

**Benefit Booklet
For Employees of
North Carolina Bar Association
Plan 20
for**

BlueOPTIONS HSASM



An Independent Licensee of the Blue Cross and Blue Shield Association

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

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BENEFIT BOOKLET

Please read this benefit booklet carefully.

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

In the event of a conflict between this benefit book and the terms in the Trust Agreement, the Trust Agreement will control.

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

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

Quick Reference - Other Coverage Offered Through Your Employer

Life Insurance

Your employer offers life insurance coverage through US Able Life Insurance Company. The types of life insurance coverage offered may include:

- Employee Life
- Accidental Death and Dismemberment
- Dependent Life
- Supplemental Life
- Supplemental Accident Death and Dismemberment

If you have any questions about your benefits, please contact your employer or you may call or write:

US Able Life Insurance Company
Claims Department
320 W. Capitol
Suite 700
Little Rock, AR 72201
1--800--648--0271 (toll free)

To see if you are eligible for these services, check your benefits summary in this guide or talk to your benefits administrator.

MEMBER RIGHTS AND RESPONSIBILITIES

As a member of the North Carolina Bar Association Health Benefit Trust, with a plan administered by Blue Cross and Blue Shield of North Carolina, you have the right to:

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

As a member of the North Carolina Bar Association Health Benefit Trust, with a plan administered by Blue Cross and Blue Shield of North Carolina, you have the responsibility to:

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

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, court order, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption or foster care, except when adding a dependent child will not change your coverage type or premiums that are owed.

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

BCBSNC Customer Service
Blue Cross and Blue Shield of North Carolina
PO Box 2291
Durham, NC 27702
1-877-275-9787 (toll-free)

Important Notice of Women's Health And Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

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

BCBSNC Customer Service
Blue Cross and Blue Shield of North Carolina
PO Box 2291
Durham, NC 27702
1-877-275-9787 (toll-free)

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GETTING STARTED WITH BLUE OPTIONS HSA

IMPORTANT INFORMATION REGARDING THE PLAN:

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

This benefit booklet provides important information about your benefits and can help you understand how to maximize them. 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 dollar amount you must incur for COVERED SERVICES in a BENEFIT PERIOD before benefits are payable under the PLAN. The deductible does not include coinsurance, charges in excess of the ALLOWED AMOUNT, amounts exceeding any maximum, or charges for noncovered services. The PLAN has an embedded deductible which means you have an individual deductible and if DEPENDENTS are covered, you also have a combined family deductible. You must meet your individual deductible before benefits are payable under the PLAN. However, once the family deductible is met, 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.
Coinsurance	The sharing of charges by the PLAN and you for COVERED SERVICES, after you have met your BENEFIT PERIOD deductible. This is stated as a percentage. The coinsurance listed is your share of the cost of a COVERED SERVICE.
TOTAL OUT-OF-POCKET LIMIT	The TOTAL OUT-OF-POCKET LIMIT is the dollar amount you pay for COVERED SERVICES in a BENEFIT PERIOD before the PLAN pays 100% of COVERED SERVICES. It does not include charges over the ALLOWED AMOUNT, premiums, and charges for noncovered services. The PLAN has an individual TOTAL OUT-OF-POCKET LIMIT and if DEPENDENTS are covered, you also have a combined family TOTAL OUT-OF-POCKET LIMIT. Once the family TOTAL OUT-OF-POCKET LIMIT is met, it is met for all MEMBERS. Charges for IN-NETWORK services apply to your IN-NETWORK TOTAL OUT-OF-POCKET LIMIT and charges for TOTAL OUT-OF-NETWORK services apply to your OUT-OF-NETWORK TOTAL OUT-OF-POCKET LIMIT.

GETTING STARTED WITH BLUE OPTIONS HSA (cont.)

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

	IN-NETWORK	OUT-OF-NETWORK
A. Total Bill	\$5,000	\$5,000
B. ALLOWED AMOUNT	\$4,250	\$4,250
C. Deductible Amount	\$1,000	\$2,000
D. ALLOWED AMOUNT Minus Deductible (B-C)	\$3,250	\$2,250
E. Your Coinsurance Amount (x% times D)	(10%) \$325	(30%) \$675
F. Amount You Owe Over ALLOWED AMOUNT	\$0 (IN-NETWORK charges limited to ALLOWED AMOUNT)	\$750 (difference between Total Bill and ALLOWED AMOUNT)
G. Total Amount You Owe (C+E+F)	\$1,325	\$3,425

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

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

Aviso para los AFILIADOS que no hablan inglés

Este manual de beneficios contiene un resumen en inglés de sus derechos y beneficios que el plan. Si tiene dificultad para entender alguna sección de este manual, por favor llame al ADMINISTRADOR DE PLAN para recibir ayuda. También puede comunicarse con el Departamento de Servicio al Cliente al número que aparece en su tarjeta del seguro, si desea solicitar los servicios bilingües o de intérprete para ayudarle con información relacionada a sus beneficios o servicios médicos.

WHO TO CONTACT?

Toll-Free Phone Numbers, Website and Addresses

Corporation Website: bcbsnc.com	Find a network PROVIDER by location or specialty, get information about top-performing facilities and information and news about the CORPORATION.
Blue Connect Website: www.bcbsnc.com/members/nbar	Use the CORPORATION'S secure website that reflects your specific benefits and information to verify benefits and eligibility, check claims status, download claim and other forms, manage your account, request new ID CARDS, get helpful wellness information and more.
Customer Service: 1-877-275-9787 (toll free)	For questions regarding your benefits, claims inquiries, and new ID CARD requests or to voice a complaint.
PRIOR REVIEW and CERTIFICATION MEMBERS call: 1-877-275-9787 (toll free) PROVIDERS, call: 1-800-214-4844 (toll-free)	Some services require PRIOR REVIEW and CERTIFICATION by the CORPORATION before they are considered for coverage. The list of these services may change from time to time. Current information about which services require PRIOR REVIEW can be found online at www.bcbsnc.com/members/nbar .
Magellan Behavioral Health: 1-800-359-2422 (toll free)	For mental health and substance abuse services, the CORPORATION delegates the administration of these benefits by contract to Magellan Behavioral Health, which is not associated with the CORPORATION. You must contact Magellan Behavioral Health directly and request PRIOR REVIEW for inpatient and certain outpatient services, except in EMERGENCIES. In the case of an EMERGENCY, please notify Magellan Behavioral Health as soon as possible.
Out of North Carolina Care 1-800-810-2583 (toll free)	For help in obtaining care outside of North Carolina or the U.S., call this number or visit bcbs.com .
HealthLine BlueSM 1-877-477-2424 (toll free)	Talk to a nurse 24/7 to receive timely information and advice on a number of health-related issues. Nurses are available by phone in both English and Spanish.
Condition Care: 1-800-260-0091 (toll free)	Talk to a Condition Care Coach for information about programs and support for managing specific health conditions, such as asthma, diabetes, heart failure, coronary artery disease and COPD.
Condition Care Maternity: 1-855-301-2229 (BABY)	Speak one-on-one with a specialized maternity nurse for the support you need. The 24/7 BabyLine [®] can provide information about programs and support for managing your pregnancy.
Healthy Outcomes Customer Service: 1-877-719-9004	Talk with a representative to receive assistance with any technical issues with the website including navigation, and browser compatibility as well as questions about the Healthy Outcomes program.

WHO TO CONTACT? (cont.)

Toll-Free Phone Numbers, Website and Addresses (con't)

Cobra Direct 1-877-916-5015 (toll free)	For EMPLOYER groups of 20 or more employees, contact your COBRA Administrator.
Medical Claims Filing: BCBSNC Claims Department PO Box 35 Durham, NC 27702-0035	Mail completed medical claims to this address.
Prescription drugs Administered by Express Scripts, Inc. 1-844-457-9196	The CORPORATION does not administer your prescription drug benefits. See the Pharmacy Schedule of Benefits and Information.

Value-Added Programs

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

Chiropractic Services 1-877-275-9787 (toll free)	For information about discounts on chiropractic services and a practitioner directory, call or visit www.bcbsnc.com/members/nbar .
TruHearingsm 1-877-343-0745 (toll free) 1-800-975-2674	For information about discounts on hearing aids, call or visit www.bcbsnc.com/members/nbar .
Blue365TM 855-511-2583 (BLUE)	Health and wellness information support and services, and special member savings available 365 days a year. Call or visit www.bcbsnc.com/members/nbar .
Davis Vision[®] 1-888-897-9350 (toll free)	For information about discounts on corrective laser eye surgery, call or visit www.bcbsnc.com/members/nbar .

**Important Notice from North Carolina Bar Association Health Benefit Trust
About Your Prescription Drug Coverage and Medicare**

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with NC Bar Association Health Benefit Trust and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offer prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. NC Bar Association Health Benefit Trust has determined that the prescription drug coverage is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare prescription drug plan when you first become eligible for Medicare and each year from October 15 to December 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide To Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current coverage may be affected. Please contact us for more information about what happens to your coverage if you enroll in a Medicare prescription drug program.

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

You should also know that if you drop or lose your current coverage with NC Bar Association Health Benefit Trust and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan and if this coverage through NC Bar Association Health Benefit Trust changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

IMPORTANT NOTICE - PRESCRIPTION DRUG COVERAGE AND MEDICARE *(cont.)*

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

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

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

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Name of Entity/Sender: NC Bar Association Health Benefit Trust
Contact--Position/Office: Benefits Department
Address: 8000 Weston Pkwy, Suite 200, Cary, NC 27513
Phone Number: 919-677-8900

SUMMARY OF BENEFITS

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

- Coinsurance percentages shown in this section are the part that you pay for COVERED SERVICES
- Deductible and coinsurance amounts are based on the ALLOWED AMOUNT
- Amounts applied to the deductible also count toward any visit or day maximums for those services
- PROVIDERS may collect an estimated amount of the MEMBER'S deductible and coinsurance when services are provided. If a MEMBER uses a Health Savings Account (HSA) funds to pay their PROVIDER and a PROVIDER refunds money to the MEMBER as a result of an overestimation of the MEMBER'S deductible or coinsurance, the MEMBER must return this money to the HSA in order to avoid any tax impacts.

Please Note: The list of IN-NETWORK PROVIDERS may change from time to time, so please verify that the PROVIDER is still in the PPO network before receiving care. Find a PROVIDER on the website at bcbsnc.com/members/nchar or call Customer Service at the number listed on your ID CARD or in "Who to Contact?"

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

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

SUMMARY OF BENEFITS *(cont.)*

BENEFIT PERIOD - October 1, 2015 through September 30, 2016

Member groups with renewal dates after October 1 will have the benefits outlined in this booklet upon their renewal date and for the following 12 months.

Benefits	IN-NETWORK	OUT-OF-NETWORK
LIFETIME MAXIMUM, Deductible, and TOTAL OUT-OF-POCKET LIMIT		
LIFETIME MAXIMUM Unlimited for all services, except orthotic devices for POSITIONAL PLAGIOCEPHALY, INFERTILITY and INFERTILITY drugs. 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.	Unlimited	Unlimited
Deductible EMPLOYEE, per BENEFIT PERIOD \$5,000 Family, per BENEFIT PERIOD \$10,000 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.	\$5,000 \$10,000	\$7,000 \$14,000
TOTAL OUT-OF-POCKET LIMIT EMPLOYEE, per BENEFIT PERIOD \$5,000 Family, per BENEFIT PERIOD \$10,000 The EMPLOYEE TOTAL OUT-OF-POCKET LIMIT applies if you selected EMPLOYEE only coverage; otherwise, the family TOTAL OUT-OF-POCKET LIMIT applies.	\$5,000 \$10,000	\$10,000 \$20,000
CERTIFICATION Requirements		
<p>Certain services, regardless of the location, require PRIOR REVIEW and CERTIFICATION by the CORPORATION in order to receive benefits. IN-NETWORK PROVIDERS in North Carolina will request PRIOR REVIEW when necessary. IN-NETWORK inpatient facilities outside of North Carolina will also request PRIOR REVIEW for you, except for Veterans' Affairs (VA) and military PROVIDERS. Otherwise, if you go to an OUT-OF-NETWORK PROVIDER in North Carolina or to any other PROVIDER outside of North Carolina, you are responsible for ensuring that you or your PROVIDER requests PRIOR REVIEW by the CORPORATION. The CORPORATION delegates administration of mental health and substance abuse benefits to Magellan Behavioral Health. Magellan Behavioral Health is not associated with the CORPORATION. Failure to request PRIOR REVIEW and receive CERTIFICATION may result in allowed charges being reduced by 25% or a full denial of benefits. See "COVERED SERVICES" and "PRIOR REVIEW (Pre-Service)" in "UTILIZATION MANAGEMENT" for additional information about those services which require PRIOR REVIEW and CERTIFICATION. Also see, "Mental Health and Substance Abuse Services" section in "COVERED SERVICES."</p> <p>To request PRIOR REVIEW, please see the number in "Who to Contact?"</p>		

SUMMARY OF BENEFITS (cont.)

