

Benefit Booklet
For Students of
University of North
Carolina at Chapel Hill
for
Student BlueSM



An Independent Licensee of the Blue Cross and Blue Shield Association

BENEFIT BOOKLET

This benefit booklet, along with the UNIVERSITY OF NORTH CAROLINA CONTRACT, is the legal contract between the group and Blue Cross and Blue Shield of North Carolina. **Please read this benefit booklet carefully.**

Blue Cross and Blue Shield of North Carolina agrees to provide benefits to the qualified SUBSCRIBERS and eligible DEPENDENTS who are listed on the enrollment application and who are accepted in accordance with the provisions of the UNIVERSITY OF NORTH CAROLINA CONTRACT entered into between Blue Cross and Blue Shield of North Carolina and the SUBSCRIBER'S GROUP. A summary of benefits, conditions, limitations, and exclusions is set forth in this Benefit Booklet for easy reference.

Blue Cross and Blue Shield of North Carolina has directed that this Benefit Booklet be issued and signed by the President and the Secretary.



Attest:

A handwritten signature in cursive script, appearing to read "J. Bradley Wilson".

President

A handwritten signature in cursive script, appearing to read "Alvin Parker".

Secretary

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

TABLE OF CONTENTS

GETTING STARTED WITH STUDENT BLUE.....	2
WHO TO CONTACT?.....	3
SUMMARY OF BENEFITS.....	5
HOW STUDENT BLUE WORKS.....	13
STUDENT HEALTH CENTER (SHC).....	13
OUT-OF-NETWORK BENEFIT EXCEPTIONS.....	15
CARRY YOUR IDENTIFICATION CARD.....	15
THE ROLE OF A PRIMARY CARE PROVIDER (PCP) OR SPECIALIST.....	15
COVERED SERVICES.....	17
OFFICE SERVICES.....	17
Office Services Exclusion.....	17
PREVENTIVE CARE.....	17
Federally-Mandated Preventive Care Services.....	17
Bone Mass Measurement Services.....	18
Colorectal Screening.....	18
Gynecological Exam and Cervical Cancer Screening.....	19
Newborn Hearing Screening.....	19
Ovarian Cancer Screening.....	19
Prostate Screening.....	19
Screening Mammograms.....	19
Non-Mandated Preventive Care Services.....	19
Routine Eye Exams.....	19
Obesity Treatment/Weight Management.....	19
DIAGNOSTIC SERVICES.....	20
Diagnostic Services Exclusion.....	20
EMERGENCY CARE.....	20
What to Do in an Emergency.....	20
URGENT CARE.....	21
MATERNITY CARE AND FAMILY PLANNING.....	21
Maternity Care.....	21
Termination of Pregnancy (Abortion).....	22
Complications Of Pregnancy.....	22
Infertility Services.....	23
Sexual Dysfunction Services.....	23
Sterilization.....	23
Contraceptive Devices.....	23
FACILITY SERVICES.....	23
OTHER SERVICES.....	24
Ambulance Services.....	24
Blood.....	24
Clinical Trials.....	24
Dental Treatment Covered Under Your Medical Benefit.....	25
Diabetes-Related Services.....	25
Durable Medical Equipment.....	25
Hearing Aids.....	26
Home Health Care.....	26
Home Infusion Therapy Services.....	26
Hospice Services.....	26
Lymphedema-Related Services.....	26
Medical Supplies.....	26
Orthotic Devices.....	27
Pediatric Dental Services.....	27

TABLE OF CONTENTS *(cont.)*

Basic Services.....	27
Diagnostic And Preventive Services.....	29
PEDIATRIC VISION SERVICES.....	29
Private Duty Nursing.....	30
Prosthetic Appliances.....	30
SURGICAL BENEFITS.....	30
Anesthesia.....	30
Mastectomy Benefits.....	31
TEMPOROMANDIBULAR JOINT (TMJ) SERVICES.....	31
Temporomandibular Joint (TMJ) Services Exclusions.....	31
THERAPIES.....	31
Rehabilitative and Habilitative Therapies.....	31
Other Therapies.....	31
Therapy Exclusions.....	32
TRANSPLANTS.....	32
Transplants Exclusions.....	32
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES.....	32
Office Visit Services.....	32
Outpatient Services.....	32
Inpatient Services.....	33
Residential Treatment Facility Services.....	33
How to Access Mental Health and Substance Abuse Services.....	33
PRESCRIPTION DRUG BENEFITS.....	33
Prescription Drug Benefit Exclusions.....	36
ADULT LENSES AND FRAMES.....	36
WHAT IS NOT COVERED?.....	38
WHEN COVERAGE BEGINS AND ENDS.....	42
COVERAGE FOR YOUR DEPENDENTS.....	42
ENROLLING IN THIS HEALTH BENEFIT PLAN.....	43
TYPES OF COVERAGE.....	43
MULTIPLE COVERAGE.....	43
REPORTING CHANGES.....	43
CONTINUING COVERAGE.....	43
When my Coverage Under this Health Benefit Plan Ends.....	43
Certificate of Creditable Coverage.....	43
TERMINATION OF MEMBER COVERAGE.....	43
UTILIZATION MANAGEMENT.....	45
RIGHTS AND RESPONSIBILITIES UNDER THE UM PROGRAM.....	45
PRIOR REVIEW (PRE-SERVICE).....	45
Urgent Prior Review.....	46
CONCURRENT REVIEWS.....	46
Urgent Concurrent Review.....	46
RETROSPECTIVE REVIEWS (POST-SERVICE).....	46
CARE MANAGEMENT.....	47
CONTINUITY OF CARE.....	47
DELEGATED UTILIZATION MANAGEMENT.....	48
EVALUATING NEW TECHNOLOGY.....	48
WHAT IF YOU DISAGREE WITH OUR DECISION?.....	49
STEPS TO FOLLOW IN THE APPEALS PROCESS.....	49
QUALITY OF CARE COMPLAINTS.....	49
Internal Appeals.....	49
Expedited Appeals (Available only for noncertifications).....	50
Second Level Review (Limited Grievances Only).....	50

TABLE OF CONTENTS *(cont.)*

External Review (Available only for Noncertifications).....	50
ADDITIONAL TERMS OF YOUR COVERAGE.....	53
BENEFITS TO WHICH MEMBERS ARE ENTITLED.....	53
BCBSNC'S DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI).....	53
ADMINISTRATIVE DISCRETION.....	53
NORTH CAROLINA PROVIDER REIMBURSEMENT.....	53
SERVICES RECEIVED OUTSIDE OF NORTH CAROLINA.....	54
TRAVEL ASSISTANCE SERVICES.....	54
SERVICES RECEIVED OUTSIDE THE UNITED STATES.....	54
MEDICAL EVACUATION.....	54
REPATRIATION OF MORTAL REMAINS.....	55
MEDICAL EVACUATION/REPATRIATION OF MORTAL REMAINS LIMITATIONS AND EXCLUSIONS.....	55
BCBSNC CONTRACT.....	55
<u>Premium Payment</u>	55
NOTICE OF CLAIM.....	56
LIMITATION OF ACTIONS.....	56
SPECIAL PROGRAMS.....	57
PROGRAMS OUTSIDE YOUR REGULAR BENEFITS.....	57
HEALTH INFORMATION SERVICES.....	57
GLOSSARY.....	58

GETTING STARTED WITH STUDENT BLUE

IMPORTANT INFORMATION REGARDING THIS HEALTH BENEFIT PLAN:

This health benefit plan includes coverage of a core set of benefits, called ESSENTIAL HEALTH BENEFITS, and certain limits on DEDUCTIBLES, copayments, and out-of-pocket costs. See "Glossary" for a list of the services that are considered ESSENTIAL HEALTH BENEFITS.

Note that while no annual or lifetime dollar limits are allowed on ESSENTIAL HEALTH BENEFITS, federal law does allow insurance companies to include annual or lifetime dollar limits on non-essential health benefits. This health benefit plan covers non-essential health benefits for routine adult eye exams, acupuncture/massage for stress therapy, and adult lenses and frames. See "Summary of Benefits" for limits that apply.

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

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:

Copayment	The fixed dollar amount you may pay for some COVERED SERVICES at the time you receive them. Copayments are not credited to the BENEFIT PERIOD DEDUCTIBLE.
DEDUCTIBLE	The dollar amount you must incur for COVERED SERVICES in a BENEFIT PERIOD before benefits are payable under this health benefit plan. The DEDUCTIBLE does not include medical services received at SHC, inpatient newborn care for well baby, coinsurance, charges in excess of the ALLOWED AMOUNT, amounts exceeding any maximum, or charges for noncovered services. 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 BCBSNC and you for COVERED SERVICES, after you have met any BENEFIT PERIOD DEDUCTIBLE. This is stated as a percentage of the ALLOWED AMOUNT. The coinsurance listed is your share of the cost of a COVERED SERVICE.
OUT-OF-POCKET LIMIT	The OUT-OF-POCKET LIMIT is the dollar amount you pay for COVERED SERVICES in a BENEFIT PERIOD before BCBSNC pays 100% of COVERED SERVICES. It does not include charges over ALLOWED AMOUNTS, charges for noncovered services, and premiums. This health benefit plan has an individual OUT-OF-POCKET LIMIT. Charges for IN-NETWORK services apply to your IN-NETWORK OUT-OF-POCKET LIMIT and charges for OUT-OF-NETWORK services apply to your OUT-OF-NETWORK OUT-OF-POCKET LIMIT.

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.

