Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

▶ **Complete all entries in accordance with the instructions to the Form 5500.**

OMB Nos. 1210-0110
1210-0089

2024

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2024 or fiscal plan year beginning 07/01/2024 and ending 06/30/2025

A This return/report is for:
- ☐ a multiemployer plan
- ☐ a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.)
- ☒ a single-employer plan
- ☐ a DFE (specify) ____

B This return/report is:
- ☐ the first return/report
- ☐ the final return/report
- ☐ an amended return/report
- ☐ a short plan year return/report (less than 12 months)

C If the plan is a collectively-bargained plan, check here. . . . . ▶ ☐

D Check box if filing under:
- ☐ Form 5558
- ☐ automatic extension
- ☐ the DFVC program
- ☐ special extension (enter description)

E If this is a retroactively adopted plan permitted by SECURE Act section 201, check here. . . . . ▶ ☐

Part II Basic Plan Information—enter all requested information

1a Name of plan
SCHNEIDER MILLS, INC - HEALTH PLAN

1b Three-digit plan number (PN) ▶ 502

1c Effective date of plan 12/10/1972

2a Plan sponsor's name (employer, if for a single-employer plan)
Mailing address (include room, apt., suite no. and street, or P.O. Box)
City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)
SCHNEIDER MILLS INC

PO BOX 519
TAYLORSVILLE, NC 28681-0519

1170 HWY 16 N
TAYLORSVILLE, NC 28681

2b Employer Identification Number (EIN) 56-1577874

2c Plan Sponsor's telephone number 828-632-8181

2d Business code (see instructions) 313000

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

SIGN HERE	Filed with authorized/valid electronic signature.	10/06/2025	EVAN LOHRMAN
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	10/06/2025	EVAN LOHRMAN
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

3a Plan administrator's name and address [X] Same as Plan Sponsor

3b Administrator's EIN

3c Administrator's telephone number

4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report:

a Sponsor's name

c Plan Name

4b EIN

4d PN

5	Total number of participants at the beginning of the plan year	**5**	252
6	Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines **6a(1), 6a(2), 6b, 6c,** and **6d**).		
a(1)	Total number of active participants at the beginning of the plan year	**6a(1)**	252
a(2)	Total number of active participants at the end of the plan year	**6a(2)**	241
b	Retired or separated participants receiving benefits	**6b**	
c	Other retired or separated participants entitled to future benefits	**6c**	
d	Subtotal. Add lines **6a(2)**, **6b**, and **6c**.	**6d**	241
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	**6e**	
f	Total. Add lines **6d** and **6e**.	**6f**	241
g(1)	Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)	**6g(1)**	
g(2)	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g(2)**	
h	Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.	**6h**	
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	**7**	

8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:

b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:

4A 4E

9a Plan funding arrangement (check all that apply)

- **(1)** [X] Insurance
- **(2)** [ ] Code section 412(e)(3) insurance contracts
- **(3)** [ ] Trust
- **(4)** [X] General assets of the sponsor

9b Plan benefit arrangement (check all that apply)

- **(1)** [X] Insurance
- **(2)** [ ] Code section 412(e)(3) insurance contracts
- **(3)** [ ] Trust
- **(4)** [X] General assets of the sponsor

10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)

a Pension Schedules

- **(1)** [ ] **R** (Retirement Plan Information)
- **(2)** [ ] **MB** (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary
- **(3)** [ ] **SB** (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary
- **(4)** [ ] **DCG** (Individual Plan Information) – Number Attached _____
- **(5)** [ ] **MEP** (Multiple-Employer Retirement Plan Information)

b General Schedules

- **(1)** [ ] **H** (Financial Information)
- **(2)** [ ] **I** (Financial Information – Small Plan)
- **(3)** [X] **A** (Insurance Information) – Number Attached 1
- **(4)** [X] **C** (Service Provider Information)
- **(5)** [ ] **D** (DFE/Participating Plan Information)
- **(6)** [ ] **G** (Financial Transaction Schedules)

Part III Form M-1 Compliance Information (to be completed by welfare benefit plans)

11a If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.) ..... ☐ Yes ☒ No

If "Yes" is checked, complete lines 11b and 11c.

