

**07/01/2026 Self-Funded RENEWAL CHANGE FORM  
NON-ERISA CUSTOM GROUPS**

**Group Name:**

**Benefit Plan Name:**

**Strategic Client Consultant:**

**Benefit Period:**

**Group Number(s):**

**I. OPTIONAL CHANGES:**

The following enhancements to Blue Cross NC base benefits are optional and would become effective beginning January 1, 2026, or upon the group's renewal.

Current Benefit/Eligibility Description	Product/Plans Impacted	Optional Benefit/Eligibility Changes	Choose Option
<p>For ASO and BF group plans, Accredo specialty pharmacy is the exclusive specialty pharmacy.</p>	<p>Blue Options ®            Blue Options ® 1-2-3 SM            Blue Options HSA ®            BlueHPN ®            BlueHPN ® 1-2-3            BlueHPN ® 1-2-3SM            Blue Options ® All Copay            BlueHPN ® All Copay</p>	<p>*For all non-ERISA, non-grandfathered and Grandfathered ASO and Balanced Funding (BF) group plans <b>beginning July 1, 2026</b>, upon renewal, the Blue Cross NC Specialty Network with Free Market Health (FMH) will be the new standard specialty pharmacy network.</p>	<ul style="list-style-type: none"> <li>• New Standard – Blue Cross NC Specialty Network (includes FMH)</li> <li>• Blue Cross NC Network Retail</li> </ul> <p>Not Applicable (Rx Carved Out)</p>
<p>Asthma and Respiratory Durable Medical Equipment (DME) that are covered currently at member cost share of 25% coinsurance.</p>	<p>Blue Options ®            Blue Options ® 1-2-3 SM            Blue Options HSA ®            BlueHPN ® 1-2-3            BlueHPN ® 1-2-3SM            Blue Options ® All Copay            BlueHPN ® All Copay</p>	<p>For all non-grandfathered plans <b>beginning January 1, 2026</b>, upon renewal, Asthma and Respiratory Durable Medical Equipment (DME) will be covered at the assigned drug tier cost share for the formulary.</p>	<ul style="list-style-type: none"> <li>• New Standard</li> <li>• Keep Current</li> </ul> <p>Not Applicable (Rx Carved Out)</p>

**II. GROUP CHANGE REQUESTS**

The group requests benefit and/or eligibility changes as noted below to be effective upon the group's renewal date. Blue Cross NC will review the benefit change requests to determine Blue Cross NC's ability to administer the benefits as described.

**Please note: HDHP eligible plans that include a HSA fund offer (with HealthEquity or carved out to another fund administrator) must meet annual IRS and ACA regulated minimum and maximum deductible and out of pocket limit requirements.**

Benefit/Eligibility Description	Product Lines	Requested Eligibility Changes

**III. GRANDFATHERED STATUS:**

Will the group be grandfathered for the benefit period **(yes/no)?** \_\_\_\_\_

**IV. SUMMARY OF BENEFITS AND COVERAGE (SBC):**

The group intends for Blue Cross NC to develop and provide the SBC document(s) to the group for their plan offerings for the group to distribute to members as required bylaw **(yes/no\*)?** \_\_\_\_\_

*\*If the group checks "no," Blue Cross NC is relieved of the contractual obligation to provide the SBC document(s) to the group unless Blue Cross NC is further notified in writing.*

**V. ESSENTIAL HEALTH BENEFITS BENCHMARK:**

No Annual/Dollar limits for Essential Health Benefits under PPACA (*All grandfathered and non-grandfathered plans apply*).

Essential health benefits may be defined by any available state benchmark plan; to the extent essential health benefits are covered under the selected benchmark plan, dollar limits and annual limits must be removed. Unless otherwise selected, the North Carolina benchmark plan will be the default.

The group intends to use the default benchmark through North Carolina **(yes/no)?** \_\_\_\_\_

If no, what state benchmark does the group intend to use? \_\_\_\_\_

**ATTESTATION** *(To be signed upon Blue Cross NC approval of benefit and eligibility change)*

By signing below, you attest and agree as follows:

- (1) The last signed Custom Group Summary, as modified by this and previous Renewal Change Forms, accurately describe the benefit selections, eligibility requirements and general Group Health Plan administration effective for the Benefit Period. Unless otherwise noted, Blue Cross NC will apply our prior approval and certification requirements and follow Blue Cross NC's medical policy to determine eligibility of payment. Any changes to the above selections and/or descriptions may require (1) approval through an additional Custom Group Summary, (2) a benefit exception request or (3) an amendment to the Administrative Services Agreement(ASA).
- (2) The Plan Administrator and Plan Sponsor represent and warrant that the last signed Custom Group Summary together with this and previous Renewal Change Forms confirm benefit selections and eligibility requirements desired and intended by the Plan. By signing below, the Plan Administrator and/or Plan Sponsor understand and agree that the Plan Administrator and/or Plan Sponsor is responsible for all aspects of ensuring that the Group Health Plan (including the plan design) is in compliance with applicable laws and regulations, including but not limited to (where applicable), the requirements of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), ERISA, the Patient's Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (including, but not limited to the designation of a plan as a grandfathered plan), the Americans with Disabilities Act (ADA), Title VII of the Civil Rights Act of 1964, COBRA, HIPAA, Public Health Services Act, the Consolidated Appropriations Act (CAA), the Internal Revenue Code and all applicable regulations and guidance. This responsibility has not been delegated to Blue Cross NC unless specifically delegated in the ASA. Plan Administrator and/or Plan Sponsor shall release, indemnify and hold harmless Blue Cross NC, its affiliates, and their respective directors, officers, employees and agents for any and all losses, liabilities, damages, expenses, claims, lawsuits, settlements, injuries, damages, taxes, interest charges, administrative penalties and other costs or obligations, including reasonable attorneys' and consultants' fees and costs for which Blue Cross NC may become liable, due to or arising out of compliance with applicable laws.

**Authorized Signature** *(for Plan Administrator)*

**Print Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Title:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**FOR INTERNAL USE ONLY**

Revisions made during the negotiation process must be tracked for internal reference only. This section will be completed by the Client Manager and Account Implementation Specialist.

Rev #	Revision Date	Section Revised	Revision Details	Supersedes Rev #