GETTING STARTED WITH STUDENT BLUE *(cont.)*

	IN-NETWORK	OUT-OF-NETWORK
A. Total Bill	\$5,000	\$5,000
B. ALLOWED AMOUNT	\$4,250	\$4,250
C. DEDUCTIBLE Amount	\$250	\$500
D. ALLOWED AMOUNT Minus DEDUCTIBLE (B-C)	\$4,000	\$3,750
E. Your Coinsurance Amount (x% times D)	(10%) \$400	(30%) \$1,125
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)	\$650	\$2,375

DEDUCTIBLE and coinsurance amounts are for example only, please see "Summary of Benefits" for your benefits.

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

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

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. The terms "we," "us," and "BCBSNC" refer to Blue Cross and Blue Shield of North Carolina. The term "student health center (SHC)" refers to the student or campus health services at the school associated with this health benefit plan.

WHO TO CONTACT?

Toll-Free Phone Numbers, Website and Addresses

<p>BCBSNC Customer Service 1-888-351-8283</p>	<p>For questions about your benefits or claims, ID CARD requests, or to voice a complaint.</p>
<p>bcbnsnc.com/unc</p>	<p>Use this website to view your claims, get benefit information, claim forms, including international claim forms, health and wellness information, drug FORMULARY updates, find a DOCTOR, change your address, and request new ID CARDS.</p>
<p>PRIOR REVIEW and CERTIFICATION:</p> <p>MEMBERS call: 1-888-351-8283</p> <p>PROVIDERS, call: 1-800-672-7897</p>	<p>Some services require PRIOR REVIEW and CERTIFICATION from BCBSNC before they are considered for coverage. The list of these services may change from time to time. Please visit the website at bcbnsnc.com/unc or call BCBSNC at the number listed above for current information about which services require PRIOR REVIEW.</p>
<p>Magellan Behavioral Health: 1-800-359-2422</p>	<p>For mental health and substance abuse services, BCBSNC delegates the administration of these benefits by contract to Magellan Behavioral Health, which is not associated with BCBSNC. 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.</p>
<p>Out of North Carolina Care: 1-800-810-BLUE (2583)</p>	<p>For help in obtaining care outside of North Carolina or the U.S., call this number or visit the national website at bcbnsnc.com.</p>
<p>HealthLine BlueSM: 1-877-477-2424</p>	<p>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. This program may not be available to you.</p>
<p>Student Assistance Program: 1-855-577-7651 achievesolutions.net/studentblue</p>	<p>The Student Assistance Program provided by Value Options offers counseling, education, referral services, travel assistance, medical evacuation and repatriation services. Available educational resources include an online health assessment to enable students to assess their overall well-being and general health risks.</p>
<p>Medical Claims Filing: BCBSNC Claims Department PO Box 35 Durham, NC 27702-0035</p>	<p>Mail completed medical and pediatric dental or vision claims, including international claim forms, to this address.</p>
<p>PRESCRIPTION DRUG Claims Filing: Prime Therapeutics Mail Route: BCBSNC P.O. Box 14501 Lexington, KY 40512-4501</p>	<p>Mail completed PRESCRIPTION DRUG claims to this address.</p>

WHO TO CONTACT? *(cont.)*

Value-Added Programs

These programs are not covered benefits and are outside of this health benefit plan. To see if you are eligible for these programs, contact BCBSNC. BCBSNC does not accept claims or reimburse for these goods or services, and MEMBERS are responsible for paying all bills. BCBSNC may change or discontinue these programs at any time.

TruHearingSM 1-877-343-0745 1-800-975-2674 (TTY toll-free)	For information about discounts on hearing aids, call or visit BlueConnectNC.com.
Blue365TM 1-855-511-2583 8 a.m. - 6 p.m. Monday-Friday, except holidays	Health and wellness information support and services, and special MEMBER savings available 365 days a year.
Davis Vision[®] 1-888-897-9350 8 a.m. - 11 p.m. Monday-Friday 9 a.m. - 4 p.m. Saturday 12 p.m. - 4 p.m. Sunday	For information about discounts on corrective laser eye surgery, call or visit BlueConnectNC.com.

SUMMARY OF BENEFITS

This section provides a summary of your Student Blue 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:

- Multiple OFFICE VISITS or emergency room visits on the same day may result in multiple copayments
- Coinsurance percentages shown in this section are the part of the ALLOWED AMOUNT that you pay for COVERED SERVICES
- Amounts applied to any DEDUCTIBLE and coinsurance are based on the ALLOWED AMOUNT
- Amounts applied to any DEDUCTIBLE also count toward any visit or day maximums for those services

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

SUMMARY OF BENEFITS (cont.)

BENEFIT PERIOD - August 1, 2015 through July 31, 2016

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

Benefits	IN-NETWORK	OUT-OF-NETWORK												
<p>PROVIDER'S Office See Outpatient for OUTPATIENT CLINIC or HOSPITAL-based services.</p>														
<p>OFFICE VISITS</p> <p>Student Health Center (SHC) PRIMARY CARE PROVIDER (PCP)</p> <p style="text-align: center;">No Charge</p> <p style="text-align: center;">\$25 copayment, then 20% after DEDUCTIBLE</p> <p style="text-align: center;">Benefits not available</p> <p style="text-align: center;">\$25 copayment, then 30% after DEDUCTIBLE</p> <p>SPECIALIST</p> <p style="text-align: center;">\$25 copayment, then 20% after DEDUCTIBLE</p> <p style="text-align: center;">\$25 copayment, then 30% after DEDUCTIBLE</p> <p>Includes office SURGERY, x-rays and lab tests.</p> <p>CT scans, MRIs, MRAs and PET scans</p> <p style="text-align: center;">20% after DEDUCTIBLE</p> <p style="text-align: center;">30% after DEDUCTIBLE</p>														
<p>PREVENTIVE CARE Services</p> <p>This benefit is only for services that your PROVIDER indicates a primary diagnosis of preventive or wellness on the claim that is submitted to BCBSNC. Also see "PREVENTIVE CARE" in "COVERED SERVICES." For PREVENTIVE CARE services that are not mandated by federal or state law, benefits will depend on where the services are received.</p> <table border="0" style="width: 100%;"> <tr> <td style="width: 45%;">Federally-mandated PREVENTIVE CARE</td> <td style="width: 25%; text-align: center;">No Charge</td> <td style="width: 30%; text-align: center;">30% after DEDUCTIBLE</td> </tr> </table> <p>For the most up-to-date list of PREVENTIVE CARE services that are covered under federal law, including PRESCRIPTION contraceptives and certain preventive over-the-counter medications, general preventive services and screenings, immunizations, well-baby/well-child care, and women's PREVENTIVE CARE, see the website at www.bcbsnc.com/preventive or call the number in "Who to Contact?" Routine eye exams are covered IN-NETWORK as PREVENTIVE CARE. Nutritional counseling visits are covered IN-NETWORK for any diagnosis and are also available OUT-OF-NETWORK at 30% after DEDUCTIBLE.</p> <table border="0" style="width: 100%;"> <tr> <td style="width: 45%;">State-mandated PREVENTIVE CARE</td> <td style="width: 25%; text-align: center;">No Charge</td> <td style="width: 30%; text-align: center;">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 (regardless of diagnosis), colorectal screening, bone mass measurement, prostate-specific antigen tests, and newborn hearing screening.</p> <table border="0" style="width: 100%;"> <tr> <td style="width: 45%;">REHABILITATIVE and HABILITATIVE THERAPIES</td> <td style="width: 25%; text-align: center;">\$25 copayment, then 20% after DEDUCTIBLE</td> <td style="width: 30%; text-align: center;">\$25 copayment, then 30% after DEDUCTIBLE</td> </tr> </table> <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. Benefits for acupuncture/massage for stress therapy are limited to \$500 per BENEFIT PERIOD. 30 visits per BENEFIT PERIOD for speech therapy. Any visits in excess of these BENEFIT PERIOD MAXIMUMS are not COVERED SERVICES.</p> <table border="0" style="width: 100%;"> <tr> <td style="width: 45%;">OTHER THERAPIES</td> <td style="width: 25%; text-align: center;">20% after DEDUCTIBLE</td> <td style="width: 30%; text-align: center;">30% after DEDUCTIBLE</td> </tr> </table> <p>Includes chemotherapy, dialysis and cardiac rehabilitation provided in the office. See Outpatient for OTHER THERAPIES provided in an outpatient setting.</p>			Federally-mandated PREVENTIVE CARE	No Charge	30% after DEDUCTIBLE	State-mandated PREVENTIVE CARE	No Charge	30% after DEDUCTIBLE	REHABILITATIVE and HABILITATIVE THERAPIES	\$25 copayment, then 20% after DEDUCTIBLE	\$25 copayment, then 30% after DEDUCTIBLE	OTHER THERAPIES	20% after DEDUCTIBLE	30% after DEDUCTIBLE
Federally-mandated PREVENTIVE CARE	No Charge	30% after DEDUCTIBLE												
State-mandated PREVENTIVE CARE	No Charge	30% after DEDUCTIBLE												
REHABILITATIVE and HABILITATIVE THERAPIES	\$25 copayment, then 20% after DEDUCTIBLE	\$25 copayment, then 30% after DEDUCTIBLE												
OTHER THERAPIES	20% after DEDUCTIBLE	30% after DEDUCTIBLE												

SUMMARY OF BENEFITS (cont.)