Benefits	IN-NETWORK	OUT-OF-NETWORK						
<p>Preventive Care</p>								
<p>For PREVENTIVE CARE services that are not mandated by federal or state law, benefits will depend on where the services are received. This benefit is only for services that your PROVIDER indicates a primary diagnosis of preventive or wellness on the claim that is submitted to the CORPORATION. Also see "PREVENTIVE CARE" in "COVERED SERVICES."</p> <table border="0" data-bbox="175 535 1421 577"> <tr> <td data-bbox="175 535 784 577">Federally-mandated PREVENTIVE CARE Services</td> <td data-bbox="784 535 1125 577">No Charge</td> <td data-bbox="1125 535 1466 577">30% after deductible</td> </tr> </table> <p>Available in an office-based, outpatient, ambulatory surgical setting, or URGENT CARE center. For the most up-to-date list of PREVENTIVE CARE services that are covered under federal law, including general preventive services and screenings, immunizations, well-baby/well-child care, and women's preventive care, see the CORPORATION'S website at www.bcbsnc.com/preventive or call Customer Service at the number in "Who To Contact?"</p> <p>Nutritional counseling visits are covered IN-NETWORK at no cost to you, regardless of diagnosis and OUT-OF-NETWORK. Routine eye exams are covered as non-mandated PREVENTIVE CARE IN-NETWORK and OUT-OF-NETWORK.</p> <table border="0" data-bbox="175 913 1421 955"> <tr> <td data-bbox="175 913 784 955">State-mandated PREVENTIVE CARE Services</td> <td data-bbox="784 913 1125 955">No Charge</td> <td data-bbox="1125 913 1466 955">30% after deductible</td> </tr> </table> <p>The following services are state-mandated and required to be offered both IN- and OUT-OF-NETWORK: gynecological exams, cervical cancer screening, ovarian cancer screening, screening mammograms, colorectal screening, bone mass measurement, prostate-specific antigen tests, and newborn hearing screening.</p>			Federally-mandated PREVENTIVE CARE Services	No Charge	30% after deductible	State-mandated PREVENTIVE CARE Services	No Charge	30% after deductible
Federally-mandated PREVENTIVE CARE Services	No Charge	30% after deductible						
State-mandated PREVENTIVE CARE Services	No Charge	30% after deductible						
<p>PROVIDER'S Office See Outpatient Services for OUTPATIENT CLINIC or HOSPITAL-based services.</p>								
<p>OFFICE VISIT Services PRIMARY CARE PROVIDER OR SPECIALIST This includes: office SURGERY, x-rays, diagnostic imaging, and lab tests.</p>	<p>0% after deductible</p>	<p>30% after deductible</p>						

SUMMARY OF BENEFITS (cont.)

Benefits	IN-NETWORK	OUT-OF-NETWORK
<p>Therapy Services Benefits for ABA therapy are limited to \$10,000 per BENEFIT PERIOD and \$50,000 per lifetime per MEMBER. Any services in excess of these maximums are not COVERED SERVICES.</p> <p>REHABILITATIVE and HABILITATIVE THERAPIES</p> <p>Combined IN- and OUT-OF-NETWORK BENEFIT PERIOD MAXIMUMS apply to home, office and outpatient settings. 30 visits per BENEFIT PERIOD for physical/occupational therapy, including chiropractic services. 30 visits per BENEFIT PERIOD for speech therapy. Any visits in excess of these BENEFIT PERIOD MAXIMUMS are not COVERED SERVICES.</p> <p>OTHER THERAPIES</p> <p>Includes chemotherapy, dialysis and cardiac rehabilitation. See Outpatient Services for OTHER THERAPIES provided in an outpatient setting.</p>	<p>0% after deductible</p> <p>0% after deductible</p>	<p>30% after deductible</p> <p>30% after deductible</p>
<p>INFERTILITY Services</p> <p>Combined IN- and OUT-OF-NETWORK LIFETIME MAXIMUM of \$5,000 per MEMBER for INFERTILITY services, provided in all places of service (includes INFERTILITY prescription drugs). Any services in excess of this LIFETIME MAXIMUM are not COVERED SERVICES.</p>	<p>0% after deductible</p>	<p>30% after deductible</p>
<p>Obesity Treatment/Weight Management</p>		
<p>PRIMARY CARE PROVIDER OR SPECIALIST</p> <p>Outpatient Services</p> <p>Inpatient Services</p> <p>OFFICE VISITS for the evaluation and treatment of obesity are limited to a combined IN- and OUT-OF-NETWORK maximum of four visits per BENEFIT PERIOD. Any visits in excess of this BENEFIT PERIOD MAXIMUMS are not COVERED SERVICES.</p> <p>Bariatric Surgery</p> <p>This benefit is only available for services received at a Blue Distinction Center for Bariatric Surgery[®] ("BDC"). This applies to all places of service.</p> <p>*Please note that if a Blue Distinction Center for Bariatric Surgery[®] is not within a 50 mile radius, this benefit shall be available at the IN-NETWORK benefit level if received from a non-BDC IN-NETWORK PROVIDER or at the OUT-OF-NETWORK benefit level if received from an OUT-OF-NETWORK PROVIDER. For more information, see "Obesity Treatment/Weight Management" in "COVERED SERVICES."</p>	<p>0% after deductible</p> <p>0% after deductible</p> <p>0% after deductible</p> <p>0% after deductible</p>	<p>30% after deductible</p> <p>30% after deductible</p> <p>30% after deductible</p> <p>Benefits not available*</p>

SUMMARY OF BENEFITS (cont.)

Benefits	IN-NETWORK	OUT-OF-NETWORK
URGENT CARE Centers, EMERGENCY Room and Ambulance		
URGENT CARE and EMERGENCY Services	0% after deductible	0% after deductible
Ambulance Services	0% after deductible	0% after deductible
AMBULATORY SURGICAL CENTER		
AMBULATORY SURGICAL Services	0% after deductible	30% after deductible
Outpatient		
Outpatient Services Includes physician services, HOSPITAL and HOSPITAL-based services, HOSPITAL-based or OUTPATIENT CLINIC services, outpatient diagnostic services, and therapy services including REHABILITATIVE and HABILITATIVE THERAPIES, and OTHER THERAPIES including dialysis. See Physician Office Services for visit maximums.	0% after deductible	30% after deductible
Inpatient		
Inpatient Services Includes physician services, HOSPITAL and HOSPITAL-based services and maternity delivery, prenatal and post-delivery care. If you are in a HOSPITAL as an inpatient at the time you begin a new BENEFIT PERIOD, you may have to meet a new deductible for COVERED SERVICES from DOCTORS or OTHER PROFESSIONAL PROVIDERS.	0% after deductible	30% after deductible
Transplants This benefit is only available for covered transplants and transplant services received at a Blue Distinction Center for Transplants [®] ("BDC"). *Please note that if a Blue Distinction Center for Transplants [®] is not located within a 50 mile radius, this benefit shall be available at the IN-NETWORK benefit level if received from a non-BDC IN-NETWORK PROVIDER or at the OUT-OF-NETWORK benefit level if received from an OUT-OF-NETWORK PROVIDER. For more information see "Transplants" in "COVERED SERVICES."	0% after deductible	Benefit not available*

SUMMARY OF BENEFITS (cont.)

Benefits	IN-NETWORK	OUT-OF-NETWORK
SKILLED NURSING FACILITY		
SKILLED NURSING FACILITY Services Combined IN- and OUT-OF-NETWORK maximum of 60 days per BENEFIT PERIOD. Services applied to the deductible count towards this day maximum. Any services in excess of this BENEFIT PERIOD MAXIMUM are not COVERED SERVICES.	0% after deductible	30% after deductible
Other Services		
Includes DURABLE MEDICAL EQUIPMENT, HOSPICE services, MEDICAL SUPPLIES, orthotic devices, private duty nursing, PROSTHETIC APPLIANCES, and home health care. Orthotic devices for correction of POSITIONAL PLAGIOCEPHALY are limited to one device per MEMBER per lifetime. When covered, benefits for hearing aids are limited to \$2,500 per hearing-impaired ear every 36 months for MEMBERS up to age 22. Any services in excess of these maximums are not COVERED SERVICES.	0% after deductible	30% after deductible
Mental Health And Substance Abuse Services		
Mental Health Office Services	0% after deductible	30% after deductible
Mental Health Inpatient/Outpatient Services	0% after deductible	30% after deductible
Substance Abuse Office Services	0% after deductible	30% after deductible
Substance Abuse Inpatient/Outpatient Services	0% after deductible	30% after deductible

HOW BLUE OPTIONS HSA WORKS

As a member of the NC Bar Association Health Benefit Trust with a Blue Options plan administered by the CORPORATION, you will enjoy quality health care from a network of health care PROVIDERS and easy access to SPECIALISTS. You also have the freedom to choose any health care PROVIDERS who do not participate in the PPO network - the main difference will be the cost to you. Benefits are available for services from an IN- OR OUT-OF-NETWORK PROVIDER that is recognized by the CORPORATION as eligible. For a list of eligible PROVIDERS, please visit the website at bcbsnc.com/members/nbar or call Customer Service at the number listed in "Who to Contact?" The CORPORATION contracts with a broad network of North Carolina PROVIDERS to deliver COVERED SERVICES to MEMBERS of the PLAN. IN-NETWORK PROVIDERS include:

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

Here's a look at how it works:

	IN-NETWORK	OUT-OF-NETWORK
Type of PROVIDER	<p>IN-NETWORK PROVIDERS are health care professionals and facilities that have contracted with the CORPORATION, or a PROVIDER participating in the BlueCard[®] program. ANCILLARY PROVIDERS outside North Carolina are considered IN-NETWORK only if they contract directly with the Blue Cross or Blue Shield plan in the state where the services were received. IN-NETWORK PROVIDERS agree to limit charges for COVERED SERVICES to the ALLOWED AMOUNT.</p> <p>The list of IN-NETWORK PROVIDERS may change from time to time. IN-NETWORK PROVIDERS are listed on the the CORPORATION'S website at www.bcbsnc.com/members/nbar, or call Customer Service at the number listed in "Who to Contact?"</p>	<p>OUT-OF-NETWORK PROVIDERS are not designated as a PPO PROVIDER by the CORPORATION. Also see "OUT-OF-NETWORK Benefit Exceptions."</p>
ALLOWED AMOUNT vs. Billed Amount	<p>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 noncovered expenses.</p>	<p>You may be responsible for paying any charges over the ALLOWED AMOUNT in addition to any applicable deductible, coinsurance, noncovered expenses and CERTIFICATION penalty amounts, if any, except for EMERGENCY SERVICES in the case of an EMERGENCY.</p>
Referrals	<p>The CORPORATION does not require you to obtain any referrals.</p>	<p>You are not required to obtain any referrals.</p>
Care Outside of North Carolina	<p>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.</p>	<p>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."</p>
	<p>IN-NETWORK PROVIDERS in North</p>	

HOW BLUE OPTIONS HSA WORKS *(cont.)*

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

OUT-OF-NETWORK Benefit Exceptions

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

For more information, see one of the following sections: "EMERGENCY Care," in COVERED SERVICES" or "Continuity of Care" in "UTILIZATION MANAGEMENT." For information about the CORPORATION'S access to care standards, see the website at bcbsnc.com/members/nccbar and type "access to care" in the search bar. If you believe an IN-NETWORK PROVIDER is not reasonably available, you can help assure that benefits are paid at the correct benefit level by calling the CORPORATION before receiving care from an OUT-OF-NETWORK PROVIDER.

Carry Your IDENTIFICATION CARD

HOW BLUE OPTIONS HSA WORKS *(cont.)*

Your ID CARD identifies you as a MEMBER of the North Carolina Bar Association Health Benefits Trust with a Blue Options HSA plan administered by the CORPORATION. Be sure to carry your ID CARD with you at all times and present it each time you seek health care.

For ID CARD requests, please visit the website at bcbsnc.com/members/nbar or call Customer Service at the number listed in "Who to Contact?"

The Role Of A PRIMARY CARE PROVIDER (PCP) Or SPECIALIST

The CORPORATION does not require that you designate a PCP to manage your health care. However, it is important for you to maintain a relationship with a PCP, who will help you manage your health and make decisions about your health care. If you change PCP'S, be sure to have your medical records transferred, especially immunization records, to provide your new DOCTOR with your medical history. You should participate actively in all decisions related to your health care and discuss all treatment options with your health care PROVIDER regardless of cost or benefit coverage. PCP'S 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 PCP'S.

Please visit the website at bcbsnc.com/members/nbar and click on Find A Doctor or call Customer Service to confirm that the PROVIDER is in the network before receiving care.