11b Is the plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.) ..... ☐ Yes ☐ No

11c Enter the Receipt Confirmation Code for the 2024 Form M-1 annual report. If the plan was not required to file the 2024 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code_____

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

▶ **File as an attachment to Form 5500.**

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2024

This Form is Open to Public Inspection

For calendar plan year 2024 or fiscal plan year beginning 07/01/2024 and ending 06/30/2025

A Name of plan
SCHNEIDER MILLS, INC - HEALTH PLAN

B Three-digit plan number (PN) ▶ 502

C Plan sponsor's name as shown on line 2a of Form 5500
SCHNEIDER MILLS INC

D Employer Identification Number (EIN)
56-1577874

Part I **Information Concerning Insurance Contract Coverage, Fees, and Commissions** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
BLUE CROSS BLUE SHIELD OF NORTH CAROLINA

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
56-0894904		141619949001	241	07/01/2024	06/30/2025

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	(b) Total amount of fees paid
	424654

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

BLUE CROSS BLUE SHIELD OF NC
PO BOX 2291
DURHAM, NC 27702

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
	424654	ADMINISTRATIVE FEES & STOP LOSS PREMIUMS	5

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4	Current value of plan's interest under this contract in the general account at year end	**4**	
5	Current value of plan's interest under this contract in separate accounts at year end	**5**	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b	Premiums paid to carrier	**6b**	
c	Premiums due but unpaid at the end of the year	**6c**	
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount.	**6d**	

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity

(3) ☐ other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other ▶

b	Balance at the end of the previous year			**7b**	
c	Additions: (1) Contributions deposited during the year	**7c(1)**			
	(2) Dividends and credits	**7c(2)**			
	(3) Interest credited during the year	**7c(3)**			
	(4) Transferred from separate account	**7c(4)**			
	(5) Other (specify below)	**7c(5)**			
	▶				
	(6)Total additions			**7c(6)**	
d	Total of balance and additions (add lines **7b** and **7c(6)**).			**7d**	
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	**7e(1)**			
	(2) Administration charge made by carrier	**7e(2)**			
	(3) Transferred to separate account	**7e(3)**			
	(4) Other (specify below)	**7e(4)**			
	▶				
	(5) Total deductions			**7e(5)**	
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			**7f**	

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- **a** [X] Health (other than dental or vision)
- **b** [ ] Dental
- **c** [X] Vision
- **d** [ ] Life insurance
- **e** [ ] Temporary disability (accident and sickness)
- **f** [ ] Long-term disability
- **g** [ ] Supplemental unemployment
- **h** [X] Prescription drug
- **i** [X] Stop loss (large deductible)
- **j** [ ] HMO contract
- **k** [X] PPO contract
- **l** [ ] Indemnity contract
- **m** [ ] Other (specify) ▶

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**	424654		
(2) Increase (decrease) in amount due but unpaid	**9a(2)**			
(3) Increase (decrease) in unearned premium reserve	**9a(3)**			
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	424654
b Benefit charges (1) Claims paid	**9b(1)**	3434229		
(2) Increase (decrease) in claim reserves	**9b(2)**	-377451		
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	3056778
(4) Claims charged			**9b(4)**	3056778
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**			
(B) Administrative service or other fees	**9c(1)(B)**	67976		
(C) Other specific acquisition costs	**9c(1)(C)**			
(D) Other expenses	**9c(1)(D)**			
(E) Taxes	**9c(1)(E)**			
(F) Charges for risks or other contingencies	**9c(1)(F)**			
(G) Other retention charges	**9c(1)(G)**	356678		
(H) Total retention			**9c(1)(H)**	424654
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [X] credited.)			**9c(2)**	4823
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	
(2) Claim reserves			**9d(2)**	66463
(3) Other reserves			**9d(3)**	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.			**10b**	

Specify nature of costs.

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? [ ] Yes [X] No

12 If the answer to line 11 is "Yes," specify the information not provided. ▶

SCHEDULE C (Form 5500)	Service Provider Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ **File as an attachment to Form 5500.**	**2024** **This Form is Open to Public Inspection.**

For calendar plan year 2024 or fiscal plan year beginning 07/01/2024 and ending 06/30/2025

A Name of plan	**B** Three-digit plan number (PN) ▶
SCHNEIDER MILLS, INC - HEALTH PLAN	502
C Plan sponsor's name as shown on line 2a of Form 5500	**D** Employer Identification Number (EIN)
SCHNEIDER MILLS INC	56-1577874

Part I Service Provider Information (see instructions)

You must complete this Part, in accordance with the instructions, to report the information required for **each person** who received, directly or indirectly, $5,000 or more in total compensation (i.e., money or anything else of monetary value) in connection with services rendered to the plan or the person's position with the plan during the plan year. If a person received **only** eligible indirect compensation for which the plan received the required disclosures, you are required to answer line 1 but are not required to include that person when completing the remainder of this Part.