Benefits	IN-NETWORK	OUT-OF-NETWORK
<p>Pediatric DENTAL SERVICES</p>		
Preventive and Diagnostic Services	\$25 copayment	\$50 copayment
Basic and Major Services	20% after deductible	40% after deductible
Orthodontic Services (if CLINICALLY NECESSARY)	20% after deductible	40% after deductible
<p>The benefits listed above are only available for MEMBERS up to the end of the month in which they become age 19. See "Pediatric DENTAL SERVICES" in "COVERED SERVICES" for a description of the available benefits. NOTE: there is a 12-month WAITING PERIOD on orthodontic services.</p>		
<p>Pediatric Vision Services</p>		
Professional Services	\$25 copayment, then 20% after DEDUCTIBLE	\$25 copayment, then 30% after DEDUCTIBLE
Lenses and/or Contact Lenses	Cost up to \$100 - No Charge Cost between \$100 and \$300 - \$50 copayment Cost over \$300 - 50%	
Frames	Cost up to \$100 - No Charge Cost between \$100 and \$300 - \$50 copayment Cost over \$300 - 50%	
<p>The benefits listed above are only available for MEMBERS up to the end of the month in which they become age 19. See "Pediatric Vision Services" in "COVERED SERVICES" for a description of these benefits. See "PREVENTIVE CARE" for routine eye examination, which is also covered.</p>		

SUMMARY OF BENEFITS (cont.)

Benefits	IN-NETWORK	OUT-OF-NETWORK
Obesity Treatment/Weight Management		
<p>PRIMARY CARE PROVIDER</p> <p>SPECIALIST</p> <p>Outpatient Services</p> <p>Inpatient Physician Services</p> <p>Inpatient HOSPITAL and HOSPITAL-based 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 these BENEFIT PERIOD MAXIMUMS are not COVERED SERVICES.</p>	<p>\$25 copayment, then 20% after DEDUCTIBLE</p> <p>\$25 copayment, then 20% after DEDUCTIBLE</p> <p>20% after DEDUCTIBLE</p> <p>20% after DEDUCTIBLE</p> <p>20% after DEDUCTIBLE</p>	<p>\$25 copayment, then 30% after deductible</p> <p>\$25 copayment, then 30% after deductible</p> <p>30% after deductible</p> <p>30% after deductible</p> <p>30% after deductible</p>
URGENT CARE Centers, Ambulance, and Emergency Room		
<p>URGENT CARE Centers</p> <p>Ambulance</p> <p>Emergency Room Visit</p> <p>If admitted to the HOSPITAL from the emergency room, the emergency room copayment does not apply; instead, inpatient HOSPITAL benefits apply to all COVERED SERVICES provided in both the emergency room and during inpatient hospitalization. If held for observation, the emergency room copayment does not apply; instead, outpatient benefits apply to all COVERED SERVICES provided in both the emergency room and during observation. If you are sent to the emergency room from an URGENT CARE center, the URGENT CARE copayment will be waived.</p>	<p>\$75 copayment, then 20% after DEDUCTIBLE</p> <p>20% after DEDUCTIBLE</p> <p>\$400 copayment, then 20% after DEDUCTIBLE</p>	<p>\$75 copayment, then 20% after DEDUCTIBLE</p> <p>20% after DEDUCTIBLE</p> <p>\$400 copayment, then 20% after deductible</p>

SUMMARY OF BENEFITS *(cont.)*

Benefits	IN-NETWORK	OUT-OF-NETWORK
AMBULATORY SURGICAL CENTER		
	20% after DEDUCTIBLE	30% after DEDUCTIBLE
Outpatient Services		
Outpatient Services	20% after DEDUCTIBLE	30% after DEDUCTIBLE
HOSPITAL-based or OUTPATIENT CLINIC	20% after DEDUCTIBLE	30% after DEDUCTIBLE
Outpatient Diagnostic Services		
Outpatient lab tests and mammography	20% after DEDUCTIBLE	30% after DEDUCTIBLE
Outpatient lab tests and mammography, when performed with another service		
<div style="text-align: right; padding-right: 20px;">Physician Services</div>	20% after DEDUCTIBLE	30% after DEDUCTIBLE
<div style="text-align: right; padding-right: 20px;">HOSPITAL and HOSPITAL-based Services</div>	20% after DEDUCTIBLE	30% after DEDUCTIBLE
Outpatient x-rays, ultrasounds, diagnostic tests (EEGs, EKGs and pulmonary function tests) and scans (CT scans, MRIs, MRAs and PET scans)	20% after DEDUCTIBLE	30% after DEDUCTIBLE
Inpatient Services		
Physician Services	20% after DEDUCTIBLE	30% after DEDUCTIBLE
HOSPITAL and HOSPITAL-based Services	20% after DEDUCTIBLE	30% after DEDUCTIBLE
<p>Includes 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.</p>		

SUMMARY OF BENEFITS *(cont.)*

Benefits	IN-NETWORK	OUT-OF-NETWORK
SKILLED NURSING FACILITY		
<p style="text-align: center;"> 20% after DEDUCTIBLE 30% after DEDUCTIBLE </p> <p>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 these BENEFIT PERIOD MAXIMUMS are not COVERED SERVICES.</p>		
Other Services		
<p style="text-align: center;"> 20% after DEDUCTIBLE 30% after DEDUCTIBLE </p> <p>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. Benefits for hearing aids are limited to one hearing aid per hearing-impaired ear every 36 months for MEMBERS under the age of 22. Any services in excess of these BENEFIT PERIOD or LIFETIME MAXIMUMS are not COVERED SERVICES.</p>		
Mental Health and Substance Abuse Services		
Mental Health/Substance Abuse Office Services	\$25 copayment, then 20% after DEDUCTIBLE	\$25 copayment, then 30% after DEDUCTIBLE
Mental Health/Substance Abuse Inpatient Services	20% after DEDUCTIBLE	30% after DEDUCTIBLE
Mental Health/Substance Abuse Outpatient Services	20% after DEDUCTIBLE	30% after DEDUCTIBLE

SUMMARY OF BENEFITS (cont.)

Benefits	IN-NETWORK	OUT-OF-NETWORK
LIFETIME MAXIMUMS, DEDUCTIBLE, and OUT-OF-POCKET LIMIT		
<p>The following DEDUCTIBLES and maximums apply to the services listed above in the "Summary of Benefits" unless otherwise noted.</p>		
<p>LIFETIME MAXIMUM</p> <p>Unlimited for all services, except orthotic devices for POSITIONAL PLAGIOCEPHALY. 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.</p>	<p>Unlimited</p>	<p>Unlimited</p>
<p>Evacuation and Repatriation of Mortal Remains</p> <p>LIFETIME MAXIMUM</p>		<p>\$1,000,000</p>
<p>Deductible</p> <p>Individual, per BENEFIT PERIOD</p> <p>Charges for the following do not apply to the BENEFIT PERIOD DEDUCTIBLE:</p> <ul style="list-style-type: none"> • Medical services received at SHC • Inpatient newborn care for well baby • PRESCRIPTION DRUGS. 	<p>\$500</p>	<p>\$500</p>
<p>OUT-OF-POCKET LIMIT</p> <p>Individual, per BENEFIT PERIOD</p>	<p>\$4,000</p>	<p>\$8,000</p>
CERTIFICATION Requirements		
<p>Certain services require PRIOR REVIEW and CERTIFICATION in order to receive benefits. IN-NETWORK PROVIDERS in North Carolina will request PRIOR REVIEW when necessary. IN-NETWORK inpatient FACILITIES outside of North Carolina will also request PRIOR REVIEW for you, except for Veterans' Affairs (VA) and military providers. Otherwise, if you go to an OUT-OF-NETWORK PROVIDER in North Carolina or to any other PROVIDER outside of North Carolina, you are responsible for ensuring that you or your PROVIDER requests PRIOR REVIEW by BCBSNC. BCBSNC delegates administration of your mental health and substance abuse benefits to Magellan Behavioral Health. Magellan Behavioral Health is not associated with BCBSNC. Failure to request PRIOR REVIEW and receive CERTIFICATION 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 numbers in "Who to Contact?"</p>		

SUMMARY OF BENEFITS (cont.)

Benefits	IN-NETWORK	OUT-OF-NETWORK
PRESCRIPTION DRUGS		
<p>PRESCRIPTION DRUGS Purchased at SHC:</p> <p>One copayment for up to a 30-day supply. 31-60-day supply is two copayments, and 61-90-day supply is three copayments.</p>	<p>\$15 copayment</p>	<p>Benefits not applicable</p>
<p>PRESCRIPTION DRUGS Purchased at any Pharmacy other than SHC:</p>		
Tier 1 Drugs	\$30 copayment	\$30 copayment
Tier 2 Drugs	\$60 copayment	\$60 copayment
Tier 3 or Tier 4 Drugs	\$120 copayment	\$120 copayment
<p>Diabetic Supplies, Spacers and Peak Flow Meters</p> <p>One copayment for up to a 30-day supply. 31-60-day supply is two copayments, and 61-90-day supply is three copayments.</p>	<p>25%</p>	<p>25%</p>
<p>Preventive over-the-counter medications and PRESCRIPTION contraceptive drugs and devices as listed at www.bcbsnc.com/preventive*</p> <p>*Please visit the website at www.bcbsnc.com/preventive or call the number in "Who to Contact?" for guidelines on which preventive over-the-counter medications are covered and individuals who may qualify, as well as more information and any limitations that apply for contraceptives. PRESCRIPTION contraceptive drugs and devices that are not covered at the PREVENTIVE CARE benefit level will be covered according to your regular PRESCRIPTION DRUG benefits. Also see "PREVENTIVE CARE" in "COVERED SERVICES."</p> <p>***"No Charge" indicates no obligation for MEMBERS to pay any portion of the ALLOWED AMOUNT. For OUT-OF-NETWORK benefits, you may be required to pay any difference between the ALLOWED AMOUNT and the billed charge.</p>	<p>No Charge</p>	<p>No Charge**</p>
Adult Lenses And Frames		
<p>\$200 per BENEFIT PERIOD</p> <p>This benefit is a non-essential health benefit and is available for MEMBERS age 19 and older. For MEMBERS up to age 19, see Pediatric Vision. BCBSNC will reimburse you up to the BENEFIT PERIOD MAXIMUM for prescribed eyeglasses and hard, soft or disposable contact lenses. Any services in excess of this BENEFIT PERIOD MAXIMUM are not COVERED SERVICES. There are normally no DEDUCTIBLES to be met before benefits begin.</p>		

HOW STUDENT BLUE WORKS

As a MEMBER of the Student Blue plan, you enjoy quality health care from a network of health care PROVIDERS and easy access to SPECIALISTS. You also have the freedom to choose health care PROVIDERS who do not participate in the PPO network - the main difference will be the cost to you. Benefits are available for services received from an IN- or OUT-OF-NETWORK PROVIDER that is recognized by BCBSNC as eligible. For a list of eligible PROVIDERS, please visit the BCBSNC website at bcbnsnc.com/unc or call the number listed in "Who to Contact?"