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

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

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

COVERED SERVICES

The PLAN covers only those services that are **MEDICALLY NECESSARY**. Also keep in mind as you read this section:

- **Certain services require PRIOR REVIEW and CERTIFICATION in order for you to avoid a partial (penalty) or full denial of benefits. General categories of services are noted in the sections below as requiring PRIOR REVIEW. Also see "PRIOR REVIEW/(Pre-Service)" in "UTILIZATION MANAGEMENT" for information about the review process, visit the website at bcbssc.com/members/nbar or call Customer Service to ask whether a specific service requires PRIOR REVIEW and CERTIFICATION.**
- 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 they apply to each service, read "COVERED SERVICES," "Summary of Benefits" and "What Is Not Covered?"
- 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.
- You may also receive, upon request, information about the procedure and medical criteria used by the CORPORATION to determine whether a procedure, treatment, facility, equipment, drug or device is **MEDICALLY NECESSARY** and eligible for coverage, INVESTIGATIONAL or EXPERIMENTAL, or requires PRIOR REVIEW and CERTIFICATION by the CORPORATION. The CORPORATION'S medical policies are guides considered by the CORPORATION when making coverage determinations. If you need more information about medical policies, see the website at bcbssc.com/members/nbar, or call Customer Service at the number listed in "Who to Contact?"

Office Services

Care you receive as part of an OFFICE VISIT electric visit, or house call is covered, except as otherwise noted in this benefit booklet.

Prescription drugs for hemophilia may have previously been provided by a physician in an office or outpatient setting and billed to the CORPORATION as a medical service. Effective January 1, 2016, these drugs are no longer covered under the office visit services benefit.

Office Services Exclusion

- Certain self-injectable prescription drugs that can be self-administered. The list of these drugs may change from time to time. See the website at www.bcbssc.com/members/nbar or call Customer Service for a list of these drugs excluded in the office.

PREVENTIVE CARE

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

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

Federally-Mandated PREVENTIVE CARE Services

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

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

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

COVERED SERVICES *(cont.)*

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

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

COVERED SERVICES (cont.)

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

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

State-Mandated PREVENTIVE CARE Services:

The following benefits are available IN-NETWORK and OUT-OF-NETWORK. See your "Summary of Benefits," since benefits may vary depending on where services are received:

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 your IN-NETWORK 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. Please note that if lab work is done as a result of a colorectal screening exam, the lab work will be covered under your diagnostic benefit and not be considered PREVENTIVE CARE. It will be subject to your in-network benefit level for the location where services are received.

The PROVIDER search on the website at bcbsnc.com/members/nbar can help you find office-based PROVIDERS or call Customer Service at the number listed in "Who to Contact?" for this information.

Gynecological Exam and Cervical Cancer Screening

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

Newborn Hearing Screening

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

Ovarian Cancer Screening

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

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

Prostate Screening

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

Screening Mammograms

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

A female MEMBER is "at risk" if she:

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

Non-Mandated PREVENTIVE CARE Services

Routine Eye Exams

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

PREVENTIVE CARE Exclusions

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

Obesity Treatment/Weight Management

The PLAN provides coverage for OFFICE VISITS for the evaluation and treatment of obesity; see "Summary of Benefits" for visit maximums.

The PLAN also provides benefits for nutritional counseling visits to an IN- or OUT-OF-NETWORK PROVIDER as part of your PREVENTIVE CARE benefits. The nutritional counseling visits may include counseling specific to achieving or

COVERED SERVICES (cont.)

maintaining a healthy weight. Nutritional counseling visits are separate from the obesity-related OFFICE VISITS noted above.

Bariatric Surgery

Benefits are provided for surgical treatment of morbid obesity (bariatric surgery) only when covered services are performed at a Blue Distinction Center for Bariatric Surgery[®] ("BDC"). This benefit is only available IN-NETWORK. If a Blue Distinction Center for Bariatric Surgery[®] is not within a 50 mile radius, this benefit shall be available at the IN-NETWORK benefit level if received from a non-BDC IN-NETWORK PROVIDER or at the OUT-OF-NETWORK benefit level if received from an OUT-OF-NETWORK PROVIDER. PRIOR REVIEW must be requested and CERTIFICATION obtained or services will not be covered. Side effects and complications arising from bariatric surgery performed at a non-Blue Distinction Center for Bariatric Surgery will not be covered except for EMERGENCY SERVICES. For a list of Blue Distinction Centers for Bariatric Surgery[®], call Customer Service at the number listed in "Who to Contact?"

Obesity Treatment/Weight Management Exclusions

- Removal of excess skin from the abdomen, arms or thighs
- Any costs associated with membership in a weight management program
- Drugs indicated for the short-term or long-term treatment of clinical obesity
- Any services not described above
- Bariatric surgery services provided at a non-Blue Distinction Center for Bariatric Surgery unless one is not available within a 50 mile radius.

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 imaging procedures, such as CT scans, PET scans and MRIs, may require PRIOR REVIEW and CERTIFICATION or services will not be covered.

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

Diagnostic Services Exclusion

- Lab tests that are not ordered by your DOCTOR or OTHER PROVIDER.

Emergency Care

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. PRIOR REVIEW is not required for emergency services. If you are unsure if your condition is an EMERGENCY, you can call HealthLine Blue and a HealthLine Blue nurse will provide information and support that may save you an unnecessary trip to the emergency room.

Benefits for services in the EMERGENCY room

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

URGENT CARE

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

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

Family Planning

Maternity Care

Maternity care benefits, including prenatal care, labor and delivery and post-delivery care, are available to all female MEMBERS. However, maternity benefits for DEPENDENT CHILDREN cover only treatment for COMPLICATIONS OF PREGNANCY. Coverage for breastfeeding counseling and certain breast pumps for pregnant or post-partum MEMBERS are covered under your PREVENTIVE CARE benefit. See www.bcbsnc.com/preventive or call BCBSNC Customer Service for additional information and any limitations that may apply.

COVERED SERVICES (cont.)

	Mother	Newborn	Payment
Prenatal care	Care related to the pregnancy before birth		Deductible and coinsurance 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 EMPLOYEE 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 CERTIFICATION are required in order to avoid a penalty.	

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

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.

Termination of Pregnancy (Abortion)

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

COMPLICATIONS OF PREGNANCY

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

INFERTILITY Services

Benefits are provided for certain services related to the diagnosis, treatment and correction of any underlying causes of INFERTILITY for all MEMBERS except DEPENDENT CHILDREN. See "Summary of Benefits" for limitations that may apply.

SEXUAL DYSFUNCTION Services

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

Sterilization

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

Contraceptive Devices

This benefit is available for all MEMBERS. Coverage includes the insertion or removal of and any MEDICALLY NECESSARY examination associated with the use of intrauterine devices, diaphragms, injectable contraceptives and implanted hormonal contraceptives. Certain FDA-approved contraceptive methods for female members are covered under your PREVENTIVE CARE benefit. See www.bcbsnc.com/preventive or call BCBSNC Customer Service for information about procedures that are covered according to federal regulations and any limitations that may apply.

Family Planning Exclusions

- Associated reproductive technologies as defined by the Centers for Disease Control and Prevention, including, but not limited to, artificial insemination, in-vitro fertilization (IVF) with fresh or frozen embryos, ovum or embryo placement, intracytoplasmic sperm injection (ICSI), zygote intra-fallopian transfer (ZIFT), specialized sperm retrieval techniques, and gamete intrafallopian (GIFT) and associated services
- Oocyte and sperm donation
- Cryopreservation of oocytes, sperm, or embryos
- Surrogate mothers
- Care or treatment of the following:
 - maternity for DEPENDENT CHILDREN
 - elective termination of pregnancy (abortion) for DEPENDENT CHILDREN
 - reversal of sterilization
 - INFERTILITY for DEPENDENT CHILDREN
- Elective termination of pregnancy (abortion) after 16 weeks of pregnancy
- Treatment for INFERTILITY or reduced fertility that results from a prior sterilization procedure or a normal physiological change such as menopause.

FACILITY SERVICES

Benefits are provided for:

- Outpatient services received in a HOSPITAL, a HOSPITAL-based facility, NONHOSPITAL FACILITY or a HOSPITAL-based or OUTPATIENT CLINIC
- Inpatient services received in a HOSPITAL or NONHOSPITAL FACILITY. You are considered an inpatient if you are admitted to the HOSPITAL or NONHOSPITAL FACILITY as a registered bed patient for whom a room and board charge is made. Your IN-NETWORK PROVIDER is required to use the PPO network HOSPITAL where he/she practices, unless that HOSPITAL cannot provide the services you need. If you are admitted before the EFFECTIVE DATE, benefits will not be available for services received prior to the EFFECTIVE DATE. PRIOR REVIEW must be requested and CERTIFICATION must be obtained in advance from the CORPORATION for inpatient admissions, except for maternity deliveries and EMERGENCIES. See "Maternity Care" and "EMERGENCY Care." In-network providers in North Carolina are responsible for requesting PRIOR REVIEW and obtaining CERTIFICATION. **If PRIOR REVIEW is not requested and CERTIFICATION is not obtained for covered OUT-OF-NETWORK inpatient admissions, allowed charges will be reduced by 25%, then deductible and coinsurance will be applied.** Also,

COVERED SERVICES (cont.)

the CORPORATION requires notification for MEMBERS who have Medicare as their primary coverage and who are admitted to a Medicare-certified HOSPITAL or NONHOSPITAL FACILITY.

- Surgical services received in an AMBULATORY SURGICAL CENTER
- COVERED SERVICES received in a SKILLED NURSING FACILITY. SKILLED NURSING FACILITY services are limited to a combined IN- NETWORK and OUT-OF-NETWORK day maximum per BENEFIT PERIOD. See "Summary of Benefits." PRIOR REVIEW must be requested and CERTIFICATION must be obtained in advance from the CORPORATION or services will not be covered. However, CERTIFICATION is not required for MEMBERS who have Medicare as their primary coverage and who are admitted to a Medicare-certified SKILLED NURSING FACILITY.

Other Services

Ambulance Services

The PLAN covers services in a ground AMBULANCE traveling:

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

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

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

The PLAN covers services in an air ambulance 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. Air ambulance services are eligible for coverage only when ground transportation is not medically appropriate due to the severity of the illness or the pick-up point is inaccessible by land.

Ambulance Service Exclusions

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

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 drugs that must be dispensed under a PROVIDER'S supervision in an office, outpatient setting, or through home infusion. These drugs are covered under your medical benefit. Coverage of some of these drugs may be limited to certain provider settings (such as office, outpatient, AMBULATORY SURGICAL CENTER). For a list of drugs covered under your medical benefit that are covered only at certain provider settings, visit the website at bcbsnc.com/members/nbar.

Clinical Trials

The PLAN provides benefits for participation in clinical trials phases I, II, III, and IV. Coverage is provided only for MEDICALLY NECESSARY costs of health care services associated with the trials, 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

COVERED SERVICES (cont.)

- Be approved by centers or groups funded by the National Institutes of Health, the U.S. Food and Drug Administration (FDA), the Centers for Disease Control and Prevention, the Agency for Health Care Research and Quality, the Department of Defense or the Department of Veterans Affairs
- Be conducted in a setting and by personnel of high expertise based on training, experience and patient volume.

Clinical Trials Exclusions

- Non-health care services, such as services provided for data collection and analysis
- INVESTIGATIONAL drugs and devices and services that are not for the direct clinical management of the patient.

Dental Treatment Covered Under Your Medical Benefit

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

The PLAN also provides 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.

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

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

Dental Treatment Excluded Under Your Medical Benefit

Treatment for the following conditions:

- Injury related to chewing or biting
- Preventive dental care, diagnosis or treatment of or related to the teeth or gums
- Periodontal disease or cavities, and disease due to infection or tumor

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

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

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.

DURABLE MEDICAL EQUIPMENT

Benefits are provided for DURABLE MEDICAL EQUIPMENT and supplies required for operation of equipment when prescribed by a DOCTOR. 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
- Repair or replacement of equipment due to abuse or desire for new equipment.

Hearing Aids

The PLAN provides coverage for MEDICALLY NECESSARY hearing aids and related services that are ordered by a DOCTOR or a licensed audiologist for each MEMBER up to age 22. Benefits are provided for one hearing aid per hearing-impaired ear, and replacement hearing aids when alterations to an existing hearing aid are not adequate to meet the MEMBER'S needs. This benefit is limited to once every 36 months. Benefits are also provided for the evaluation, fitting, and adjustments of hearing aids or replacement of hearing aids, and for supplies, including ear molds. A maximum dollar amount applies; see "Other Services" in "Summary of Benefits."

HOME HEALTH Care

HOME HEALTH care services are covered when ordered by your DOCTOR for a MEMBER who is homebound due to illness or injury, and you need part-time or intermittent skilled nursing care from a REGISTERED NURSE (RN) or LICENSED PRACTICAL NURSE (LPN), and/or other skilled care services like REHABILITATIVE and HABILITATIVE THERAPIES. Usually, a HOME HEALTH AGENCY coordinates the services your DOCTOR orders for you. Services from a HOME HEALTH aide may be eligible for coverage only when the care provided supports a skilled service being delivered in the home. HOME HEALTH care requires PRIOR REVIEW and CERTIFICATION or services will not be covered.

HOME HEALTH Care Exclusions

- 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.