1 Information on Persons Receiving Only Eligible Indirect Compensation

a Check "Yes" or "No" to indicate whether you are excluding a person from the remainder of this Part because they received only eligible indirect compensation for which the plan received the required disclosures (see instructions for definitions and conditions).. . . . . ☐ Yes ☒ No

b If you answered line 1a "Yes," enter the name and EIN or address of each person providing the required disclosures for the service providers who received only eligible indirect compensation. Complete as many entries as needed (see instructions).

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

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2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, $5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

(a) Enter name and EIN or address (see instructions)

BLUE CROSS BLUE SHIELD OF NC

PO BOX 2291
DURHAM, NC 27702

56-0894904

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 22	THIRD PARTY ADMINISTRATOR	424654	Yes [X] No [ ]	Yes [X] No [ ]		Yes [X] No [ ]

(a) Enter name and EIN or address (see instructions)

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes [ ] No [ ]	Yes [ ] No [ ]		Yes [ ] No [ ]

(a) Enter name and EIN or address (see instructions)

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes [ ] No [ ]	Yes [ ] No [ ]		Yes [ ] No [ ]

Part I Service Provider Information (continued)

3. If you reported on line 2 receipt of indirect compensation, other than eligible indirect compensation, by a service provider, and the service provider is a fiduciary or provides contract administrator, consulting, custodial, investment advisory, investment management, broker, or recordkeeping services, answer the following questions for (a) each source from whom the service provider received $1,000 or more in indirect compensation and (b) each source for whom the service provider gave you a formula used to determine the indirect compensation instead of an amount or estimated amount of the indirect compensation. Complete as many entries as needed to report the required information for each source.

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation

(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation

(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation

(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.

Part II Service Providers Who Fail or Refuse to Provide Information

4 Provide, to the extent possible, the following information for each service provider who failed or refused to provide the information necessary to complete this Schedule.

(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide

(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide

(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide

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(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide

(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide

Part III Termination Information on Accountants and Enrolled Actuaries (see instructions)

(complete as many entries as needed)

a Name:	**b** EIN:
c Position:	
d Address:	**e** Telephone:

Explanation:

a Name:	**b** EIN:
c Position:	
d Address:	**e** Telephone:

Explanation:

a Name:	**b** EIN:
c Position:	
d Address:	**e** Telephone:

Explanation:

a Name:	**b** EIN:
c Position:	
d Address:	**e** Telephone:

Explanation:

a Name:	**b** EIN:
c Position:	
d Address:	**e** Telephone:

Explanation:

BLUE CROSS AND BLUE SHIELD OF NORTH CAROLINA

EIC DISCLOSURE FOR PHARMACY FEES

Blue Cross and Blue Shield of North Carolina ("BLUE CROSS NC") or BLUE CROSS NC's pharmacy benefit services management vendor, Prime Therapeutics LLC ("Prime"), have entered into, and may in the future, arrangements with companies under which a portion of prescription drug charges are rebated. Pharmaceutical Rebates may be associated with drug claims processed under the Group Health Plan's pharmacy or, if applicable, medical benefit. The Rebate amount varies based upon the status of a drug in BLUE CROSS NC's prescription drug formulary, drug utilization, benefit coverage, and other factors.

In addition, Prime may receive administrative reimbursement directly from BLUE CROSS NC or other companies for services they provide to BLUE CROSS NC and the companies. Administrative reimbursement shall be the sum of per claim charges of all services that BLUE CROSS NC purchases from Prime, including but not limited to network management, Rebate administration, and account management.

As compensation for costs and services provided in connection with pharmacy benefit services management and other services provided under this agreement, BLUE CROSS NC will retain one hundred percent (100%) of the Rebates it receives from Prime related to Group Health Plan's prescription drug utilization.

On an annual basis, after BLUE CROSS NC has received Rebate payment and a reconciliation report from Prime, the "Average Rebate" will be calculated taking the average of the Rebate amount received per Eligible Prescription Drug Claim based on the aggregate of such amounts received by BLUE CROSS NC from Prime for BLUE CROSS NC administered ASO health plans participating in such arrangements BLUE CROSS NC. An "Eligible Prescription Drug Claim" is any electronically or manually adjudicated claim payable under the prescription drug benefit for a prescription drug that is covered within established benefit limits for a Member. Eligible Prescription Drug Claims may exclude certain specialty medications, medications that have 'A' Rated Generics, OTC medications, compounds, vaccines, biosimilars or any paid claims where coverage is subsequently denied, or claims filed on behalf of persons who do not have coverage at the time the prescription drug is filled.