Student Health Center (SHC)

The student health center (SHC) at your school provides access to medical care for all students who have paid the student health fee. In order to make the most of your benefits, visit SHC first. If the services you receive at SHC are not covered by the student health fee, you may need to complete a claim form and file with BCBSNC. You may also be responsible for requesting PRIOR REVIEW and receiving CERTIFICATION from BCBSNC when necessary. Please visit the website at bcbnsnc.com/unc or call the number listed in "Who to Contact?" to find out if your SHC will file claims and request PRIOR REVIEW for you. See "How to File a Claim" and "PRIOR REVIEW/Pre-Service." If you require services of a DOCTOR outside SHC, they can guide you to the appropriate PROVIDER.

	IN-NETWORK	OUT-OF-NETWORK
Type of PROVIDER	<p>IN-NETWORK PROVIDERS are health care professionals and facilities that have contracted with BCBSNC, or a PROVIDER participating in the BlueCard[®] program. ANCILLARY PROVIDERS outside North Carolina are considered IN-NETWORK only if they contract directly with the Blue Cross or Blue Shield plan in the state where services are received, even if they participate in the BlueCard[®] program. See the "Glossary" for a description of ANCILLARY PROVIDERS and the criteria for determining where services are received.</p> <p>The list of IN-NETWORK PROVIDERS may change from time to time. IN-NETWORK PROVIDERS are listed at bcbnsnc.com/unc, or call the number listed in "Who to Contact?"</p>	<p>OUT-OF-NETWORK PROVIDERS are not designated as a PPO PROVIDER by BCBSNC. 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 copayment, DEDUCTIBLE, coinsurance, and noncovered expenses. (See Filing Claims below for additional information.)</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>

HOW STUDENT BLUE WORKS (cont.)

Referrals	BCBSNC does not require you to obtain any referrals.	
After-hours Care	If you need nonemergency services after your PROVIDER'S office has closed, please call your PROVIDER'S office for their recorded instructions. You may also contact the nurse advice line, HealthLine Blue, for assistance.	
Care Outside of North Carolina	Your ID CARD gives you access to participating PROVIDERS outside the state of North Carolina through the BlueCard® Program, and benefits are provided at the IN-NETWORK benefit level.	If you are in an area that has participating PROVIDERS and you choose a PROVIDER outside the network, you will receive the lower OUT-OF-NETWORK benefit. Also see "OUT-OF-NETWORK Benefit Exceptions."
PRIOR REVIEW	<p>IN-NETWORK PROVIDERS in North 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 BCBSNC 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 all other medical services. PRIOR REVIEW is not required for an EMERGENCY or for an inpatient HOSPITAL stay for 48 hours after a vaginal delivery or 96 hours after a Cesarean section.</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 BCBSNC. Failure to request PRIOR REVIEW and obtain CERTIFICATION may result in a partial or full denial of benefits. Before receiving the service, you may want to verify with BCBSNC that CERTIFICATION has been obtained. If PRIOR REVIEW is not requested and CERTIFICATION obtained for covered OUT-OF-NETWORK inpatient admissions, allowed charges will be reduced by 25%, then DEDUCTIBLE and coinsurance will be applied. 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>Although PRIOR REVIEW and CERTIFICATION are not required for OUT-OF-NETWORK inpatient or outpatient mental health and substance abuse services, Magellan Behavioral Health can assist in finding an appropriate PROVIDER. See "Who to Contact?"</p>

Filing Claims	<p>IN-NETWORK PROVIDERS in North Carolina are responsible for filing claims directly with BCBSNC. However, you will have to file a claim if you do not show your ID CARD when you obtain a PRESCRIPTION from an IN-NETWORK pharmacy, or the IN-NETWORK pharmacy's records do not show as eligible for coverage.</p> <p>In order to recover the full cost of the PRESCRIPTION minus any applicable copayment or coinsurance you owe, return to the IN-NETWORK pharmacy within 14 days of receiving your PRESCRIPTION so that it can be reprocessed with your correct eligibility information and the pharmacy will make a refund to you. If you are unable to return to the pharmacy within 14 days, mail claims in time to be received within 18 months of the date of the service in order to receive IN-NETWORK benefits. Claims not received within 18 months from the service date will not be covered, except in the absence of legal capacity of the MEMBER.</p>	<p>You may have to pay the OUT-OF-NETWORK PROVIDER in full and submit your own claim to BCBSNC. Mail claims in time to be received within 18 months of the date the service was provided. Claims not received within 18 months from the service date will not be covered, except in the absence of legal capacity of the MEMBER.</p>
---------------	--	--

OUT-OF-NETWORK Benefit Exceptions

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

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

Carry Your IDENTIFICATION CARD

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

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

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

BCBSNC does not require that you designate a PCP to manage your health care. However, it is important for you to maintain a relationship with a PCP, who will help you manage your health and make decisions about your health care. If you change PCPs, be sure to have your medical records transferred, especially immunization records, to provide your new

HOW STUDENT BLUE WORKS *(cont.)*

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

Please visit our website at bcbsnc.com/unc, or call the number listed in "Who to Contact?" to confirm that the PROVIDER is in the network before receiving care.

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

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

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

COVERED SERVICES

Student Blue 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 below as requiring PRIOR REVIEW. Also see "PRIOR REVIEW/Pre-Service" in "UTILIZATION MANAGEMENT" for information about the review process, and contact BCBSNC at email@studentbluenc.com 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 that apply to each service, read "COVERED SERVICES," "Summary of Benefits" and "What Is Not Covered?"
- You may receive, upon request, information about Student Blue, 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 BCBSNC 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 BCBSNC. BCBSNC medical policies are guides considered by BCBSNC when making coverage determinations. If you need more information about medical policies, see our website at bcbsnc.com or call the number listed in "Who to Contact?"

Office Services

Care you receive as part of an OFFICE VISIT, electronic visit, or house call is covered.

Some DOCTORS or OTHER PROVIDERS may practice in HOSPITAL-based or OUTPATIENT CLINICS or provide HOSPITAL-based services in their offices. These services are covered as outpatient services and are listed as HOSPITAL-based or OUTPATIENT CLINIC.

Beginning with dates of service on and after January 1, 2016, MEMBERS who receive PRESCRIPTION DRUGS for hemophilia may notice a difference in how these claims are reimbursed. Previously these drugs may have been provided by a physician in an office or outpatient setting and billed to BCBSNC as a medical service. In 2016, these drugs will be reimbursed on the highest drug tier, according to your PRESCRIPTION DRUG benefits. Please see "PRESCRIPTION DRUGS" in the "Summary of Benefits" included in your Benefit Booklet.

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 BCBSNC website at bcbsnc.com or call BCBSNC for a list of drugs excluded in the office. Also see "PRESCRIPTION DRUG Benefits" for information about purchasing self-injectable PRESCRIPTION DRUGS at a pharmacy.

PREVENTIVE CARE

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

PREVENTIVE CARE services may fall into three categories: (1) federally-mandated PREVENTIVE CARE services (required to be covered at no cost to you IN-NETWORK); (2) state-mandated PREVENTIVE CARE services (required to be offered 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 website at bcbsnc.com/preventive or call the number in "Who to Contact?" for the most up-to-date information on PREVENTIVE CARE that is covered under federal law, including general preventive services and screenings, immunizations, well-baby/well-child care, women's PREVENTIVE CARE and certain over-the-counter medications. These over-the-counter medications are covered only as indicated and when a PROVIDER'S PRESCRIPTION is presented at a pharmacy.

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

- Services are designated as PREVENTIVE CARE services under federal law (see above website for the most up-to-date information);
- Services are performed by an IN-NETWORK PROVIDER;
- Services are provided in an office-based, outpatient or ambulatory setting or URGENT CARE CENTER; and

COVERED SERVICES (cont.)

- Services are filed with a primary diagnosis of preventive or wellness, and do not include any additional procedures, such as diagnostic services.

Please note that if a particular PREVENTIVE CARE service does not have a federal recommendation or guideline concerning the frequency, method, treatment or setting in which it must be provided, BCBSNC may use reasonable medical management procedures to determine any coverage limitations or restrictions that may apply. Services that would otherwise be excluded under this health benefit plan will be covered with no cost sharing if the criteria mentioned above are met. Visit bcbnsnc.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 this health benefit plan.

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

Situation	Example	Reason/Result
How your PREVENTIVE CARE service is filed	A colonoscopy includes a primary diagnosis of non-preventive.	Certain PREVENTIVE CARE services will not pay in full because the primary diagnosis filed on the claim is something other than preventive. In this instance, the colonoscopy is subject to any applicable copayment, deductible or coinsurance.
Type of PREVENTIVE CARE service	A routine exam includes an additional procedure, such as a urinalysis.	This urinalysis will not pay in full because it is not identified as a federally-mandated PREVENTIVE CARE service required to be paid at 100%. 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, such as a HOSPITAL.	Certain PREVENTIVE CARE services will not pay at 100% because they are not performed in an office-based, outpatient or ambulatory setting or URGENT CARE CENTER. In this example, the mammogram is subject to deductible and coinsurance.