Home Infusion Therapy Services

Home infusion therapy is covered for the administration of prescription drugs directly into a body organ or cavity or via intravenous, intraspinal, intramuscular, subcutaneous or epidural routes, under a plan prescribed by a DOCTOR. These services must be provided under the supervision of an RN or LPN. PRIOR REVIEW and CERTIFICATION are required for certain home infusion therapy services or services will not be covered.

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.

HOSPICE Services Exclusion

- Homemaker services, such as cooking, housekeeping, food or meals.

Lymphedema-Related Services

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

Lymphedema-Related Services Exclusion

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

MEDICAL SUPPLIES

Coverage is provided for MEDICAL SUPPLIES.

To obtain MEDICAL SUPPLIES and equipment, please find a PROVIDER on the CORPORATION'S website at www.bcbsnc.com/members/nbar or call Customer Service.

MEDICAL SUPPLIES Exclusion

- MEDICAL SUPPLIES not ordered by a DOCTOR for treatment of a specific diagnosis or procedure.

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 for correction of POSITIONAL PLAGIOCEPHALY, including dynamic orthotic cranioplasty (DOC) bands and soft helmets, have a benefit limit; see "Summary of Benefits."

Orthotic Devices Exclusions

- Pre-molded foot orthotics
- Over-the-counter supportive devices.

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 is receiving active care management. See "Care Management." Private duty nursing provides more individual and continuous skilled care than can be provided in a skilled nursing visit through a HOME HEALTH AGENCY. Private duty nursing requires PRIOR REVIEW and CERTIFICATION must be obtained or services will not be covered.

Private Duty Nursing Exclusion

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

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

- Dental appliances except when MEDICALLY NECESSARY for the treatment of temporomandibular joint disease or obstructive sleep apnea
- COSMETIC improvements, such as implantation of hair follicles and skin tone enhancements
- Lenses for keratoconus or any other eye procedure except as specifically covered under the PLAN.

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. Surgical benefits include diagnostic SURGERY, such as biopsies, and reconstructive SURGERY performed to correct CONGENITAL defects that result in functional impairment of newborn, adoptive, and FOSTER CHILDREN. Certain surgical procedures, including those that are potentially COSMETIC, require PRIOR REVIEW and CERTIFICATION or services will not be covered.

Multiple surgical procedures performed on the same date of service and/or during the same patient encounter, may not be eligible for separate reimbursement.

For information about coverage of multiple surgical procedures, please refer to the CORPORATION'S reimbursement policies, which are on the website at bcbsnc.com/members/nbar, or call Customer Service at the number listed in "Who to Contact?"

Anesthesia

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

COVERED SERVICES (cont.)

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.

Mastectomy Benefits

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

- Reconstruction of the breast on which the mastectomy has been performed
- SURGERY and reconstruction of the nondiseased breast to produce a symmetrical appearance without regard to the lapse of time between the mastectomy and the reconstructive SURGERY
- Prostheses and physical complications of all stages of the mastectomy, including lymphedemas. See Physician Office Services, or for external prostheses, see PROSTHETIC APPLIANCES in Other Services in the "Summary of Benefits."

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

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

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. If TMJ is caused by malocclusion, benefits are provided for surgical correction of malocclusion when surgical management of the TMJ is MEDICALLY NECESSARY. Please have your PROVIDER contact the CORPORATION before receiving surgical treatment for TMJ. PRIOR REVIEW and CERTIFICATION are required for certain surgical procedures or these services will not be covered, unless treatment is for an EMERGENCY.

Temporomandibular Joint (TMJ) Services Exclusions

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

Therapies

The PLAN provides coverage for the following therapy services for an illness, disease or injury when ordered by a DOCTOR or OTHER PROFESSIONAL PROVIDER. Benefits are also provided for applied behavioral analysis (ABA) therapy for treatment of autism. Benefit maximums apply; see "Summary of Benefits."

REHABILITATIVE AND HABILITATIVE THERAPIES

The following therapies are covered only for treatment of conditions that are expected to result in significant clinical improvement in a MEMBER'S condition:

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

Benefits are limited to a combined IN-NETWORK and OUT-OF-NETWORK BENEFIT PERIOD visit maximum for each of these two categories of therapies: (1) occupational and/or physical therapy, or any combination of these therapies; and (2) speech therapy. These 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 and HABILITATIVE THERAPIES received while an inpatient is not included in the BENEFIT PERIOD MAXIMUMS. Benefits may vary depending on where services are received. See "Summary of Benefits" for additional information and visit maximums.

OTHER THERAPIES

The PLAN covers:

COVERED SERVICES (cont.)

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

Therapy Exclusions

- Cognitive therapy
- Group classes for pulmonary rehabilitation.

Transplants

This benefit is available only when performed at a Blue Distinction Centers for Transplants® ("BDC"). If a Blue Distinction Centers for Transplants® is not within a 50 mile radius, this benefit shall be available at the IN-NETWORK benefit level if received from a non-BDC IN-NETWORK PROVIDER or at the OUT-OF-NETWORK benefit level if received from an OUT-OF-NETWORK PROVIDER. A transplant is the surgical transfer of a human organ, bone marrow, tissue, or peripheral blood stem cells taken from the body and returned or grafted into another area of the same body or into another body. The PLAN provides benefits for transplants, including hospital and professional services for covered transplant procedures. The Plan provides care management for transplant services and will help you find a Blue Distinction Centers for Transplants®, that provides the transplant services required. Travel and lodging expenses may be reimbursed based on the CORPORATION'S guidelines that are available upon request from a transplant coordinator.

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

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

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

Some transplant services are INVESTIGATIONAL and 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
- Transplants performed at a non-Blue Distinction Center for Transplants®, except when one is not located within a 50 mile radius.

Mental Health and Substance Abuse Services

The PLAN provides benefits for the treatment of MENTAL ILLNESS and substance abuse by a HOSPITAL, DOCTOR or OTHER PROVIDER.

Your coverage for inpatient and certain outpatient services is coordinated through Magellan Behavioral Health. The CORPORATION delegates administration of these benefits to Magellan Behavioral Health. Magellan Behavioral Health is not associated with the CORPORATION. To understand more about when you need to contact Magellan Behavioral Health, see "How to Access Mental Health and Substance Abuse Services."

OFFICE VISIT Services

The following professional services are covered when provided in an office setting:

- Evaluation and diagnosis
- MEDICALLY NECESSARY biofeedback and neuropsychological testing
- Individual and family counseling
- Group therapy.

Outpatient Services

Covered outpatient services when provided in a mental health or substance abuse treatment facility include:

- Each service listed in this section under OFFICE VISIT services
- Partial-day/night hospitalization services (minimum of four hours per day and 20 hours per week)
- Intensive therapy services (less than four hours per day and minimum of nine hours per week).

Certain outpatient services, such as partial hospitalization and intensive therapy, require PRIOR REVIEW and CERTIFICATION or services will not be covered. Call Magellan Behavioral Health listed in "Who to Contact" for a detailed list of these services. The list of services that require PRIOR REVIEW may change from time to time.

Inpatient Services

Covered inpatient treatment services also include:

- Each service listed in this section under OFFICE VISIT services
- Room and board
- Detoxification to treat substance abuse

PRIOR REVIEW must be requested and CERTIFICATION must be obtained in advance for inpatient services except for EMERGENCIES. IN-NETWORK PROVIDERS in North Carolina are responsible for requesting PRIOR REVIEW and obtaining CERTIFICATION. If PRIOR REVIEW is not requested and CERTIFICATION is not obtained for covered OUT-OF-NETWORK inpatient admissions, allowed charges will be reduced by 25%, then deductible and coinsurance will be applied.

RESIDENTIAL TREATMENT FACILITY Services

PRIOR REVIEW must be requested and CERTIFICATION must be obtained in advance for mental health and substance abuse services received in a RESIDENTIAL TREATMENT FACILITY. IN-NETWORK PROVIDERS in North Carolina are responsible for requesting PRIOR REVIEW and obtaining CERTIFICATION. If PRIOR REVIEW is not requested and CERTIFICATION is not obtained for covered OUT-OF-NETWORK RESIDENTIAL TREATMENT FACILITY services, allowed charges will be reduced by 25%, then deductible and coinsurance will be applied.

How to Access Mental Health and Substance Abuse Services

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

When you need inpatient or certain outpatient services that require PRIOR REVIEW and CERTIFICATION, call a Magellan Behavioral Health customer service representative at the number listed in "Who to Contact?" The Magellan Behavioral Health customer service representative can also help you find an appropriate IN-NETWORK PROVIDER and give you information about PRIOR REVIEW and CERTIFICATION requirements. Failure to request PRIOR REVIEW and receive CERTIFICATION may result in allowed charges being reduced by 25% or a full denial of benefits.

Mental Health and Substance Abuse 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.

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

A

Acupuncture and acupressure

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

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

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

B

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

C

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

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

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

Cosmetic services, which include removal of excess skin from the abdomen, arms or thighs, skin tag excisions, cryotherapy or chemical exfoliation for active acne and acne scarring, superficial dermabrasion, injection of dermal fillers, services for hair transplants, electrolysis, 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

WHAT IS NOT COVERED? (cont.)

or the home setting with substantial assistance and supervision nor is there reasonable likelihood that the disability will be reduced to that level even with treatment. Custodial care includes, but is not limited to, help in walking, bathing, dressing, feeding, preparation of special diets and supervision over medications that could otherwise be self-administered. Such services and supplies are custodial as determined by the CORPORATION without regard to the place of service or the PROVIDER prescribing or providing the services.

D

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

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

The following **drugs**:

- Prescription drugs except as specifically covered by the PLAN
- Injections by a health care professional of injectable PRESCRIPTION DRUGS which can be self-administered, unless medical supervision is required

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, pools or memberships to health clubs
- Standing frames
- Personal computers.

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

F

ROUTINE **FOOT CARE** that is palliative or COSMETIC

G

Genetic testing, except for high risk patients when the therapeutic or diagnostic course would be determined by the outcome of the testing

H

Routine **hearing** examinations and **hearing aids** or examinations for the fitting of hearing aids except for MEMBERS over the age of 22

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 primary 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**

WHAT IS NOT COVERED? (cont.)

N

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

P

Body **piercing**

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

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

R

The following **residential care** services:

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

Treatment or studies leading to or in connection with **sex changes** or modifications and related care

SEXUAL DYSFUNCTION unrelated to organic disease

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

T

The following types of **therapy**:

- Music therapy, remedial reading, recreational or activity therapy, all forms of special education and supplies or equipment used similarly
- Massage therapy

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

V

The following **vision** services:

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

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

WHAT IS NOT COVERED? *(cont.)*

W

Wigs, hairpieces and hair implants for any reason

WHEN COVERAGE BEGINS AND ENDS

To be covered under the PLAN, you must be an active full-time EMPLOYEE, based on your employer's employment practices, who works a minimum of 20 or more hours per week and is otherwise eligible for coverage. However, your EMPLOYER may establish additional criteria you must meet before you are eligible for coverage. This may include satisfying a probationary period before your coverage begins. Eligibility may also extend to EMPLOYEES who may not be actively at work due to an approved leave of absence, temporary layoff, injury, illness, maternity or personal leave, or disability as a result of injury or illness. If your EMPLOYER extends eligibility as a result of one of the circumstances listed above, coverage shall be limited to the EMPLOYER'S personnel practice or twelve (12) months, whichever is less.

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

- Your spouse, under a legally valid, existing marriage between persons of the opposite or same sex. Please check with your PLAN ADMINISTRATOR to verify spousal coverage.
- Your or your spouse's DEPENDENT CHILDREN to the end of the month of their 26th birthday, including newborn children from date of birth, stepchildren, adoptive children from date of placement for adoption, FOSTER CHILDREN from date of placement in the foster home, and children for whom health benefit coverage is required under a court or administrative order.
- A DEPENDENT CHILD who is and continues to be either mentally or physically handicapped and incapable of self-support may continue to be covered under the PLAN regardless of age if the condition exists and coverage is in effect when the child reaches the end of eligibility for DEPENDENT CHILDREN. Proof of incapacity must be provided within 31 days of the dependent child's 26th birthday. The handicap must be medically certified by the child's DOCTOR and may be verified annually by the CORPORATION.

Enrolling in the PLAN

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

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

- You or your DEPENDENTS become eligible for coverage under the PLAN
- You get married or obtain a DEPENDENT through birth, court order, adoption, placement in anticipation of adoption, or foster care placement of an eligible child
- You or your DEPENDENTS lose coverage under another health benefit plan, and each of the following conditions is met:
 - ☞ you and/or your DEPENDENTS are otherwise eligible for coverage under the PLAN, and
 - ☞ you and/or your DEPENDENTS were covered under another health benefit plan at the time this coverage was previously offered and declined enrollment due to the other coverage, and
 - ☞ you and/or your DEPENDENTS lose coverage under another health benefit plan due to i) the exhaustion of the COBRA continuation period, or ii) the loss of eligibility for that coverage for reasons including, but not limited to, legal separation, divorce, loss of DEPENDENT status, death of the EMPLOYEE, termination of employment, or reduction in the number of hours of employment, or iii) the termination of the other plan's coverage, or iv) the offered health benefit plan not providing benefits in your service area and no other health benefit plans are available, or v) the termination of EMPLOYER contributions toward the cost of the other plan's coverage, or vi) meeting or exceeding the lifetime benefit maximum, or vii) the discontinuance of the health benefit plan to similarly situated individuals.
- You or your DEPENDENTS lose coverage due to loss of eligibility under Medicaid or the Children's Health Insurance Program (CHIP) and apply for coverage under this PLAN within 60 days
- You or your DEPENDENTS become eligible for premium assistance with respect to coverage under this PLAN under Medicaid or Children's Health Insurance Program (CHIP) and apply for coverage under this PLAN within 60 days.