For the purpose of ERISA reporting, BLUE CROSS NC's compensation received under this Section shall be calculated as the Average Rebate per Eligible Prescription Drug Claim (determined as described in the above paragraph) multiplied (x) by the number of Eligible Prescription Drug Claims. BLUE CROSS NC shall make available to the Group Health Plan the Average Rebate amount and the number of Eligible Prescription Drug Claims upon request. Requests should be made through the Group Health Plan's BLUE CROSS NC Account Manager.

BLUE CROSS AND BLUE SHILED OF NORTH CAROLINA EIC DISCLOSURE FOR THE BLUECARD PROGRAM

As you know, one of the benefits Members receive is access to healthcare services outside the geographic area BCBSNC serves under a Program known as BlueCard. Typically in that situation, Members obtain care from healthcare providers that have a contractual agreement the local Blue Cross and/or Blue Shield Licensee in that other geographic area (the "Host Blue"). Within that arrangement, BCBSNC is referred to as the "Home Blue." The BlueCard Program is established and operated pursuant to policies established and enforced by the Blue Cross and Blue Shield Association.

The Department of Labor has amended its regulations governing the Form 5500 annual reporting and disclosure requirements. A plan sponsor's reporting requirements for a self-funded plan on Schedule C are significantly streamlined for "eligible indirect compensation" about which a service provider has shared certain information. As such, below is a list of eligible indirect compensation that has been received in connection with the BlueCard Program. Note that the fees and compensation subject to disclosure under the Department of Labor rules include amounts that are not necessarily passed on to you or your Members. The financial terms of the BlueCard Program, and additional details about the Program, are described in your administrative services agreement.

1. BlueCard Access Fees: Access Fees are the fees charged by the Host Blue for making its provider network available to the Home Blue's Members.

   Access Fees incurred in connection with your ERISA plan's BlueCard arrangement with Blue Cross are defined in your Administrative Services Agreement. Fees incurred in connection with your Plan may be calculated on a per-claim percentage of savings (PCPS) basis or a per-contract per-month (PCPM) basis. Access Fees that are calculated on a PCPS basis will be systematically directly billed as a part of your claims. Access Fees calculated on a PCPM basis will be included as a part of your Monthly Administrative Charge.

   Depending on the size and distribution of your ERISA Plan's enrollment, the Access Fees that Blue Cross pays to Host Plans may be a negotiated PCPM fee or will be one or more of the following PCPS arrangements,:

   Access Fees for calendar year 2023:

   Standard Blue Card Arrangement
   3.62% of savings (max = $2,000 per claim)
   Reduced BlueCard PPO Arrangement
   2.02% of savings (max = $2,000 per claim)
   Jumbo BlueCard PPO Arrangement
   1.87% of savings (max = $2,000 per claim)
   Super Jumbo BlueCard PPO Arrangement
   N/A

Access Fees for calendar year 2024:

Standard Blue Card Arrangement
3.46% of savings (max = $2,000 per claim)

Reduced BlueCard PPO Arrangement
1.93% of savings (max = $2,000 per claim)

Jumbo BlueCard PPO Arrangement
1.79% of savings (max = $2,000 per claim)

Super Jumbo BlueCard PPO Arrangement
N/A

Note: To be considered for reduced BlueCard PPO fees, the claim must be for an account which enrolled under a custom arrangement and the total BlueCard PPO enrollment exceeds 1,000 enrolled contracts. To be considered for Jumbo BlueCard PPO fees, the claim must be for an account which enrolled under a custom arrangement and the total BlueCard PPO enrollment exceeds 10,000 enrolled contracts. To be considered for Super Jumbo BlueCard PPO fees, the claim must be for an account which enrolled under a custom arrangement and the total BlueCard PPO enrollment exceeds 50,000 enrolled contracts.

2. Administrative Expense Allowances (AEA): AEA is a fee paid by the Home Blue to the Host Blue to cover the cost of administrative services that the Host Blue incurs in processing the claims for Home Blue members. These fees, usually calculated on a flat per-claim basis, will be included as a part of your Monthly Administrative Charge.