State-Mandated PREVENTIVE CARE Services:

Bone Mass Measurement Services

This health benefit plan covers one scientifically proven and approved bone mass measurement for the diagnosis and evaluation of osteoporosis or low bone mass during any 23-month period for certain qualified individuals only. Additional follow-up bone mass measurement tests will be covered if MEDICALLY NECESSARY. Please note that bone mass measurement tests will be covered under your diagnostic benefit (not your PREVENTIVE CARE benefit) if the claim for these services indicates a primary diagnosis of something other than preventive or wellness. Your diagnostic benefit will be subject to your 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 hemocult 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/unc can help you find office-based PROVIDERS or you can call the number in "Who to Contact?" for this information.

Gynecological Exam and Cervical Cancer Screening

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

Newborn Hearing Screening

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

Ovarian Cancer Screening

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

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

Prostate Screening

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

Screening Mammograms

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

A female MEMBER is "at risk" if she:

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

Non-Mandated PREVENTIVE CARE Services

Routine Eye Exams

Benefits are only available IN-NETWORK and are covered at no cost to you. This benefit is a non-essential health benefit for MEMBERS age 19 and older. For MEMBERS up to age 19 also see Pediatric Vision for additional eye care benefits.

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

PREVENTIVE CARE Exclusions

- Immunizations required for occupational hazard
- Fitting for contact lenses, glasses or other hardware
- Diagnostic services that are not a component of a routine vision examination.

Obesity Treatment/Weight Management

COVERED SERVICES (cont.)

This health benefit plan provides coverage for OFFICE VISITS for the evaluation and treatment of obesity. See "Summary of Benefits" for visit maximums. Benefits are also provided for surgical treatment of morbid obesity. Morbid obesity surgical services require PRIOR REVIEW and CERTIFICATION or services will not be covered. Coverage is also provided for PRESCRIPTION DRUGS approved by the U.S. Food and Drug Administration (FDA) for long-term use in the treatment of obesity. See "PRESCRIPTION DRUG Benefits."

This health benefit 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 maintaining a healthy weight. Nutritional counseling visits are separate from the obesity-related OFFICE VISIT noted above.

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
- Any services not described above.

Diagnostic Services

Diagnostic procedures such as laboratory 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 BCBSNC.

Diagnostic Services Exclusion

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

EMERGENCY Care

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

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

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

What to Do in an EMERGENCY

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

COVERED SERVICES (cont.)

Benefits for services in the emergency room

Situation	Benefit
You go to an IN-NETWORK HOSPITAL emergency room.	Applicable ER copayment and/or DEDUCTIBLE and 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

This health benefit plan also provides benefits for URGENT CARE services. When you need URGENT CARE during the normal hours of operation of SHC and you are in the Durham area, you should go to SHC first. You may also 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.

Maternity Care and Family Planning

Maternity Care

Maternity care benefits, including pre-natal care, labor and delivery, and post-delivery care, are available to all female MEMBERS. Coverage for breastfeeding counseling and certain breast pumps for pregnant or post-partum MEMBERS are covered under your PREVENTIVE CARE benefit. See bcbsnc.com/preventive or call the number in "Who to Contact?" for additional information and any limitations that may apply. If this health benefit plan has an OFFICE VISIT copayment and you change PROVIDERS during pregnancy, terminate coverage during pregnancy, or the pregnancy does not result in delivery, one or more copayments may be charged for prenatal services depending upon how the services are billed by the PROVIDER.

	Mother	Newborn	Payment
Prenatal care	Care related to the pregnancy before birth.		A copayment, if applicable, may apply for the OFFICE VISIT to diagnose pregnancy. Otherwise, DEDUCTIBLE and coinsurance apply.

COVERED SERVICES *(cont.)*

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."	For the first 48/96 hours, only one BENEFIT PERIOD DEDUCTIBLE and admission copayment, if applicable, is required for both mother and baby.
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.	Not available.	

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.

COMPLICATIONS OF PREGNANCY

Benefits for COMPLICATIONS OF PREGNANCY are available to all female MEMBERS. 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.

Benefits for ovulation induction cycles only include the following services during each 4-5 week stimulation period:

- Ultrasound
- Laboratory (Estradiol, FSH, LH, progesterone, HCG)
- Sperm washing and preparation
- Intrauterine or intracervical insemination.

Benefits are provided for a LIFETIME MAXIMUM of three ovulation induction cycles per MEMBER, with or without insemination, combined IN- and OUT-OF-NETWORK, provided in all places of service. BCBSNC medical policies are guides considered by BCBSNC when making coverage determinations. For more information about medical policies on infertility, see our website at www.bcbsnc.com and search on "infertility", or call BCBSNC Customer Service at the number listed in "Who to Contact?" For information about coverage of PRESCRIPTION DRUGS for INFERTILITY, see "PRESCRIPTION DRUG Benefits."

SEXUAL DYSFUNCTION Services

This health benefit plan provides benefits for certain services related to the diagnosis, treatment and correction of any underlying causes of SEXUAL DYSFUNCTION for all MEMBERS. Benefits may vary depending on where services are received.

Sterilization

This benefit is available for all MEMBERS. Sterilization includes female tubal occlusion and male vasectomy. Certain sterilization procedures for female MEMBERS are covered under your PREVENTIVE CARE benefit. See bcbsnc.com/preventive or call the number in "Who to Contact?" 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 bcbsnc.com/preventive or call Customer Service for information about procedures that are covered according to federal regulations and any limitations that may apply. See "PRESCRIPTION DRUG Benefits" for coverage of oral contraceptives.

Maternity Care and Family Planning Exclusions

- Assisted reproductive technologies as defined by the Centers for Disease Control and Prevention, including, but not limited to, in-vitro fertilization (IVF) with fresh or frozen embryos, ovum or embryo placement, intracytoplasmic sperm injection (ICSI), zygote intra-fallopian transfer (ZIFT), specialized sperm retrieval techniques, and gamete intrafallopian transfer (GIFT) and associated services
- Oocyte and sperm donation
- Cryopreservation of oocytes, sperm, or embryos
- Surrogate mothers
- Care or treatment of the following:
 - reversal of sterilization
- 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. Take home drugs are covered as part of your PRESCRIPTION DRUG benefit. PRIOR REVIEW must be requested and CERTIFICATION must be obtained in advance from BCBSNC for

COVERED SERVICES (cont.)

inpatient admissions to avoid a penalty, except for maternity deliveries and EMERGENCIES. Also, BCBSNC requires notification for MEMBERS who have Medicare as their primary coverage and who are admitted to a Medicare-certified HOSPITAL or NONHOSPITAL FACILITY. **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.**

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

Other Services

Ambulance Services

This health benefit plan covers services in a ground ambulance traveling:

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

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

This health benefit 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.

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

Ambulance Services Exclusions

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

Blood

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

Blood Exclusion

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

Clinical Trials

This health benefit plan provides benefits for participation in clinical trials phases I, II, III, and IV. Coverage is provided only for MEDICALLY NECESSARY costs of health care services associated with the trials, 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 a life-threatening medical condition with services that are medically indicated and preferable for that MEMBER compared to non-INVESTIGATIONAL alternatives. In addition, the trial must:

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

Clinical Trials Exclusions

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

Dental Treatment Covered Under Your Medical Benefit

For MEMBERS who are up to age 19 see “Pediatric Dental” for additional dental care benefits. This health benefit plan provides benefits for services provided by a duly licensed DOCTOR, DOCTOR of dental SURGERY or DOCTOR of dental medicine for diagnostic, therapeutic or surgical procedures, including oral SURGERY involving bones or joints of the jaw, when the procedure or dental treatment is related to one of the following conditions:

- Accidental injury of 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 for dentures.

This health benefit plan provides benefits for dental implants and related procedures, such as bone grafting, associated with the above three conditions.

Benefits are also provided for extractions, root canal therapy, crowns, bridges, and dentures necessary for treatment of accidental injury or for reconstruction for the conditions listed above. In addition, benefits may be provided for dentures and orthodontic braces if used to treat CONGENITAL deformity including cleft lip and cleft palate.

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

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 persons with serious mental or physical conditions and persons with significant behavioral problems. The treating PROVIDER must certify that the patient's age, condition or problem requires hospitalization or general anesthesia in order to safely and effectively perform the procedure. Other DENTAL SERVICES, including the charge for SURGERY, are not covered unless specifically covered by this health benefit plan.

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

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

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
- Extraction of impacted wisdom teeth
- 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 BCBSNC. BCBSNC provides

COVERED SERVICES (cont.)

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

This health benefit plan provides coverage for **MEDICALLY NECESSARY** hearing aids and related services that are ordered by a **DOCTOR** or a licensed audiologist for each **MEMBER** under the age of 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. When covered, benefits for hearing aids are limited to one hearing aid per hearing-impaired ear every 36 months for **MEMBERS** under age 22. Benefits are also provided for the evaluation, fitting, and adjustments of hearing aids or replacement of hearing aids, and for supplies, including ear molds.

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, and food or meal preparation.

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

COVERED SERVICES (cont.)

Coverage is provided for MEDICAL SUPPLIES. Your benefits are based on where supplies are received, either as part of your MEDICAL SUPPLIES benefit or your PRESCRIPTION DRUG benefit. Select diabetic supplies and spacers for metered dose inhalers and peak flow meters are also covered under your PRESCRIPTION DRUG benefit.

To obtain MEDICAL SUPPLIES and equipment, please find a PROVIDER on the website at bcbsnc.com/unc, or call the number listed in "Who to Contact?"

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, are subject to a benefit limit of one device per MEMBER per lifetime.

Orthotic Devices Exclusions

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

Pediatric DENTAL SERVICES

This benefit is only available for MEMBERS up to the end of the month in which they become age 19.