Adding or Removing a DEPENDENT

WHEN COVERAGE BEGINS AND ENDS (cont.)

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

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

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

You may remove DEPENDENTS from your coverage by contacting the PLAN ADMINISTRATOR and completing the proper form. DEPENDENTS must be removed from coverage when they are no longer eligible, such as when a child is no longer eligible due to age, or when a spouse is no longer eligible due to divorce or death. Failure to timely notify your PLAN ADMINISTRATOR of the need to remove a DEPENDENT could result in loss of eligibility for continuation of coverage.

Qualified Medical Child Support Order

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

Types of Coverage

These are the types of coverage available:

- EMPLOYEE-only coverage-The PLAN covers only you
- EMPLOYEE-spouse coverage-The PLAN covers you and your spouse
- EMPLOYEE-children coverage-The PLAN covers you and your DEPENDENT CHILDREN
- Family coverage-The PLAN covers you, your spouse and your DEPENDENT CHILDREN.

Reporting Changes

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

Continuing Coverage

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

You may have certain options such as enrolling in Medicare or continuing health insurance under this PLAN.

For DEPENDENTS of an active full-time employee who elects Medicare only enrolled prior to October 1, 2015:

- DEPENDENTS of an active full-time EMPLOYEE who elect Medicare only will continue their eligibility under the PLAN until the time the active EMPLOYEE terminates employment or DEPENDENTS become eligible for Medicare, Medicaid, or other group or individual coverage. All other eligibility provisions apply to these DEPENDENTS.

For DEPENDENTS of an active full-time employee who elects Medicare only enrolled after October 1, 2015:

- DEPENDENTS of an active full-time EMPLOYEE who elect Medicare only after October 1, 2015, who are eligible for COBRA, will have their coverage terminated and COBRA rights will apply for a period not to exceed 36 months. All other eligibility provisions apply to these DEPENDENTS.
- DEPENDENTS of an active full-time EMPLOYEE who elect Medicare only after October 1, 2015, who are eligible for State Continuation, will continue their eligibility for a period of 18 months at which time they will be terminated from the PLAN and allowed an additional 18 months of continuing coverage under State Continuation. All other eligibility provisions apply to these DEPENDENTS.

Medicare

WHEN COVERAGE BEGINS AND ENDS (cont.)

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 - EMPLOYER Groups with 20 or more EMPLOYEES

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 or legal separation
- Your entitlement to Medicare
- A DEPENDENT CHILD ceasing to be a DEPENDENT under the terms of this coverage.

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

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

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

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

- Divorce
- Ineligibility of a DEPENDENT CHILD.

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

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

- Your EMPLOYER ceases to provide a health benefit plan to EMPLOYEES (except in the case of solo practitioners who dissolve their law office - in this case continuation coverage will be offered for 6 months)
- 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
- The continuing person is no longer disabled and is within the 11-month extension for disability.

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

WHEN COVERAGE BEGINS AND ENDS (cont.)

NOTE: You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace (“Marketplace”). By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse’s plan), even if that plan generally doesn’t accept late enrollees.

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

Continuation Under State Law

Under state law, you and your covered DEPENDENTS of any size EMPLOYER group have the option to continue group coverage for 18 months from the date that you and/or your DEPENDENTS cease to be eligible for coverage under the PLAN. You and your DEPENDENTS are not eligible for continuation under state law if:

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

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

Under state law, continuation of coverage under the PLAN will end at the completion of the applicable continuation period or earlier if:

- Your EMPLOYER ceases to provide a health benefit plan to EMPLOYEES (except in the case of solo practitioners who dissolve their law office – in this case continuation coverage will be offered for 6 months)
- The continuing person fails to pay the monthly fee
- The continuing person obtains similar coverage under another group plan.

Certificate of Creditable Coverage

The CORPORATION or its designee will supply a Certificate of Creditable Coverage when you 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 BCBSNC Customer Service while you are still covered under the PLAN and up to 24 months following your termination. You may call Customer Service at 1-877-275-9787 (toll free) or visit the website at bcbsnc.com/members/nbar.

Termination of MEMBER Coverage

The CORPORATION will terminate coverage under the PLAN in accordance with eligibility information provided by the EMPLOYER. A MEMBER’S termination shall be effective at 11:59 p.m. on the last day of the month following the date that eligibility ends, unless the termination must be made on the date of the event, such as death or divorce.

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

Termination for Cause

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

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

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

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

- Fraud or intentional misrepresentation of a material fact by 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

WHEN COVERAGE BEGINS AND ENDS (cont.)

30 days advance written notice of this rescission and may submit an appeal; see "What if You Disagree With a Decision?" If your policy is rescinded, any premiums paid will be returned unless the CORPORATION deducts the amount for any claims paid.

- A MEMBER has been convicted of (or a restraining order has been issued for) communicating threats of harm to the CORPORATION'S personnel or property
- A MEMBER permits the use of his or her or any other MEMBER'S ID CARD by any other person not enrolled under the PLAN, or uses another person's ID CARD.

Guaranteed Renewability

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

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

Plan Amendment or Termination

North Carolina Bar Association Health Benefit Trust reserves the full, absolute and discretionary right to amend, modify, suspend, withdraw, discontinue or terminate the PLAN in whole or in part at any time for any and all participants of the PLAN by formal action taken by the Trustees, or by the execution of a written amendment by the PLAN SPONSOR. If the PLAN is amended, modified, suspended, withdrawn, discontinued or terminated, covered EMPLOYEES and covered DEPENDENTS will be entitled to benefits for claims incurred prior to the date of such action. Such changes may include, but are not limited to, the right to (1) change or eliminate benefits, (2) increase or decrease participant contributions, (3) increase or decrease deductibles and/or copayments, and (4) change the class(es) of EMPLOYEES or DEPENDENTS covered by the PLAN.

UTILIZATION MANAGEMENT

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

Rights and Responsibilities Under the UM Program

Your MEMBER Rights

Under the UM program, you have the right to:

- A UM decision that is timely, meeting applicable state and federal time frames
- The reasons for the CORPORATION'S ADVERSE BENEFIT DETERMINATION of a requested treatment or health care service, including an explanation of the UM criteria and treatment protocol used to reach the decision
- Have a medical director from the CORPORATION make a final determination of all ADVERSE BENEFIT DETERMINATIONS that were based upon MEDICAL NECESSITY
- Request a review of an ADVERSE BENEFIT DETERMINATION through the appeals process. See "What if You Disagree With a Decision?"
- Have an authorized representative pursue 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 appoint an authorized representative, references to "you" under the "UTILIZATION MANAGEMENT" section mean "you or your authorized representative" (i.e., the authorized representative may pursue your rights and shall receive all notices and benefit determinations).

The CORPORATION'S Responsibilities

As part of all UM decisions, the CORPORATION will:

- Provide you and your PROVIDER with a toll-free telephone number to call UM review staff when CERTIFICATION of a health care service is needed.
- Limit what the CORPORATION requests from you or your PROVIDER to information that is needed to review the service in question
- Request all information necessary to make the UM decision, including pertinent clinical information
- Provide you and your PROVIDER prompt notification of the UM decision consistent with applicable state and federal law and the PLAN.

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

PRIOR REVIEW (Pre-Service)

The PLAN requires that certain health care services receive PRIOR REVIEW as noted in "COVERED SERVICES." These types of reviews are called pre-service reviews. If PRIOR REVIEW is required by the CORPORATION, you or your PROVIDER must request PRIOR REVIEW regardless of whether the PLAN is your primary or secondary coverage (see "Coordination of Benefits (Overlapping Coverage)"). **If neither you nor your PROVIDER requests PRIOR REVIEW and receives CERTIFICATION, this may result in an ADVERSE BENEFIT DETERMINATION. The list of services that require PRIOR REVIEW may change from time to time.**

General categories of services with this requirement are noted in "COVERED SERVICES." You may also visit the website at bcbsnc.com/members/nbar or call Customer Service at the number listed in "Who to Contact?" for a detailed list of these services. The list of services that require PRIOR REVIEW may change from time to time.

If you fail to follow the procedures for filing a request, the CORPORATION will notify you of the failure and the proper procedures to be followed in filing your request within five days of receiving the request. If the requested CERTIFICATION is denied, you have the right to appeal. See "What If You Disagree With a Decision?" for more information. Certain services may not be covered OUT-OF-NETWORK. See "COVERED SERVICES."

The CORPORATION will make a decision on your request for CERTIFICATION within a reasonable amount of time taking into account the medical circumstances. The decision will be made and communicated to you and your PROVIDER within three business days after the CORPORATION receives all necessary information but no later than 15 days from the date the CORPORATION received the request. The CORPORATION may extend this period one time for up to 15 days if additional information is required and will notify you and your PROVIDER before the end of the initial 15-day period of the information needed and the date by which the CORPORATION expects to make a decision. You will have 45 days to provide the requested information. As soon as the CORPORATION receives all the requested information, or at the end of the 45 days, whichever is earlier, the CORPORATION will make a decision within three business days. The CORPORATION will notify you and the PROVIDER 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 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. The CORPORATION will notify you and your PROVIDER of its decision as soon as possible, taking into account the medical circumstances. The CORPORATION will notify you and your PROVIDER 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 provided to you and your PROVIDER. If the CORPORATION needs more information to process your urgent review, the CORPORATION will notify you and your PROVIDER 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. As soon as the CORPORATION receives the requested information, or at the end of the time period specified for you to provide the information, whichever is earlier, the CORPORATION will make a decision on your request within a reasonable time but no later than 48 hours after receipt of requested information or the end of the time period given to the PROVIDER to submit necessary clinical information.

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

Concurrent Reviews

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

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

In the event of an ADVERSE BENEFIT DETERMINATION, the CORPORATION will notify you, your HOSPITAL'S or other facility's UM department and your PROVIDER within three business days after receipt of all necessary clinical information, but no later than 15 days after the CORPORATION receives the request. Written confirmation of the decision will also be sent to your home by U.S. mail. For concurrent reviews, the PLAN 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 communicated to the requesting HOSPITAL or other facility as soon as possible, but no later than 24 hours after the CORPORATION receives the request.

If a request for extension of treatment is urgent, and the request is not received at least 24 hours before the expiration of a previously approved inpatient stay or course of treatment at the requesting HOSPITAL or other facility, a decision will be made and communicated as soon as possible, but no later than 72 hours after the CORPORATION receives the request. If the CORPORATION needs more information to process your urgent review, the CORPORATION will notify the requesting HOSPITAL or other facility of the information needed as soon as possible but no later than 24 hours after the CORPORATION receives the request. The requesting HOSPITAL or other facility will then be given a reasonable amount of time, but not less than 48 hours, to provide the requested information. The CORPORATION will make a decision 48 hours of the earlier of receipt of the requested information, or the end of the time period given to the requesting HOSPITAL or other facility to provide the information.

Retrospective Reviews (Post-Service)

The CORPORATION also reviews the coverage of health care services after you receive them (retrospective/post-service reviews). Retrospective review may include a review to determine if services received in an emergency setting qualify as an EMERGENCY. The CORPORATION make all retrospective review decisions and notify you and your PROVIDER of its decision within a reasonable time but no later than 30 days from the date the CORPORATION received the request. In the event of an ADVERSE BENEFIT DETERMINATION, the CORPORATION will notify you and your PROVIDER in writing within five business days of the decision. All decisions will be based on MEDICAL NECESSITY and whether the service received was a benefit under this PLAN. If more information is needed before the end of the initial 30-day period, the CORPORATION will notify you of the information needed. You will then have 90 days to provide the requested information. As soon as the CORPORATION receives the requested information, or at the end of the 90 days, whichever is earlier, the CORPORATION will make a decision within 15 days. Services that were approved in advance by the CORPORATION will not be subject to denial for MEDICAL NECESSITY once the claim is received, unless the CERTIFICATION was based on a material misrepresentation about your health condition or you were not eligible for these services under the PLAN due to termination of coverage or nonpayment of premiums. All other services may be subject to retrospective review and could be denied for MEDICAL NECESSITY or for a benefit limitation or exclusion.

Care Management

MEMBERS with complicated and/or chronic medical needs may be eligible for care management services. Care management (or case management) encourages MEMBERS with complicated or chronic medical needs, their PROVIDERS, and the PLAN to work together to meet the individual's health needs and promote quality outcomes.

