pharmacists access our proprietary, electronic patient profile interface. This information enables pharmacists and patient care advocates to provide patient-centered member counseling when members call.

Patient care advocates are trained to recognize calls that require the expertise of our pharmacists. These pharmacists assist members in understanding their prescription regimen and are prepared to assist members with questions regarding:

- Adherence concerns
- Medication affordability
- Drug interactions and side effects
- Proper dosing
- New product availability
- Proper use of devices such as inhalers, needles, and syring

Therapeutic Resource Center systems and clinicians regularly conduct quality and safety reviews to identify concerns and direct appropriate intervention. When a safety alert is identified for a patient filling prescriptions at a retail pharmacy, safety alerts are pushed to that retail pharmacy where action is dependent on the retail pharmacist. For prescriptions being filled in one of our home delivery pharmacies, our specialist pharmacists address the concerns as appropriate.

PLAN HIGHLIGHTS

Benefit coverage levels of the prescription drug plans are outlined below

This plan is subject to the **deductible** as outlined in Section 5.

Benefits	In-Network	Out of Network*	Limitations and Explanations
Retail Pharmacy (up to a 30-day supply)			
Generic	20%	NA	If you fill prescription at

Brand (formulary)	20%	NA	non-network pharmacy, you must pay full cost of prescription and file paper claim for reimbursement, less applicable copay.
Brand (nonformulary)	20%	NA	
Specialty drugs**	20%	NA	One fill allowed at retail, when available; additional fills must be purchased through mail service. Limited to a 30 day supply.
HDHP Preventive Brand drugs	20%	NA	$0 copay for applicable generic medications that are considered preventive in nature.
ACA Preventive drugs*	$0	NA	Examples Include aspirin, folic acid, vitamin D, oral fluorides, contraceptives and smoking cessation medication.
Mail Service Pharmacy or CVS Pharmacy (up to a 90-day supply)			
Generic	20%	NA	
Brand (formulary)	20%	NA	
Brand (non-formulary)	20%	NA	
HDHP Preventive Brand drugs	20%	NA	$0 copay for applicable generic medications that are considered preventive in nature.

ACA Preventive drugs*	$0	NA	Examples Include aspirin, folic acid, vitamin D, oral fluorides, contraceptives and smoking cessation medication.

*For purchases out of network, member will pay 100% and submit charges for reimbursement for innetwork discounts.

**Pre-Authorization may be required for these drugs. Note: Members may get the first fill at any pharmacy, however, additional prescriptions must be filled via Accredo Specialty Pharmacy (different from mail).

ADDITIONAL COVERAGE DETAILS

To determine if a medication that you are taking is covered or not covered, please contact Express Scripts Member Services at 1-800-797-2283 or visit www.express-scripts.com.

CLAIM AND APPEALS PROCEDURES

Initial coverage review

A member has the right to request that a medicine be covered or be covered at a higher benefit (such as a lower copay or higher quantity). The first request for coverage is called an initial coverage review. Express Scripts reviews both clinical and administrative coverage review requests.

- Clinical coverage review request: A request for coverage of a medication that is based on clinical conditions of coverage that are set by the Plan. For example, medications that require a prior authorization.
- Administrative coverage review request: A request for coverage of a medication that is based on the Plan's benefit design.

How to request an initial coverage review

To request an initial clinical coverage review, also called prior authorization, the prescriber submits the request electronically. Information about electronic options can be found at express-scripts.com/PA.

To request an initial administrative coverage review, the member or his or her representative must submit the request in writing using a Benefit Coverage Request Form, which can be obtained by calling the Customer Service phone number on the back of the prescription card.

Complete the form and fax it to 877.328.9660 or mail to:

Express Scripts
Attn: Benefit Coverage Review Department
P.O. Box 66587
St Louis, MO 63166-6587

If the patient's situation meets the definition of urgent under the law, an urgent review may be requested and will be conducted as soon as possible, but no later than 72 hours from receipt of request.

In general, an urgent situation is one, which in the opinion of the attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function or would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. If the patient or provider believes the patient's situation is urgent, the provider must request the expedited review by phone at 800.753.2851.