Preventive and Diagnostic Services

This health benefit plan provides benefits for the following dental preventive services:

- Oral evaluations
 - periodic (twice per BENEFIT PERIOD)
 - comprehensive oral or periodontal (limit one per PROVIDER and one per BENEFIT PERIOD, counts toward periodic frequency limit above)
- Consultations (one per PROVIDER, only covered if no other services except x-rays performed)
- Palliative EMERGENCY treatment for relief of pain only (limit of two per BENEFIT PERIOD)
- Cleaning - prophylaxis, including scaling and polishing above the gum line (twice each BENEFIT PERIOD)
- X-rays
 - full-mouth or panoramic for MEMBERS ages six and older (limited to once every three years unless taken for diagnosis of third molars, cysts, or neoplasms)
 - supplemental bitewings - x-rays showing the back teeth (maximum of four films per BENEFIT PERIOD)
 - vertical bitewings (limit of one set per BENEFIT PERIOD, associated with periodontics)
 - periapical and occlusal x-ray of a tooth (limited to four films per BENEFIT PERIOD)
 - Extraoral (two films per BENEFIT PERIOD)
- Pulp-testing - evaluation of tooth nerve (limited to one charge per visit, regardless of the number of teeth tested)
- Topical fluoride application to prevent decay (twice each BENEFIT PERIOD)
- Sealants for first and second permanent molars for MEMBERS ages 6 through 15 (one reapplication per tooth every 5 years)
- Space maintainers - devices to keep space from closing after loss of a primary (baby) tooth so a permanent tooth will have room to grow (limited to MEMBERS through age 15, one per tooth per lifetime)
- Diagnostic casts - only if not related to orthodontic or prosthetic services.

Basic and Major Services

This health benefit plan provides benefits for the following basic and major services:

- Routine fillings to restore diseased teeth (limit of one restoration per tooth every two years, unless new decay appears)
 - Amalgam - a soft silver which hardens after it is packed into the cavity
 - Composite resin or other tooth-colored filling materials (limited to what would have been paid for an amalgam)
- Simple extractions
- Stainless steel crowns
 - Primary posterior (one per tooth per lifetime)
 - Primary anterior (one per tooth every three years)

COVERED SERVICES (cont.)

- Permanent (one per tooth every eight years)
- Pin retention (limit of once per restoration)
- Surgical removal of teeth
- Complex oral surgery
 - Oroantral fistula closure/closure of sinus perforation (once per tooth)
 - Surgical access of unerupted tooth/process to aid eruption (once per tooth)
 - Transseptal fiberotomy (once per site every three years)
 - Alveoloplasty (once per site every three years)
 - Vestibuloplasty (once per site every three years)
 - Removal of exostosis (once per site every three years)
 - Incision and drainage of intraoral abscess
 - Frenulectomy (once per site per lifetime)
 - Excision of hyperplastic tissue or pericoronal gingival (once per site every three years)
- Anesthesia limited to deep sedation and intravenous when CLINICALLY NECESSARY and related to covered complex surgery or surgical removal of teeth when three or more quadrants are involved
- Inlays, onlays, crowns (one restoration per tooth every eight years, covered only when a filling cannot restore the tooth)
- Core build-up, cast post and core (one per tooth every eight years)
- Labial veneers, anterior only (one per tooth every five years)
- Complete dentures (once every eight years, no additional allowances for over-dentures or customized dentures)
- Removable partial dentures (once every eight years, no additional allowances for precision or semi-precision attachments)
- Fixed partial dentures (once every eight years, no additional allowances for removable partial dentures)
- Tissue conditioning done more than six months after initial insertion or rebasing or relining (once per 12 months per prosthesis)
- Denture relining done more than six months after the initial insertion (once every two years)
- Rebasing of complete and partial dentures done more than five years after the initial insertion (once every five years)
- Crown, partial and complete denture repairs and addition of teeth to existing partial dentures (limited to repairs or adjustments done after 12 months following the initial insertion)
- Replacement of broken teeth on partial or complete denture (once per tooth every three years)
- Recementing of inlays, onlays, crowns and/or fixed partial dentures
- Occlusal guard, for treatment of bruxism only (once every five years)
- Endodontics - treatment of diseases of the nerve chamber and canals
 - Pulpotomy - partial removal of a tooth's pulp and placement of medicament (once per tooth per lifetime)
 - Retrograde filling (limit one per root)
 - Root amputation (limit one per root)
 - Endodontic therapy (once per lifetime, and retreatment once per lifetime after 12 months from initial treatment)
 - Apexification - inducing root development
 - Hemisection - dividing the crown and roots of a multi-rooted tooth (once per root per lifetime)
 - Apicoectomy - removing the infected tip of the tooth's root (once per root per lifetime)
- Periodontics – treatment of the diseases of the gums and bone surrounding the teeth
 - Crown lengthening - reshaping the bone around the teeth to allow for proper prosthetic preparation (once per tooth every three years per site or quadrant)
 - Root planing and periodontal scaling - scraping to remove mineralized deposits and smooth rough, infected root surfaces (once per quadrant every three years)
 - Full mouth debridement (once every five years)
 - Provisional splinting (once every three years)
 - Periodontal maintenance following active periodontal therapy (twice each BENEFIT PERIOD)
 - Complex surgical periodontal care (limited to one complex surgical periodontal service per area every three years):
- Gingivectomy and gingivoplasty - cutting out diseased or overgrown gum tissues around the teeth
- Gingival flap procedure - soft tissue flap is reflected or resected to allow debridement of the root surface and the removal of granulation tissue
- Osseous surgery - removing or reshaping the bone around the teeth through an incision of the gum
- Bone replacement graft
- Guided tissue regeneration

COVERED SERVICES (cont.)

- Soft tissue graft/allograft/connective tissue graft
- Distal or proximal wedge
- Placement of dental implants, and any other related implantology services, including pharmacological regimens (limited to once per tooth every eight years).

Orthodontic Services

Benefits for a comprehensive orthodontic treatment are covered if CLINICALLY NECESSARY. A WAITING PERIOD of 12 months applies for orthodontic services. PRIOR REVIEW and CERTIFICATION are required for certain orthodontic treatment or services will not be covered. The following are COVERED SERVICES and considered part of comprehensive orthodontic care:

- Diagnosis, including the examination, study models, x-rays, and other aids needed to define the problem
- Appliance - a device worn during the course of treatment. Coverage includes the design, making, placement and adjustment of the device. Benefits are not provided to repair or replace an appliance.
- Treatment may include Phase I or Phase II treatment

Phase I treatment is minor orthodontic treatment and can be paid in one total fee when treatment begins. Phase II treatment is comprehensive orthodontics and is divided into multiple payments.

Pediatric Dental Exclusions

- Anesthesia, except as otherwise covered by this health benefit plan
- Attachments to conventional removable prostheses or fixed bridgework, including semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature
- Placement of fixed bridgework solely for the purpose of achieving periodontal stability
- Brush biopsy
- Cone beam, except as otherwise covered by this health benefit plan
- Indirect resin-based composite crowns
- Temporary or provisional crowns
- Removal of odontogenic and nonodontogenic cysts
- Cytology samples
- Dental implants when not CLINICALLY NECESSARY
- Dental procedures not directly associated with dental disease
- Dental procedures not performed in a dental setting
- Interim dentures
- Removable unilateral partial denture, including clasps and teeth
- Application of desensitizing materials
- Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue
- DENTAL SERVICES provided in a HOSPITAL
- Incision and drainage of an extraoral soft tissue
- Maxillofacial prosthesis
- Occlusal guards for any purpose other than control of habitual grinding
- OFFICE VISITS for purposes of observation or presentation of treatment plan
- Orthodontic services, except as otherwise covered by this health benefit plan
- Periodontal related services such as anatomical crown exposure, apically positioned flap, surgical revisions and unscheduled charges
- Temporary or provisional pontics
- Pulp cap, direct or indirect
- Radiographs not specifically stated as covered are considered noncovered, such as skull and bone survey
- Tooth re-implantation or transplantation from one site to another
- Removal of foreign bodies or non-vital bones
- Services related to the salivary gland.

Pediatric Vision Services

This benefit is only available for MEMBERS up to the end of the month in which they become age 19. For MEMBERS age 19 and over, see "Adult Lenses and Frames" and "Routine Eye Exams" in "PREVENTIVE CARE."

This health benefit plan provides benefits for either one pair of eyeglass lenses and frames or one pair of contact lenses once per BENEFIT PERIOD in place of eyeglasses and certain low vision aids such as magnifiers. Benefits are also provided

COVERED SERVICES (cont.)

for low vision care, including one comprehensive low vision examination every five years and four follow-up visits in any five year period. See "OFFICE VISIT Services" in "Summary of Benefits."

NOTE: one routine eye examination per BENEFIT PERIOD is also covered; see "PREVENTIVE CARE."

Pediatric Vision Exclusions

- Services and materials not meeting accepted standards of optometric practice
- Visual therapy
- Replacement of lost or stolen eyewear
- Non-prescription (Plano) lenses
- Two pairs of eyeglasses in lieu of bifocals
- Replacement insurance for contact lenses.

Private Duty Nursing

This health benefit plan provides benefits for MEDICALLY NECESSARY private duty services of an RN or LPN when ordered by your DOCTOR for a MEMBER who 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 or services will not be covered.

Private Duty Nursing Exclusion

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

PROSTHETIC APPLIANCES

Your coverage 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. For subsequent lens replacements, see "Lenses and Frames."

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 this health benefit 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 BCBSNC's reimbursement policies, which are on our website at bcbsnc.com/unc, or call the number listed in "Who to Contact?"

Anesthesia

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

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

Mastectomy Benefits

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

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

See PROVIDER'S Office, or for external prostheses, see PROSTHETIC APPLIANCES in Other Services in the "Summary of Benefits."