To accomplish this, MEMBERS enrolled in or eligible for care management programs may be contacted by the CORPORATION or by a representative of the CORPORATION. The PLAN is not obligated to provide the same benefits or services to a MEMBER at a later date or to any other MEMBER. Information about these services can be obtained by contacting an IN-NETWORK PCP or IN-NETWORK SPECIALIST or by calling Customer Service.

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

Continuity of Care

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

An ongoing special condition means:

- in the case of 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;
- in the case of 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;
- in the case of pregnancy, the second and third trimesters of pregnancy;
- in the case of 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 determined 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 with respect to care directly related to the treatment of the terminal illness.

Continuity of care requests will be reviewed by a medical professional based on the information provided about specific medical conditions. Claims for approved continuity of care services will be subject to the IN-NETWORK benefit level. 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 provided when the PROVIDER'S contract was terminated for reasons relating to quality of care or fraud. Such a decision may not be reviewed on appeal.

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

Further Review of UTILIZATION MANAGEMENT Decisions

If you receive an ADVERSE BENEFIT DETERMINATION as part of the PRIOR REVIEW process, you have the right to request that the PLAN review the decision through the appeals process. See "What If You Disagree with a Decision?"

Delegated UTILIZATION MANAGEMENT

The CORPORATION delegates UM and the first level appeal for inpatient and certain outpatient mental health and substance abuse services to Magellan Behavioral Health. Magellan Behavioral Health is not associated with the CORPORATION. Claims determinations and second level appeals, if eligible, are provided by the CORPORATION.

Evaluating New Technology

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

WHAT IF YOU DISAGREE WITH A DECISION?

In addition to the UM program, the PLAN offers an appeals procedure for MEMBERS.

If you want to appeal an ADVERSE BENEFIT DETERMINATION or have a GRIEVANCE, you have the right to request that the CORPORATION review the decision or GRIEVANCE, through the appeals process. The appeals process is voluntary and 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 appoint an authorized representative, references to "you" under this section mean "you or your authorized representative" (i.e., the authorized representative may pursue your rights and shall receive all notices and benefit determinations). You may request, at no charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits.

Steps to Follow in the Appeals Process

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

Any request for review should include:

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

To request a form to submit a request for a review, visit the website at bcbsnc.com/members/nccbar or call Customer Service at the number listed in "Who to Contact?"

All correspondence related to a request for a review through the CORPORATION'S appeals process should be sent to:

BCBSNC
Appeals Department
PO Box 30055
Durham, NC 27702

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

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

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

Following such request for review, a review will be conducted by the CORPORATION, by someone who is neither the individual who made the original claims denial that is the subject of the appeal, nor the subordinate of such individual. 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 with respect to whether a particular treatment, drug or other item is EXPERIMENTAL, INVESTIGATIONAL, or not MEDICALLY NECESSARY or appropriate, the CORPORATION shall consult with a health care professional with an appropriate level of training and expertise in the field of medicine involved (as determined by the CORPORATION) who was not involved in the initial claims denial and who is not a subordinate of any such individual.

Prescription Drug Appeals

The CORPORATION does not administer your prescription drug benefits. Responsibility for first level and second level appeals for retail, mail order and specialty pharmacy services is handled by Express Scripts, Inc. Express Scripts is not associated with the CORPORATION. Please forward written appeals to:

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

Delegated Appeals

WHAT IF YOU DISAGREE WITH A DECISION? (cont.)

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

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

Second level appeal is provided by the CORPORATION.

Quality of Care Complaints

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

First Level Appeal

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

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

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

Second Level Appeal

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

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

- Name, address and telephone number of the appeals coordinator
- Availability of the Health Insurance Smart NC including address and telephone number
- A statement of your rights, including the right to:
 - request and receive from the CORPORATION all information that applies to your appeal
 - participate 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, which will be conducted by a review panel coordinated by the CORPORATION using external physicians and/or benefit experts, will be held within 45 days after the CORPORATION receives a second level appeal. You will receive notice of the meeting date and time at least 15 days before the meeting, which will be held by teleconference. You have the right to a full review of your appeal even if you do not participate 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, upon request and without charge, reasonable access to, and copies of, all documents, records and other information relevant to the MEMBER'S claim for benefits
- 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 and that this will be provided without charge upon request
- 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 health benefit plan to the MEMBER'S medical circumstances, or a statement that such explanation will be provided without charge upon request; and
- The following statement: "You may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

Final Review

After the second level appeal is completed, you may request review of the appeal by the PLAN ADMINISTRATOR for a final decision. After the appeals process is completed, or in those circumstances where the appeals process does not apply, you may request review of the appeal by your PLAN ADMINISTRATOR for a final decision.

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. An expedited review may be initiated by calling 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. The CORPORATION will communicate the decision by phone to you and your PROVIDER as soon as possible, taking into account the medical circumstances, but no later than 72 hours after receiving the request. A written decision will be communicated within four days after receiving the request for the expedited appeal. Information initially given by telephone must also be given in writing.

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

External Review (Available only for NONCERTIFICATIONS)

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

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

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

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

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

- completed the PLAN'S first and second level appeals and received a written second level determination from the CORPORATION, or

WHAT IF YOU DISAGREE WITH A DECISION? (cont.)

- filed a second level appeal and have not requested or agreed to a delay in the second level appeals process, but have not received the CORPORATION'S written decision within 60 days of the date you can show that the appeal was filed with the CORPORATION, or
- received written notification that the CORPORATION has agreed to waive the requirement to exhaust the internal appeal and/or second level appeals process.

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

Standard External Review

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

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

Expedited External Review

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

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

In addition, prior to your discharge from an inpatient facility, you may also request an expedited external review after receiving a first level appeal or final internal adverse benefit determination of the admission, availability of care, continued stay or EMERGENCY health care services.

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

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

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

(Mail)
North Carolina Department of Insurance

Health Insurance Smart NC
1201 Mail Service Center
Raleigh, NC 27699-1201
Tel (toll free in NC): 855-408-1212
Fax: 919-807-6865

(In person)
For the physical address for Health Insurance Smart NC,
please visit the web-page: http://www.ncdoi.com/Smart/Smart_Contacts.aspx

(Web): www.ncdoi.com/Smart for external review information and request form.

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

WHAT IF YOU DISAGREE WITH A DECISION? *(cont.)*

Within ten business days (or, for an expedited review, within three business days) of receipt of your request for an external review, the NCDOJ will notify you and your PROVIDER of whether your request is complete and whether it has been accepted. If the NCDOJ notifies you that your request is incomplete, you must provide all requested, additional information to the NCDOJ within 150 days of the written notice from the CORPORATION upholding an ADVERSE BENEFIT DETERMINATION (generally the notice of a second level appeal decision), which initiated your request for an external review. If the NCDOJ accepts your request, the acceptance notice will include: (i) the name and contact information for the IRO assigned to your case; (ii) a copy of the information about your case that the CORPORATION has provided to the NCDOJ; and (iii) a notification that you may submit additional written information and supporting documentation relevant to the initial ADVERSE BENEFIT DETERMINATION to the assigned IRO within seven days after the receipt of the notice. It is presumed that you have received written notice two days after the notice was mailed. Within seven days of the CORPORATION'S receipt of the acceptance notice (or, for an expedited review, within the same business day), the CORPORATION shall provide the IRO and you, by the same or similar expeditious means of communication, the documents and any information considered in making the ADVERSE BENEFIT DETERMINATION or the second level appeal decision. If you choose to provide any additional information to the IRO, you must also provide that same information to the CORPORATION at the same time and by the same means of communication (e.g., you must fax the information to the CORPORATION if you faxed it to the IRO). When sending additional information to the CORPORATION, send it to:

Blue Cross Blue Shield of North Carolina
Appeals Department
HQ2540HM
PO Box 30055
Durham, NC 27702

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

The IRO will send you written notice of its decision within 45 days (or, for an expedited review, within four business days) of the date the NCDOJ received your external review request. If the IRO'S decision is to reverse the ADVERSE BENEFIT DETERMINATION, the CORPORATION will, within three business days (or, for an expedited review, within one day) of receiving notice of the IRO'S decision, reverse the ADVERSE BENEFIT DETERMINATION and provide coverage for the requested service or supply. If you are no longer covered by the PLAN at the time the CORPORATION receives notice of the IRO'S decision to reverse the ADVERSE BENEFIT DETERMINATION, the PLAN will only provide coverage for those services or supplies you actually received or would have received prior to disenrollment if the service had not been noncertified when first requested.

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

ADDITIONAL TERMS OF YOUR COVERAGE

Benefits to which MEMBERS are Entitled

The benefits described in this benefit booklet are provided only for members. These benefits and the right to receive payment under the PLAN cannot be transferred to another person or entity, including PROVIDERS. The CORPORATION may pay a PROVIDER directly. For example, the CORPORATION pays IN-NETWORK PROVIDERS directly under applicable contracts with those providers. However, any PROVIDER'S right to be paid directly is through such contract with the CORPORATION, and not through the PLAN. Under the PLAN, the CORPORATION has the sole right to determine whether payment for services is made to the PROVIDER, to the EMPLOYEE, or the PROVIDER and the EMPLOYEE allocated among both. The CORPORATION'S decision to pay a PROVIDER in no way reflects or creates any rights of the PROVIDER under the PLAN including but not limited to benefits payments or procedures.

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

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

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

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

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

Disclosure of Protected Health Information (PHI)

The CORPORATION takes your privacy seriously and handles all PHI as required by state and federal laws and regulations and accreditation standards. The CORPORATION has developed a privacy notice that explains the procedure.

To obtain a copy of the privacy notice, visit the CORPORATION'S website at bcbsnc.com or call Customer Service at the number listed in "Who to Contact?"

Administrative Discretion

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

North Carolina PROVIDER Reimbursement

The CORPORATION has contracts with certain PROVIDERS of health care services for the provision of, and payment for, health care services provided to all North Carolina Bar Association Health Benefit Trust MEMBERS entitled to health care benefits. The PLAN'S payment to PROVIDERS may be based on an amount other than the billed charges, including without limitation, an amount per confinement or episode of care, agreed upon schedule of fees, or other methodology as agreed upon by the CORPORATION and the PROVIDER. Under certain circumstances, a contracting PROVIDER may receive payments from the PLAN greater than the charges for services provided to an eligible MEMBER, or the PLAN 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.

ADDITIONAL TERMS OF YOUR COVERAGE (cont.)

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

Services Received Outside of North Carolina

The CORPORATION has a variety of relationships with other Blue Cross and/or Blue Shield licensees, generally referred to as "Inter-Plan Programs". 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 North Carolina Bar Association Health Benefit Trust. 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 service area where you receive services ("Host Blue") is responsible for contracting with and generally handling all interactions with its participating PROVIDERS.

Whenever you obtain health care services outside the area in which the CORPORATION'S network operates, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include Negotiated National Account Arrangements available between the CORPORATION and other Blue Cross and/or Blue Shield licensees. Under the BlueCard Program, the amount you pay toward such COVERED SERVICES, such as deductibles, copayments or coinsurance, is usually based on the **lesser** of:

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

This "negotiated price" can be:

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

The estimated or average price may be adjusted in the future to correct for over- or underestimation of past prices.

However, such adjustments will not affect the price that the CORPORATION uses for your claim because they will not be applied retroactively to claims already paid.

Federal law or the laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If federal law or any state law mandates other liability calculation methods, including a surcharge, your liability for any covered health care services will be calculated 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 negotiated price made available to the CORPORATION by the Host Blue.

If you receive COVERED SERVICES from a PROVIDER outside the state of North Carolina, the amount you pay will generally be based on either the Host Blue's 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 PROVIDER. In any of these situations, you may be liable for the difference between the PROVIDER'S billed amount and any payment the PLAN would make for the COVERED SERVICES.

Right of Recovery Provision

The Right of Recovery of the PLAN, as outlined below, shall apply and be effective only when the benefits paid on behalf of a member exceed \$225,000 in the current plan year.

Immediately upon paying or providing any benefit under the PLAN, the CORPORATION 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 CORPORATION.

In addition, if a MEMBER receives any payment from any potentially responsible party as a result of an injury, illness or condition, the CORPORATION has the right to recover from, and be reimbursed by, the MEMBER for all amounts the CORPORATION 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

ADDITIONAL TERMS OF YOUR COVERAGE (cont.)

funds for the benefit of the CORPORATION. Failure to hold such funds in trust will be deemed a breach of the member's fiduciary duty to the CORPORATION.

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

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 lien can be filed with or enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the CORPORATION 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 CORPORATION.

The MEMBER acknowledges that the CORPORATION'S recovery rights are a first priority claim against all potentially responsible parties and are to be paid to the CORPORATION before any other claim for the member's damages. The CORPORATION shall be entitled to full reimbursement first from any potential responsible party payments, even if such payment to the CORPORATION 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 CORPORATION will pay all fees associated with counsel it hires to represent its interests related to any recovery to which it may be entitled, but it is agreed that the CORPORATION is not required to participate in or pay court costs or attorney fees to any attorney hired by the MEMBER.

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. The PLAN is entitled to recover from **any and all** settlements or judgments, even those designated as pain and suffering or non-economic damages only.