AEA Fees for calendar years 2023/2024:

Standard BlueCard Arrangement
Institutional $11.00 per claim
Professional $ 5.00 per claim

Reduced BlueCard PPO Arrangement/Custom
Institutional $ 9.75 per claim
Professional $ 4.00 per claim

Jumbo BlueCard PPO Arrangement/Custom
Institutional $ 9.75 per claim
Professional $ 4.00 per claim

Note: To be considered for reduced BlueCard PPO fees, the claim must be for an account which enrolled under a custom arrangement and the total BlueCard PPO enrollment exceeds 1,000 enrolled contracts. To be considered for Jumbo BlueCard PPO fees, the claim must be for an account which enrolled under a custom arrangement and the total BlueCard PPO enrollment exceeds 10,000 enrolled contracts. To be considered for Super Jumbo BlueCard PPO fees, the claim must be for an account which enrolled under a custom arrangement and the total BlueCard PPO enrollment exceeds 50,000 enrolled contracts.

3. Use of Estimated or Average Pricing by Host Blues. As described in your administrative services agreement, some Host Blues use estimated or average prices to determine the negotiated price that is made available to us when plan participants access the Host Blue's participating provider network. This may result in a difference (positive or negative) between the price you pay on a specific claim and the actual amount paid to the provider by the Host Blue.

The following describes the formula used for determining an estimated or average price:

Estimated: A percentage is used to modify the claim price for covered services. This percentage (either positive or negative) allows Host Blues to incorporate adjustments and actuarial projections prospectively into the final price. The percentage is determined by figuring the aggregate cost to the Host Blue over a look-back period less any initial payments made to providers divided by the total of payments initially made to providers. The aggregate cost in the numerator includes all provider retrospective settlements, anti-fraud and abuse recoveries, provider refunds not applied on a claim-specific basis, performance-related bonuses or incentives, interest, other non-claim transactions and any positive or negative balance in the variance account. The percentage is then actuarially adjusted for anticipated changes in claims expenses for the prospective period. As of December 31, 2023, the modifying percentage applied to claims from those Host Blues that use estimated pricing ranged from -0.45% to + 8.61% of the rate of payment to the provider at the point of claim.

Average: An average price is determined for a defined category of provider (*e.g.*, institutional, professional, etc.) of a Host Blue in a given geographic area. The average is determined as follows:

Total amount paid to such providers over a look-back period, including initial payments as well as applicable claim and non-claim related transactions, which may include but are not limited to provider retrospective settlements, anti-fraud and abuse recoveries, provider refunds not applied on a claim-specific basis, performance-related bonuses or incentives, interest, etc., and any positive or negative balance in the variance account divided by Total amount of such providers' corresponding charges for covered services

over the same look-back period (claims for non-covered services are not included in the calculation) This result is an average price that is applied to each claim for the defined category of provider of the Host Blue in the geographic area and presented as the negotiated price.

Blue Cross Blue Shield Global Core. Blue Cross Blue Shield Global Core provides members with access to an international network of inpatient, outpatient and professional providers. For 2023, the Blue Cross Blue Shield Association contracted with GeoBlue for medical assistance and claim support services.
GeoBlue's fees paid by the Home Blue were as follows:

Transaction Type	Fee (USD)	Unit
Medical Assistance		
General inbound calls	$28.91	per call
Provider search (non-medical situation)	$22.71	per call
Cashless access/Guarantee of Payment (GOP)	$113.55	per GOP
Telephone translation	$64.52	per call
Fulfillment	$9.80	per call
Provider/medical assistance information provided by nurse	$98.06	per call
Misrouted calls	$22.71	per call
Medical monitoring	$299.35	per case
Claims Support		
Claim preparation, processing and/or payment (includes translation, coding, currency conversion)	$40.25	per claim
Misrouted claim (e.g., domestic)	$9.80	per claim
Claim status inquiry	$22.71	per call / member ID
Medical records translation	At Cost	
Currency conversion gains/losses	At Cost	
Wire/ACH fees	At Cost	
Additional Services		
Medical evacuation coordination	$1,290.32	per case
Medical repatriation coordination	$1,290.32	per case
Repatriation of remains coordination	$619.35	per case
Medical travel coordination	$299.35	per case
Assistance Partner Engagement (limited to ONLY countries where vendor is restricted from conducting business)	*Ranging from $100 - $500*	*per Direct Pay Letter (DPL)*
Ad hoc UCR claim research, claim line-item audit and case negotiation	*As agreed upon by Control/Home Plan and GeoBlue.*	