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

The benefits described above are subject to the same applicable DEDUCTIBLES or coinsurance and limitations as applied to other medical and surgical benefits provided under this health benefit plan.

Temporomandibular Joint (TMJ) Services

This health benefit plan provides benefits for services provided by a duly licensed DOCTOR, DOCTOR of dental SURGERY, or DOCTOR of dental medicine for diagnostic, therapeutic or surgical procedures, including oral SURGERY involving bones or joints of the jaw, face or head when the procedure is related to TMJ disease. Therapeutic benefits for TMJ disease include splinting and use of intra-oral PROSTHETIC APPLIANCES to reposition the bones. Surgical benefits for TMJ disease are limited to SURGERY performed on the temporomandibular joint. If TMJ is caused by malocclusion, benefits are provided for surgical correction of malocclusion when surgical management of the TMJ is MEDICALLY NECESSARY. Please have your PROVIDER contact BCBSNC before receiving surgical treatment for TMJ. 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

This health benefit plan provides coverage for the following therapy services for an illness, disease or injury when ordered by a DOCTOR or OTHER PROFESSIONAL PROVIDER.

REHABILITATIVE and HABILITATIVE THERAPIES

The following therapies are covered:

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

Benefits are limited to a combined IN-NETWORK and OUT-OF-NETWORK BENEFIT PERIOD 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 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 MAXIMUM. Benefits may vary depending on where services are received. See "Summary of Benefits" for benefit maximums.

OTHER THERAPIES

This health benefit plan covers:

- Cardiac rehabilitation therapy
- Pulmonary and respiratory therapy
- Dialysis treatment
- Radiation therapy

COVERED SERVICES (cont.)

- Chemotherapy, including intravenous chemotherapy. For chemotherapy received in conjunction with bone marrow or peripheral blood stem cell TRANSPLANTS, follow TRANSPLANT guidelines described in "TRANSPLANTS." Also see "PRESCRIPTION DRUG Benefits" regarding related covered PRESCRIPTION DRUGS.

Therapy Exclusions

- Cognitive therapy
- Group classes for pulmonary rehabilitation.

TRANSPLANTS

This health benefit plan provides benefits for TRANSPLANTS, including HOSPITAL and professional services for covered TRANSPLANT procedures. BCBSNC provides care management for TRANSPLANT services and will help you find a HOSPITAL or Blue Distinction Centers for Transplants that provides the TRANSPLANT services required. Travel and lodging expenses and charges related to a search for a donor may be reimbursed based on BCBSNC guidelines that are available upon request from a TRANSPLANT coordinator.

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

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.

Mental Health and Substance Abuse Services

This health benefit plan provides benefits for the treatment of MENTAL ILLNESS and substance abuse by a HOSPITAL, DOCTOR or OTHER PROVIDER.

Your coverage for IN-NETWORK inpatient and certain outpatient services is coordinated through Magellan Behavioral Health. BCBSNC delegates administration of these benefits to Magellan Behavioral Health. Magellan Behavioral Health is not associated with BCBSNC. 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 IN-NETWORK outpatient services, such as partial hospitalization and intensive therapy, require PRIOR REVIEW and CERTIFICATION or services will not be covered. However, PRIOR REVIEW and CERTIFICATION are not required for OUT-OF-NETWORK outpatient services. See "PRIOR REVIEW (Pre-Service)" in "Utilization Management" for additional information.

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 IN-NETWORK inpatient services or services will not be covered, except for EMERGENCIES. However, PRIOR REVIEW and CERTIFICATION are not required for OUT-OF-NETWORK inpatient services. See "PRIOR REVIEW (Pre-Service)" in "Utilization Management" for additional information.

RESIDENTIAL TREATMENT FACILITY Services

PRIOR REVIEW must be requested and CERTIFICATION must be obtained in advance for IN-NETWORK mental health and substance abuse services received in a RESIDENTIAL TREATMENT FACILITY or services will not be covered. However, PRIOR REVIEW and CERTIFICATION are not required for OUT-OF-NETWORK RESIDENTIAL TREATMENT FACILITY services. See "PRIOR REVIEW (Pre-Service)" in "Utilization Management" for additional information.

How to Access Mental Health and Substance Abuse Services

PRIOR REVIEW by Magellan Behavioral Health is not required for any OFFICE VISIT or in EMERGENCY situations; however, please notify Magellan Behavioral Health of an EMERGENCY your IN-NETWORK 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 help you find an appropriate IN-NETWORK PROVIDER and give you information about PRIOR REVIEW and CERTIFICATION requirements. The list of services that require PRIOR REVIEW may change from time to time. See "PRIOR REVIEW (Pre-Service)" in "Utilization Management" for additional information.

Mental Health and Substance Abuse Services Exclusion

- Counseling with relatives about a patient.

PRESCRIPTION DRUG Benefits

Your PRESCRIPTION DRUG benefits cover the following:

- PRESCRIPTION DRUGS, including self-administered injectable medications, and contraceptive drugs and devices
- Certain over-the-counter drugs when listed as covered in the FORMULARY, or under your PREVENTIVE CARE benefit, and a PROVIDER'S PRESCRIPTION for that drug is presented at the pharmacy
- Spacers for metered dose inhalers and peak flow meters
- PRESCRIPTION DRUGS related to the diagnosis and correction of underlying causes of SEXUAL DYSFUNCTION
- PRESCRIPTION DRUGS approved by the U.S. Food and Drug Administration (FDA) for long-term use in the treatment of clinical obesity
- Insulin and diabetic supplies such as: insulin needles, syringes, glucose testing strips, ketone testing strips and tablets, lancets and lancet devices. Benefits vary for MEDICAL SUPPLIES, depending on whether supplies are received at a MEDICAL SUPPLY PROVIDER or at a pharmacy. See "Summary of Benefits."
- Certain PRESCRIPTION DRUGS related to treatment of INFERTILITY. INFERTILITY drugs are limited to quantity LIFETIME MAXIMUMS per MEMBER. For medical policy on INFERTILITY, see our website at [bcbsnc.com](http://www.bcbsnc.com) and search on "infertility". For information on PRESCRIPTION DRUGS that have quantity limits, see www.bcbsnc.com/content/services/formulary/rxnotes.htm. PRESCRIPTION DRUGS indicated to treat INFERTILITY will be included in this benefit limit as they are approved by the U.S. Food and Drug Administration (FDA). Visit www.bcbsnc.com for the most up-to-date information, or call BCBSNC Customer Service at the number listed in "Who to Contact?"

COVERED SERVICES *(cont.)*

The following information will help you get the most value from your PRESCRIPTION DRUG coverage:

Situation	Value
<p>Where you get your PRESCRIPTION filled</p>	<p>Your cost will be less if you use an IN-NETWORK pharmacy in North Carolina or outside the state and show your ID CARD. If you fail to show your ID CARD or the IN-NETWORK pharmacy's records do not show as eligible for coverage, you will have to pay the full cost of the PRESCRIPTION and file a claim. In order to recover the full cost of the PRESCRIPTION minus any applicable copayment or coinsurance you owe, return to the IN-NETWORK pharmacy within 14 days of receiving your PRESCRIPTION so that it can be reprocessed with your correct eligibility information and the pharmacy will make a refund to you. If you are unable to return to the pharmacy within 14 days, mail claims in time to be received within 18 months of the date of the service in order to receive IN-NETWORK benefits. Claims not received within 18 months from the service date will not be covered, except in the absence of legal capacity of the MEMBER.</p> <p>You may also get your PRESCRIPTION filled by an OUT-OF-NETWORK pharmacy; however, you may be asked to pay the full cost of the PRESCRIPTION DRUG and submit your own claim. Any charges over the ALLOWED AMOUNT are your responsibility.</p> <p>If you had an EMERGENCY or URGENT CARE condition and went to an OUT-OF-NETWORK pharmacy, we recommend that you call BCBSNC at the number listed in "Who to Contact?" so that the claim can be processed at the IN-NETWORK level.</p>
<p>How the type of PRESCRIPTION DRUG may determine the amount you pay</p>	<p>Your PRESCRIPTION DRUG benefit has an open FORMULARY or list of PRESCRIPTION DRUGS, divided into categories or tiers. BCBSNC determines the tier placement of PRESCRIPTION DRUGS in the FORMULARY, and this determines the amount you pay. Tier placement of PRESCRIPTION DRUGS in the FORMULARY may be determined by: the effectiveness and safety of the drug, the cost of the drug, or the classification of the drug by the U.S. Food and Drug Administration (FDA) or nationally-recognized drug databases (e.g., Medispan).</p> <p>The lowest cost PRESCRIPTION DRUGS, such as GENERICS, are generally located on the lowest tiers (Tier 1 and Tier 2). Higher cost PRESCRIPTION DRUGS, such as BRAND-NAME PRESCRIPTION DRUGS are generally located on the higher tiers (Tier 3 and Tier 4). All tiers of the FORMULARY may contain GENERIC and BRAND-NAME PRESCRIPTION DRUGS.</p> <p>SPECIALTY DRUGS, if applicable, are located on the highest tiers of your health benefit plan, even though they may be classified as GENERIC, BRAND-NAME, BIOLOGIC, or BIOSIMILAR PRESCRIPTION DRUGS. Visit our website at www.bcsnc.com for additional information on the tier classification of PRESCRIPTION DRUGS.</p> <p>The PRESCRIPTION DRUGS listed in the FORMULARY or their tier placement may change from time to time due to a change in the cost of the drug or in the classification of the drug by the U.S. Food and Drug Administration (FDA) or nationally-recognized drug databases (e.g., Medispan).</p> <p>From time to time, MEMBERS may receive a reduced or waived copayment and/or coinsurance on designated drugs in connection with a program designed to reduce PRESCRIPTION DRUG costs or to encourage members to seek appropriate, high quality, efficient care based on BCBSNC criteria.</p>

COVERED SERVICES (cont.)