The MEMBER acknowledges that the CORPORATION ADMINISTRATOR has authority to assert and pursue the right of subrogation and/or reimbursement on behalf of the CORPORATION. The MEMBER shall fully cooperate with the CORPORATION ADMINISTRATOR'S efforts to recover benefits paid by the CORPORATION. It is the duty of the MEMBER to notify the CORPORATION ADMINISTRATOR 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 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 shall provide all information requested by the CORPORATION ADMINISTRATOR or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the CORPORATION ADMINISTRATOR may reasonably request.

The MEMBER shall do nothing to prejudice the CORPORATION'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 CORPORATION.

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 CORPORATION agree that the CORPORATION 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 the CORPORATION ADMINISTRATOR may elect. Upon receiving benefits under the CORPORATION, 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.

Notice of Claim

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

ADDITIONAL TERMS OF YOUR COVERAGE (cont.)

of the MEMBER. The notice must be on an approved claim form and include the data necessary for the CORPORATION to determine benefits.

Notice of Benefit Determination

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

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

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

Upon receipt of a denial of benefits, you have the right to file an appeal with the CORPORATION. See “What if You Disagree with a Decision?” for more information.

Limitation of Actions

Since the PLAN is subject to ERISA, you must only exhaust the first level appeal process following the Notice of Claim requirement. Please see “What if You Disagree with a Decision?” for details regarding the appeal process. No legal action may be taken later than three years from the date services are INCURRED. However, if you are authorized to pursue an action in federal court under ERISA, and you choose to pursue a second level appeal, the three-year limitation is temporarily suspended until that review has been resolved.

Coordination of Benefits (Overlapping Coverage)

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

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

ADDITIONAL TERMS OF YOUR COVERAGE *(cont.)*

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 EMPLOYEE under one plan and a DEPENDENT under the other	The plan covering the person as the EMPLOYEE is	√	
	The plan covering the person as a DEPENDENT is		√
The person is covered as a DEPENDENT CHILD under both plans and parents are either: 1) married or living together; or 2) divorced/separated or not living together and a court decree* states that they have joint custody without specifying which parent is responsible for the DEPENDENT CHILD'S health care coverage; or 3) Divorced/separated or not living together and a court decree* states that both parents have responsibility for the DEPENDENT CHILD'S health care coverage	The plan of the parent whose birthday occurs earlier in the calendar year (known as the birthday rule) is	√	
	The plan of the parent whose birthday is later in the calendar year is		√
	<i>Note: When the parents have the same birthday, the plan that covered the parent longer is</i>	√	
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		√
<i>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.</i>			
The person is covered as a DEPENDENT CHILD under both plans and parents are divorced/separated or not living together, and coverage is stipulated in a court decree*	The plan of the parent primarily responsible for health coverage under the court decree is	√	
	The plan of the other parent is		√
	<i>Note: If there is a court decree that requires a parent to assume financial responsibility for the child's health care coverage, and the CORPORATION or the PLAN ADMINISTRATOR has actual knowledge of those terms of the court decree, benefits under that parent's plan are</i>	√	

ADDITIONAL TERMS OF YOUR COVERAGE *(cont.)*

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

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

Please note that payment by the CORPORATION under the PLAN takes into account whether or not the PROVIDER is a participating PROVIDER. If the PLAN is the secondary plan, and the MEMBER uses a participating PROVIDER, the PLAN will coordinate up to the ALLOWED AMOUNT. The participating PROVIDER has agreed to accept the ALLOWED AMOUNT as payment in full. However, if neither the primary nor secondary plan covers a particular service, the MEMBER will be responsible for payment for that service.

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

SPECIAL PROGRAMS

Programs Outside Your Regular Benefits

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

- Discounts or promotional offers on goods and services from other companies including certain types of PROVIDERS
- Health and wellness programs
- Service programs for MEMBERS identified with complex health care needs, including a dedicated administrative contract, 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 the CORPORATION'S website
- Periodic drawings for gifts, which may include club memberships and trips to special events, based on submitting information
- Charitable donations made on your behalf by the CORPORATION.

The PLAN or the CORPORATION may not provide some or all of these discounts on goods and services items directly, but may instead arrange these for your convenience. These discounts or promotional offers are outside the Plan benefits. Neither the PLAN nor the CORPORATION is liable for problems resulting from goods and services it does not provide directly, such as goods and services not being provided or being provided negligently. The gifts and charitable donations are also outside the PLAN benefits. Neither the PLAN nor the CORPORATION is liable for third party providers' negligent provision of the gifts. The PLAN or the CORPORATION may stop or change these programs at any time.

Healthy Outcomes

The PLAN offers health and wellness programs at no additional cost to MEMBERS. These confidential programs are designed to provide MEMBERS with targeted information and support services, which can help them improve their health as well as manage specific health care needs.

MEMBERS may receive comprehensive educational materials, tools and other resources. These programs also provide the opportunity to work one-on-one with a specially trained nurse, and offer benefits for MEMBERS with certain conditions who agree to engage. The Healthy Outcomes program includes the following components:

Healthy Outcomes Case Management – provides support to MEMBERS with various high-risk health conditions to better manage the daily challenges of those conditions. MEMBERS are able to work one-on-one with a nurse coach.

Healthy Outcomes Condition Care – provides disease management assistance to MEMBERS 18 years of age and older who are at risk and diagnosed with chronic health conditions through education, empowerment and support. MEMBERS enrolled in the program receive personalized support through telephonic coaching and targeted educational materials. Conditions supported include:

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

Healthy Outcomes Maternity – provides support to female MEMBERS 18 years of age and older who are currently pregnant. This program offers initial and mid-pregnancy assessments through a health coach, and additional nurse support via a 24/7 BabyLine®, which is available through 6 weeks post delivery.

Healthy Outcomes Wellness – provides robust, integrated wellness offerings through a variety of media – on-line, telephonic and mail – to help MEMBERS improve their health. This program includes a health assessment, healthy living programs, a personal health record, as well as a variety of tools, trackers, and newsletter articles.

Health Line Blue – provides a toll-free, nurse-driven telephonic support program that empowers MEMBERS to better manage their health and make informed healthcare decisions. Highly trained registered nurses are available 24/7 to provide cost-effective solutions for MEMBERS coping with chronic and acute illnesses, episodic or injury-related events and other healthcare issues.

SPECIAL PROGRAMS *(cont.)*

Full details on these programs, including a description of what's available and how to get started, are located on the website at bcbsnc.com/members/nbar. Programs are available at the discretion of your EMPLOYER. To determine which programs are available to you, log into bcbsnc.com/members/nbar. You can also call 1-800-260-0091 to learn more about these programs and find out which ones are included in the PLAN.

Health Information Services

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

GLOSSARY

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

ADVERSE BENEFIT DETERMINATION

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

ALLOWED AMOUNT

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

AMBULATORY SURGICAL CENTER

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

- a) Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an outpatient basis
- b) Provides nursing services and treatment by or under the supervision of DOCTORS whenever the patient is in the facility
- c) Does not provide inpatient accommodations
- d) Is not other than incidentally, a facility used as an office or clinic for the private practice of a DOCTOR or OTHER PROVIDER.

ANCILLARY PROVIDER

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

- a) For independent clinical laboratories, services are received in the state where the specimen is drawn
- b) For durable/home equipment and supply PROVIDERS, services are received in the state where the equipment or supply is shipped (receiving address) or if purchased at a retail store the vendor must be contracted with the plan in the state where the retail store is located
- c) For specialty pharmacies, services are received in the state where the ordering physician is located.

BENEFIT PERIOD

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

BENEFIT PERIOD MAXIMUM

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

CERTIFICATION

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

COMPLICATIONS OF PREGNANCY

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

CONGENITAL

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

CORPORATION

Blue Cross and Blue Shield of North Carolina

COSMETIC

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

COVERED SERVICE(S)

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

CREDITABLE COVERAGE

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

DENTAL SERVICE(S)

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

DENTIST

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

DEPENDENT

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

DEPENDENT CHILD(REN)

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

DOCTOR

Includes the following: a doctor of medicine, a doctor of osteopathy, licensed to practice medicine or SURGERY by the Board of Medical Examiners in the state of practice, a doctor of dentistry, a doctor of podiatry, a doctor of chiropractic, a doctor of optometry, or a doctor of psychology who must be licensed or certified in the state of practice and has a doctorate degree in psychology and at least two years clinical experience in a recognized health setting or has met the standards of the National Register of Health Service Providers in Psychology. All of the above must be duly licensed to practice by

the state in which any service covered by the contract is performed, regularly charge and collect fees as a personal right, subject to any licensure or regulatory limitation as to location, manner or scope of practice. All services performed must be within the scope of license or certification to be eligible for reimbursement.

DURABLE MEDICAL EQUIPMENT

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

EDUCATIONAL TREATMENT

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

EFFECTIVE DATE

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

EMERGENCY(IES)

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

EMERGENCY SERVICES

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

EMPLOYEE

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

EMPLOYER

AN employer participating in the North Carolina Bar Association Health Benefit Trust whose EMPLOYEES are eligible to participate in the PLAN

ERISA

The Employee Retirement Income Security Act of 1974.

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 order of a court with proper jurisdiction and who are residing with a person appointed as guardian or custodian for so long as the guardian or custodian has assumed the legal obligation for total or partial support of the children with the intent that the children reside with the guardian or custodian on more than a temporary or short-term basis.

HABILITATIVE SERVICES

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

HOMEBOUND

A MEMBER who cannot leave their home or temporary residence due to a medical condition which requires both the assistance of another person and the aid of supportive devices or the use of special transportation. To be homebound

means that leaving home takes considerable and taxing effort. A MEMBER is not considered homebound solely because the assistance of another person is required to leave the home.

HOME HEALTH AGENCY

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

- a) Provides skilled nursing and other services on a visiting basis in the MEMBER'S home,
- b) Is responsible for supervising the delivery of such services under a plan prescribed by a DOCTOR,
- c) Is accredited and licensed or certified in the state where located,
- d) Is certified for participation in the Medicare program, and
- e) Is acceptable to the CORPORATION.

HOSPICE

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

- a) Is accredited, licensed or certified in the state where located,
- b) Is certified for participation in the Medicare program, and
- c) Is acceptable to the CORPORATION.

HOSPITAL

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

IDENTIFICATION CARD (ID CARD)

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

INCURRED

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

INFERTILITY

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

IN-NETWORK

Designated as participating in the PPO network. The CORPORATION'S payment for in-network COVERED SERVICES is described in this benefit booklet as in-network benefits or in-network benefit levels.

IN-NETWORK PROVIDER

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

INVESTIGATIONAL (EXPERIMENTAL)

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

- a) Services or supplies requiring federal or other governmental body approval, such as drugs and devices that do not have unrestricted market approval from the U.S. Food and Drug Administration (FDA) or final approval from any other governmental regulatory body for use in treatment of a specified condition. Any approval that is granted as an interim step in the regulatory process is not a substitute for final or unrestricted market approval.
- b) There is insufficient or inconclusive scientific evidence in peer-reviewed medical literature to permit the CORPORATION evaluation of the therapeutic value of the service or supply
- c) There is inconclusive evidence that the service or supply has a beneficial effect on health outcomes
- d) The service or supply under consideration is not as beneficial as any established alternatives
- e) There is insufficient information or inconclusive scientific evidence that, when utilized in a non-investigational setting, the service or supply has a beneficial effect on health outcomes and is as beneficial as any established alternatives.

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

LICENSED PRACTICAL NURSE (LPN)

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

LIFETIME MAXIMUM

The benefit maximum of certain COVERED SERVICES such as INFERTILITY services and orthotic devices for positional plagiocephaly that will be reimbursed on behalf of a MEMBER while covered under the PLAN. Services in excess of any lifetime maximum are not COVERED SERVICES, and MEMBERS may be responsible for the entire amount of the PROVIDER'S billed charge.

MEDICAL SUPPLIES

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

MEDICALLY NECESSARY (or MEDICAL NECESSITY)

Those COVERED SERVICES or supplies that are:

- a) Provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease; and, except for clinical trials as described under the PLAN, not for EXPERIMENTAL, INVESTIGATIONAL, or COSMETIC purposes,
- b) Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms,
- c) Within generally accepted standards of medical care in the community, and
- d) Not solely for the convenience of the insured, the insured's family, or the PROVIDER.

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

MEMBER

An EMPLOYEE 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, a mental condition, other than mental retardation 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"). Mental illness does not include substance-related disorders, SEXUAL DYSFUNCTIONS not due to organic disease, and disorders coded as "V" codes in the DSM-V. Those mental disorders coded in the DSM-V as substance-related disorders, SEXUAL DYSFUNCTION not due to organic disease, and those coded as "V" codes are not included in the definition of mental illness.

NONCERTIFICATION

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

NONHOSPITAL FACILITY

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

OFFICE VISIT

Medical care, SURGERY, diagnostic services, REHABILITATIVE and HABILITATIVE THERAPY services and MEDICAL SUPPLIES provided in a PROVIDER'S office.