How an initial coverage review is processed

In order to make an initial determination for a clinical coverage review request, the prescriber must submit specific information to Express Scripts for review. For an administrative coverage review request, the member must submit information to Express Scripts to support their request. The initial determination and notification to patient and prescriber will be made within the specified timeframes as follows:

Type of Claim	Decision Timeframe Decisions are completed ASAP from receipt of request and no later than:	Notification of Decision			
		APPROVAL		DENIAL	
Standard Pre-Service*	15 days (retail) 5 days (home delivery)	Patient Automated call (and letter, if call unsuccessful)	Prescriber Electronic or fax (and letter, if fax unsuccessful)	Patient Letter	Prescriber Electronic or fax (and letter, if fax unsuccessful)
Standard Post-Service*	30 days				
Urgent	72 hours**	Patient Automated call and letter	Prescriber Electronic or fax (and letter, if fax unsuccessful)	Patient Live call and letter	Prescriber Electronic or fax (and letter, if fax unsuccessful)

*If the necessary information needed to make a determination is not received from the prescriber within the decision timeframe, a letter will be sent to the patient and prescriber informing them that the information must be received within 45 days or the claim will be denied.

**Assumes all information necessary is provided. If necessary information is not provided within 24 hours of receipt, a 48-hour extension will be granted.

Level 1 appeal or urgent appeal

How to request a level 1 appeal or urgent appeal after an initial coverage review is denied.

When an initial coverage review has been denied, also referred to as an adverse benefit determination, a request for appeal may be submitted by the member or authorized representative within 180 days from receipt of notice of the initial adverse benefit determination. To initiate an appeal, the following information must be submitted by mail or fax to the appropriate department for clinical or administrative review requests:

- Name of patient
- Member ID
- Phone number
- The drug name for which benefit coverage has been denied
- Brief description of why the claimant disagrees with the initial adverse benefit determination
- Any additional information that may be relevant to the appeal, including prescriber statements/letters, bills or any other documents

Clinical appeal requests and administrative appeal requests can be mailed or faxed to the following addresses and fax numbers:

Clinical appeal requests
Express Scripts
Attn: Clinical Appeals Department
P.O. Box 66588
St. Louis, MO 63166-6588
Fax: 877.852.4070

Administrative appeal requests
Express Scripts
Attn: Administrative Appeals Department
P.O. Box 66587
St. Louis, MO 63166-6587
Fax: 877.328.9660

If the patient's situation meets the definition of urgent under the law, an urgent appeal may be requested and will be conducted as soon as possible, but no later than 72 hours from receipt of request. In general, an urgent situation is one, which in the opinion of the attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the patient or the patient's ability to regain

maximum function or would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If the patient or provider believes the patient's situation is urgent, the expedited review must be requested by phone or fax. Claims and appeals submitted by mail will not be considered for urgent processing unless a subsequent phone call or fax identifies the appeal as urgent.

Urgent clinical appeal requests
Phone: 800.753.2851
Fax: 877.852.4070

Urgent administrative appeal requests
Phone: 800.946.3979
Fax: 877.328.9660

How a level 1 appeal or urgent appeal is processed

Express Scripts completes appeals per business policies that are aligned with state and federal regulations. Depending on the type of appeal, appeal decisions are made by a pharmacist, physician, trained prior authorization staff member or independent third-party utilization management company.

Appeal decisions and notifications are made as follows:

Type of Appeal	Decision Timeframe Decisions are completed ASAP from receipt of request and no later than:	Notification of Decision			
		APPROVAL		DENIAL	
Standard Pre-Service	15 days	Patient Automated call (and letter, if call unsuccessful)	Prescriber Electronic or fax (and letter, if fax unsuccessful)	Patient Letter	Prescriber Electronic or fax (and letter, if fax unsuccessful)
Standard Post-Service	30 days				
Urgent*	72 hours	Patient Automated call and letter	Prescriber Electronic or fax (and letter, if fax unsuccessful)	Patient Live call and letter	Prescriber Electronic or fax (and letter, if fax unsuccessful)

*If new information is received and considered or relied upon in the review of the appeal, such information will be provided to the patient and prescriber together with an opportunity to respond prior to issuance of any final adverse determination. In an urgent care situation, only one level of internal appeal is provided prior to an external review.

Level 2 appeal

How to request a level 2 appeal after a level 1 appeal is denied

When a level 1 appeal has been denied, also called an adverse benefit determination, a request for a level 2 appeal may be submitted by the member or authorized representative within 90 days from receipt of notice of the level 1 appeal adverse benefit determination. To initiate a level 2 appeal, the following information must be submitted by mail or fax to the appropriate department for clinical or administrative review requests:

- Name of patient
- Member ID
- Phone number
- The drug name for which benefit coverage has been denied
- Brief description of why the claimant disagrees with the adverse benefit determination
- Any additional information that may be relevant to the appeal, including prescriber statements/letters, bills or any other documents

Clinical appeal requests and administrative appeal requests can be sent to the following addresses and fax numbers:

Clinical appeal requests
Express Scripts
Attn: Clinical Appeals Department
P.O. Box 66588
St. Louis, MO 63166-6588
Fax: 877.852.4070

Administrative appeal requests
Express Scripts
Attn: Administrative Appeals Department
P.O. Box 66587
St. Louis, MO 63166-6587
Fax: 877.328.9660

If the patient's situation meets the definition of urgent under the law, an urgent appeal may be requested and will be conducted as soon as possible, but no later than 72 hours from receipt of request. In general, an urgent situation is one, which in the opinion of the attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function or would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If the patient or provider believes the patient's situation is urgent, the expedited review must be requested by phone or fax. Claims and appeals submitted by mail will not be considered for urgent processing unless a subsequent phone call or fax identifies the appeal as urgent.

Urgent clinical appeal requests
Phone: 800.753.2851
Fax: 877.852.4070

Urgent administrative appeal requests
Phone: 800.946.3979
Fax: 877.328.9660

How a level 2 appeal is processed

Express Scripts completes appeals per business policies that are aligned with state and federal regulations. Appeal decisions are made by a pharmacist, physician, or an independent third-party utilization management company.

Appeal decisions and notifications are made as follows:

Type of Appeal	Decision Timeframe Decisions are completed ASAP from receipt of request and no later than:	Notification of Decision			
		APPROVAL		DENIAL	
Standard Pre-Service	15 days	Patient Automated call (and letter, if call unsuccessful)	Prescriber Electronic or fax (and letter, if fax unsuccessful)	Patient Letter	Prescriber Electronic or fax (and letter, if fax unsuccessful)
Standard Post-Service	30 days				
Urgent*	72 hours	Patient Automated call and letter	Prescriber Electronic or fax (and letter, if fax unsuccessful)	Patient Live call and letter	Prescriber Electronic or fax (and letter, if fax unsuccessful)

*If new information is received and considered or relied upon in the review of the appeal, such information will be provided to the patient and prescriber together with an opportunity to respond prior to issuance of any final adverse determination.

External review

When and how to request an external review

The right to request an independent external review may be available for an adverse benefit determination involving medical judgment, rescission or a decision based on medical

information, including determinations involving treatment that is considered experimental or investigational. Generally, all internal appeal rights must be exhausted prior to requesting an external review. The external review will be conducted by an independent review organization (IRO) with medical experts that were not involved in the prior determination of the claim.

To submit an external review, the request must be mailed or faxed to Express Scripts.

Express Scripts
Attn: External Appeals Department
PO Box 66588
St. Louis, MO 63166-6588
Phone: 800.753.2851
Fax: 877.852.4070

The request must be received within 4 months of the date of the final internal adverse benefit determination (If the date that is 4 months from that date is a Saturday, Sunday or holiday, the deadline will be the next business day.

How an external review is processed

Standard external review: Express Scripts will review the external review request within 5 business days to determine if it is eligible to be forwarded to an independent review organization and the patient will be notified within 1 business day of the decision.

If the request is eligible to be forwarded to an IRO, the request will randomly be assigned to an IRO and the appeal information will be compiled and sent to the IRO within 5 business days of assigning the IRO.

The IRO will notify the claimant in writing that it has received the request for an external review, and if the IRO has determined that the claim involves medical judgment or rescission, the letter will describe the claimant's right to submit additional information within 10 business days for consideration to the IRO. Any additional information the claimant submits to the IRO will also be sent back to the claims administrator for reconsideration.

The IRO will review the claim within 45 calendar days from receipt of the request and will send the claimant, the Plan and Express Scripts written notice of its decision. If the IRO has determined that the claim does not involve medical judgment or rescission, the IRO will notify the claimant in writing that the claim is ineligible for a full external review.

Urgent external review

Once an urgent external review request is submitted, the claim will immediately be reviewed to determine if it is eligible for an urgent external review. An urgent situation is one, which in the opinion of the attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize the life, health or the ability for the patient to regain maximum function or would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If the claim is eligible for urgent processing, the claim will immediately be reviewed to determine if the request is eligible to be forwarded to an IRO and the claimant will be notified of the decision.

If the request is eligible to be forwarded to an IRO, the request will randomly be assigned to an IRO and the appeal information will be compiled and sent to the IRO. The IRO will review the claim within 72 hours from receipt of the request and will send the claimant written notice of its decision.

Confidentiality

All participant and Company appeal documentation is handled in a confidential manner and in accordance with applicable statutes and regulations to protect the participant's identity and their prescription history.