OTHER PROFESSIONAL PROVIDER

A person or entity other than a DOCTOR who is accredited and licensed or certified in the state where located to provide COVERED SERVICES, and which is acceptable to the CORPORATION. Examples may include physician assistants (PAs), nurse

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

OTHER PROVIDER

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

OTHER THERAPY(IES)

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

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

OUT-OF-NETWORK

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

OUT-OF-NETWORK PROVIDER

A PROVIDER that has not been designated as a PPO PROVIDER by the CORPORATION.

OUTPATIENT CLINIC(S)

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

PLAN

The North Carolina Bar Association Health Benefit Trust.

PLAN ADMINISTRATOR

Lawyers Insurance Agency, Inc.

PLAN SPONSOR

North Carolina Bar Association

POSITIONAL PLAGIOCEPHALY

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

PRESCRIPTION

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

PREVENTIVE CARE

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

PRIMARY CARE PROVIDER (PCP)

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

PRIOR REVIEW

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

PROSTHETIC APPLIANCES

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

PROVIDER

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

REGISTERED NURSE (RN)

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

REHABILITATIVE THERAPY

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

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

RESIDENTIAL TREATMENT FACILITY

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

RESPITE CARE

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

ROUTINE FOOT CARE

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

SEXUAL DYSFUNCTION

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

SKILLED NURSING FACILITY

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

SPACERS

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

SPECIALIST

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

STABILIZE

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

SURGERY

The performance of generally accepted operative and cutting procedures including specialized instrumentations, endoscopic examinations and other invasive procedures, such as:

- a) The correction of fractures and dislocations
- b) Usual and related pre-operative and post-operative care
- c) Other procedures as reasonable and approved by the CORPORATION.

TOTAL OUT-OF-POCKET LIMIT

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

URGENT CARE

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

UTILIZATION MANAGEMENT (UM)

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

WAITING PERIOD

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

SUMMARY PLAN DESCRIPTION OF HEALTH CARE BENEFITS

Summary Plan Description

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

Name and Number of PLAN(S)

Plan Number 501 - North Carolina Bar Association Health Benefit Trust

Name, Address and Telephone Number of PLAN SPONSOR

North Carolina Bar Association
PO Box 1929
Cary, NC 27512-1929
919-677-0561

Other EMPLOYERS Adopting the Plan(s)

None

EMPLOYER Identification Number of PLAN SPONSOR

56-6595155

Identification of PLAN ADMINISTRATOR

Lawyers Insurance Agency, Inc.
8000 Weston Parkway
Suite 200
Cary, NC 27513

Benefits Provided by PLAN(S)

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

Type of PLAN ADMINISTRATION

The general administration of the PLAN is provided by the PLAN SPONSOR. The processing of claims for benefits under the terms of the Plan is provided by Blue Cross and Blue Shield of North Carolina through an administrative services agreement.

Contributions to the Cost of the PLAN(S)

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

Financial Records

The financial records of the PLAN(S) are kept on a Plan Year basis. Each PLAN year ends September 30.

Agent for Service of Legal Process

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

ERISA Rights Statement

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

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

SUMMARY PLAN DESCRIPTION OF HEALTH CARE BENEFITS *(cont.)*

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.

NOTICE REGARDING HEALTH BENEFIT PREMIUMS/CONTRIBUTIONS

NOTICE REGARDING HEALTH BENEFIT PREMIUMS/CONTRIBUTIONS

UNDER NORTH CAROLINA GENERAL STATUTE SECTION 585040, NO PERSON, EMPLOYER, PRINCIPAL, AGENT, TRUSTEE, OR THIRD PARTY ADMINISTRATOR, WHO IS RESPONSIBLE FOR THE PAYMENT OF GROUP HEALTH OR LIFE INSURANCE OR GROUP HEALTH PLAN PREMIUMS, SHALL: (1) CAUSE THE CANCELLATION OR NONRENEWAL OF GROUP HEALTH OR LIFE INSURANCE, HOSPITAL, MEDICAL, OR DENTAL SERVICE CORPORATION PLAN, MULTIPLE EMPLOYER WELFARE ARRANGEMENT, OR GROUP HEALTH PLAN COVERAGES AND THE CONSEQUENTIAL LOSS OF THE COVERAGES OF THE PERSONS INSURED, BY WILLFULLY FAILING TO PAY THOSE PREMIUMS IN ACCORDANCE WITH THE TERMS OF THE INSURANCE OR PLAN CONTRACT, AND (2) WILLFULLY FAIL TO DELIVER, AT LEAST 45 DAYS BEFORE THE TERMINATION OF THOSE COVERAGES, TO ALL PERSONS COVERED BY THE GROUP POLICY A WRITTEN NOTICE OF THE PERSON'S INTENTION TO STOP PAYMENT OF PREMIUMS. THIS WRITTEN NOTICE MUST ALSO CONTAIN A NOTICE TO ALL PERSONS COVERED BY THE GROUP POLICY OF THEIR RIGHTS TO HEALTH INSURANCE CONVERSION POLICIES UNDER ARTICLE 53 OF CHAPTER 58 OF THE GENERAL STATUTES AND THEIR RIGHTS TO PURCHASE INDIVIDUAL POLICIES UNDER THE FEDERAL HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT AND UNDER ARTICLE 68 OF CHAPTER 58 OF THE GENERAL STATUTES. VIOLATION OF THIS LAW IS A FELONY. ANY PERSON VIOLATING THIS LAW IS ALSO SUBJECT TO A COURT ORDER REQUIRING THE PERSON TO COMPENSATE PERSONS INSURED FOR EXPENSES OR LOSSES INCURRED AS A RESULT OF THE TERMINATION OF THE INSURANCE.

NC BAR ASSOCIATION HEALTH BENEFIT TRUST PRIVACY NOTICE

NORTH CAROLINA BAR ASSOCIATION HEALTH BENEFIT TRUST NOTICE OF PRIVACY PRACTICES

Your Information, Your Rights, Our Responsibilities

This notice followed by the North Carolina Bar Association Health Benefit Trust, describes how medical information about you may be used and disclosed and how you can get access to this information. The effective date of this notice is October 1, 2015. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated.

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal action

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
 - We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1- 877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

NC BAR ASSOCIATION HEALTH BENEFIT TRUST PRIVACY NOTICE (cont.)

Example: We share information about you with your dental plan to coordinate payment for your dental work

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

- We can use or share health information about you:
- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

NC BAR ASSOCIATION HEALTH BENEFIT TRUST PRIVACY NOTICE *(cont.)*

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

If you have any questions please contact;

Lawyers Insurance Agency, Inc.
Attn: Privacy Officer
8000 Weston Parkway, Suite 200
Cary, NC 27513
(919) 677-8900

SCHEDULE OF PRESCRIPTION DRUG BENEFITS

SCHEDULE OF PRESCRIPTION DRUG BENEFITS
Prescription Drug Card Program
Administered by Express Scripts, Inc.
1-844-457-9196

	In-Network	Out-of-Network
Retail: Your coinsurance amount <ul style="list-style-type: none"> • Generic • Preferred Brand • Non-Preferred Brand 	Up to a 30-day supply or 90-days for maintenance medications. After deductible is met: <ul style="list-style-type: none"> • 0%, (100% covered by the Plan) • 0%, (100% covered by the Plan) • 0%, (100% covered by the Plan) 	Up to a 30-day supply or 90-days for maintenance medications. After deductible is met: Coinsurance + charge over IN-NETWORK ALLOWED AMOUNT
Mail Order: Your coinsurance amount	Up to a 90-day supply for maintenance medications. After deductible is met: <ul style="list-style-type: none"> • 0%, (100% covered by the Plan) 	Up to a 90-day supply for maintenance medications. After deductible is met Coinsurance + charge over IN-NETWORK ALLOWED AMOUNT
Specialty: Your coinsurance amount <ul style="list-style-type: none"> • Generic • Preferred Brand • Non-Preferred Brand 	Up to a 30-day supply. After deductible is met: <ul style="list-style-type: none"> • 0%, (100% covered by the Plan) 	Up to a 30-day supply. After deductible is met: Coinsurance + charge over IN-NETWORK ALLOWED AMOUNT
Diabetic Supplies, Spacers and Peak Flow Meters	After deductible is met: <ul style="list-style-type: none"> • 0%, (100% covered by the Plan) 	After deductible is met Coinsurance + charge over IN-NETWORK ALLOWED
Certain preventive medications and prescription contraceptive drugs and device - Your coinsurance amount	<ul style="list-style-type: none"> • 0% (100% covered by the Plan), deductible does not apply 	Coinsurance + charge over IN-NETWORK ALLOWED AMOUNT
Copayments and coinsurance for the Prescription Drug Card Program do accumulate toward the global out-of-pocket expense.		

The Plan's Prescription Drug Card Program is administered by Express Scripts using the National Preferred formulary. The formulary is subject to change on an annual basis beginning January 1st of each year. Express Scripts has a national network of pharmacies which can identify covered persons and the Plan's coverage provisions. To find out which pharmacies participate or to inquire about specific coverage for prescription drugs, visit Express Scripts at www.express-scripts.com or call 1-844-457-9196.

SCHEDULE OF PRESCRIPTION DRUG BENEFITS *(cont.)*

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

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

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

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

Administered by Express Scripts

DEFINITIONS

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

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

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

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

Peak Flow Meters means devices prescribed to patients with asthma, chronic obstructive pulmonary disease (COPD), and other respiratory diseases for monitoring the severity of their disease and their response to therapy at home.

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

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

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

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

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

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

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

Supply Limits - Supply is limited to 30 days (or 90 days for maintenance medications) for PBM Network Prescriptions and Member Submit, or a 90-day supply for Mail Order Prescriptions. Prescription drug refills are not allowed until 75% of the prescribed day supply is used.

SCHEDULE OF PRESCRIPTION DRUG BENEFITS (cont.)

The amount of certain medications are limited to promote safe, clinically appropriate drug usage. If you have exceeded a limit and your physician believes you need an additional supply of a medication, it will be reviewed for medical necessity. A current list of applicable limits can be obtained by contacting Express Scripts at the number listed on your identification card.

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

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

EXCLUSIONS

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

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

The Covered Person has a right to purchase an excluded product at his or her own cost if the product is excluded under this Plan.

This Plan does not coordinate Prescription benefits.

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

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

MEMBER'S AUTHORIZATION REQUEST FORM

You may give the North Carolina Bar Association Health Benefit Trust and its administrator Blue Cross and Blue Shield of North Carolina (BCBSNC) written authorization to disclose your protected health information (PHI) to anyone that you designate and for any purpose. If you wish to authorize a person or entity to receive your PHI, please complete the information below. **Completion of this form will not change the way that North Carolina Bar Association Health Benefit Trust and BCBSNC communicate with members or subscribers. For example, explanation of benefits (EOB) will continue to be sent to the subscriber.**

Member's Name _____ Subscriber's Name (if different) _____ Member's Date of Birth ___/___/___

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

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

(Name) (Address) (Relationship to Member)

Please provide the following information to the person you have authorized so that we may verify the person's identity and authority to receive your PHI: (i) your subscriber ID number, (ii) your date of birth, and (iii) your address.

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

- Any information requested Enrollment information Benefit information Premium payment information
- All claims information Explanation of Benefits (EOB) information
- All services from a specific health care provider (List provider's name): _____
- Other (Please list specific PHI): _____

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

I would like this authorization to expire on (enter date): ___/___/___ **OR** When my policy expires.
(If no expiration date is provided, this authorization will expire twelve (12) months from the date of receipt)

I understand that I may revoke this authorization at any time by giving written notice mailed to the address below. However, if I revoke this authorization, I also understand that the revocation will *not* affect any action in reliance on this authorization before receipt of my written notice of revocation.

I also understand that the provision of health plan benefits is not conditioned on this authorization.

I also understand that if the persons or entities I authorize to receive my PHI are not health plans, covered health care providers or health care clearinghouses subject to the Health Insurance Portability and Accountability Act (HIPAA) or other federal health information privacy laws, they may further disclose the PHI and it may no longer be protected by HIPAA or federal health information privacy laws.

Signature _____ Date _____

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

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

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

Note: We will consider the effective date of this authorization to be the date it is entered into the business system, typically 5 days following receipt. If you would like this authorization to become effective on a later date, please insert the date here:
_____/_____/_____.

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



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North Carolina Bar Association Plan 20,
010400 HSA1 10/01/15 - 09/30/2015

Blue OPTIONS HSASM

North Carolina Bar Association

**Group Effective Date:
October 1, 2015**



**BlueCross BlueShield
of North Carolina**

An Independent Licensee of the Blue Cross and Blue Shield Association

Plan 20 - 07/15

Batch File: 10-02-2015_CCDL_103103_2015100115474012000002_Blue_1_1443789034564001.ps

Job ID: 103103_2015100115474012000002

Fulfillment Type: CC

Handling Type: DL

Bin Type: N/A

Extract Date: 10-02-2015

Batch No: 1

Total packages: 1

Start Doc Seq No: 1

End Doc Seq No: 1

Total Sheets: 70



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