<p>How your PRESCRIPTION is dispensed</p>	<p>In some cases, a PROVIDER may prescribe a total dosage of a drug that requires two or more different drugs in a compound to be dispensed. In these cases, you will be responsible for one copayment that of the highest tier drug in the compound, based on each 30-day supply. Please note that some PRESCRIPTION DRUGS are only dispensed in 60- or 90-day quantities. For these drugs, you will pay either two or three copayments depending on the quantity you receive. Please see "Summary of Benefits." Certain combinations of compound drugs may require PRIOR REVIEW and CERTIFICATION.</p> <p>If you need to receive an extended supply (greater than a 30-day supply and up to a 90-day supply), email or call BCBSNC or visit the website at www.bcbsnc.com/unc for a listing of retail pharmacies or mail-order service that can dispense an extended supply of your PRESCRIPTION.</p> <p>You cannot refill a PRESCRIPTION until:</p> <ul style="list-style-type: none"> • three-fourths of the time period has passed that the PRESCRIPTION was intended to cover, or • the full time period has passed that the PRESCRIPTION was intended to cover if quantity limits apply, <p>except during a government-declared state of emergency or disaster in the county in which you reside. During these circumstances, you must request a refill within 29 days after the date of the emergency or disaster (not the date of the declaration). A refill of a PRESCRIPTION with quantity limitations may take into account the proportionate dosage use prior to the disaster.</p>
<p>Use of Lower-Cost PRESCRIPTION DRUGS</p>	<p>When choosing a PRESCRIPTION DRUG, you and your DOCTOR should discuss whether a lower-cost PRESCRIPTION DRUG could provide the same results as a more expensive PRESCRIPTION DRUG. If you choose a BRAND NAME PRESCRIPTION DRUG, your cost will be higher.</p> <p>Please note: You may pay a different amount in certain situations when choosing between GENERIC and BRAND-NAME PRESCRIPTION DRUGS. If you decide you want the BRAND-NAME drug on the higher tier instead of the GENERIC equivalent on the lower tier, you will pay the BRAND-NAME copayment or coinsurance plus the cost difference between the BRAND-NAME ALLOWED AMOUNT and the GENERIC ALLOWED AMOUNT. For PRESCRIPTION DRUGS received from an OUT-OF-NETWORK pharmacy, you will also pay any charges over the ALLOWED AMOUNT.</p> <p>You may not be required to pay the difference between the BRAND-NAME ALLOWED AMOUNT and the GENERIC ALLOWED AMOUNT for certain BRAND-NAME PRESCRIPTION DRUGS if these criteria are met: 1) the BRAND-NAME PRESCRIPTION DRUG is on the Narrow Therapeutic Index (NTI). See www.ncbop.org/faqs/Pharmacist/faq_NTIDrugs.htm for a current list of these drugs; or 2) your PROVIDER required the use of a BRAND-NAME PRESCRIPTION DRUG to treat your condition. Applicable copayment or coinsurance amounts would still apply.</p>
<p>PRIOR REVIEW Requirements</p>	<p>PRIOR REVIEW and CERTIFICATION by BCBSNC are required for some PRESCRIPTION DRUGS or services will not be covered. However, PRIOR REVIEW is not required for PRESCRIPTIONS written at the SHC. BCBSNC may change the list of these PRESCRIPTION DRUGS from time to time.</p>
<p>SPECIALTY DRUGS</p>	<p>BCBSNC has a separate pharmacy network for purchasing select SPECIALTY DRUGS ("Specialty Network"). These SPECIALTY DRUGS (which include specialty GENERIC or BRAND-NAME PRESCRIPTION DRUGS, as well as BIOLOGIC or BIOSIMILAR PRESCRIPTION DRUGS) must be dispensed by a pharmacy participating in the Specialty Network in order to receive IN-NETWORK benefits. These drugs are limited to a 30-day supply. For a list of PRESCRIPTION DRUGS that are considered SPECIALTY DRUGS, visit the website at bcbsnc.com/unc.</p>

COVERED SERVICES (cont.)

Restricted-Access Drugs and Devices	Coverage will be provided for a RESTRICTED-ACCESS DRUG or device to a MEMBER without requiring PRIOR REVIEW or CERTIFICATION or use of a nonrestricted formulary drug if a MEMBER'S physician certifies in writing that the MEMBER has previously used an alternative nonrestricted-access drug or device and the alternative drug or device has been detrimental to the MEMBER'S health or has been ineffective in treating the same condition and, in the opinion of the prescribing physician, is likely to be detrimental to the MEMBER'S health or ineffective in treating the condition again.
Quantity Limitations	BCBSNC covers certain PRESCRIPTION DRUGS up to a set quantity based on criteria developed by BCBSNC to encourage the appropriate use of the drug. For these PRESCRIPTION DRUGS, PRIOR REVIEW and CERTIFICATION are required before excess quantities of these drugs will be covered. When excess quantities are approved, you may be required to pay an additional copayment, if applicable.
Benefit Limitations	Certain PRESCRIPTION DRUGS are subject to benefit limitations which may include: the amount dispensed per PRESCRIPTION, per day or per defined time period; per lifetime; per month's supply; or the amount dispensed per single copayment, if applicable. Note: Excess quantities are not covered.
Where to find more information	You may visit the website at bcbsnc.com/unc or call Customer Service at the number listed in "Who to Contact?" for the following: <ul style="list-style-type: none">• List of IN-NETWORK pharmacies (including the Specialty Network), note this list may change from time to time• List of PRESCRIPTION DRUGS that:<ul style="list-style-type: none">- require PRIOR REVIEW and CERTIFICATION- are restricted-access drugs and devices- are subject to benefit limitations- are subject to quantity limitations- must be dispensed through the Specialty Network in order to receive IN-NETWORK benefits• Any special programs that may apply• A copy of the FORMULARY.

PRESCRIPTION DRUG Benefits Exclusions

Any PRESCRIPTION DRUG that is:

- Not specifically covered in this health benefit plan
- In excess of the stated quantity limits
- Purchased to replace a lost, broken, or destroyed PRESCRIPTION DRUG except under certain circumstances during a state of emergency or disaster
- For or related to treatment of SEXUAL DYSFUNCTION, except when due to organic disease
- Any portion or refill which exceeds the maximum supply for which benefits will be provided when dispensed under any one PRESCRIPTION

And any other drug that is:

- Purchased over-the-counter unless specifically listed as a covered drug in the FORMULARY and a written PRESCRIPTION is provided
- Therapeutically equivalent to an over-the-counter drug
- Compounded and does not contain at least one ingredient is defined as a PRESCRIPTION DRUG (see "Glossary"). Compounds containing non-FDA approved bulk chemical ingredients are excluded from coverage.
- Contraindicated (should not be used) due to age, gender, drug interaction, therapeutic duplications, dose greater than maximum recommended or other reasons as determined by FDA's approved product labeling.

Adult Lenses and Frames

Your health benefit plan provides reimbursement for COVERED SERVICES for routine vision correction including eyeglass frames and prescribed lenses for single vision, bifocal or trifocal and hard, soft or disposable contact lenses. This does not include any service covered as a PROSTHETIC APPLIANCE.

COVERED SERVICES *(cont.)*

See "Summary of Benefits" for benefit maximum. This benefit is a non-essential health benefit and is available for MEMBERS age 19 and older. For MEMBERS up to age 19, see Pediatric Vision.

You may obtain services from any PROVIDER to receive this benefit. You will be required to pay for the services and then file a claim with BCBSNC for reimbursement. There are normally no DEDUCTIBLES to be met before benefits begin.

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?" This health benefit plan does not cover services, supplies, drugs or charges for:

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

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

A

Acupressure

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

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

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

B

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

C

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

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

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

COSMETIC services, which include the removal of excess skin from the abdomen, arms or thighs, and SURGERY for psychological or emotional reasons, except as specifically covered by this health benefit plan

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

Custodial care designed essentially to assist an individual with activities of daily living, with or without routine nursing care and the supervisory care of a DOCTOR. While some skilled services may be provided, the patient does not require continuing skilled services 24 hours daily. The individual is not under specific medical, surgical, or psychiatric treatment to reduce a physical or mental disability to the extent necessary to enable the patient to live outside either the institution or the home setting with substantial assistance and supervision, nor is there reasonable likelihood that the disability will be reduced to that level even with treatment. Custodial care includes, but is not limited to, help in walking, bathing, dressing,

WHAT IS NOT COVERED? (cont.)

feeding, preparation of special diets and supervision over medications that could otherwise be self-administered. Such services and supplies are custodial as determined by BCBSNC without regard to the place of service or the PROVIDER prescribing or providing the services.

D

Dental care, dentures, dental implants, oral orthotic devices, palatal expanders and orthodontics except as specifically covered by this health benefit plan

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

The following **drugs**:

- Injections by a health care professional of injectable PRESCRIPTION DRUGS which can be self-administered, unless medical supervision is required
- Drugs associated with assisted reproductive technology
- Drugs associated with SEXUAL DYSFUNCTION unrelated to diagnosis and correction of underlying causes
- EXPERIMENTAL drugs or any drug not approved by the U.S. Food and Drug Administration (FDA) for the applicable diagnosis or treatment. However, this exclusion does not apply to PRESCRIPTION DRUGS used in covered phases I, II, III and IV clinical trials, or drugs approved by the FDA for treatment of cancer, if prescribed for the treatment of any type of cancer for which the drug has been proven as effective and accepted in any one of the following:
 - The National Comprehensive Cancer Network Drugs & Biologics Compendium
 - The Thomson Micromedex DrugDex
 - The Elsevier Gold Standard's Clinical Pharmacology
 - Any other authoritative compendia as recognized periodically by the United States Secretary of Health and Human Services.

E

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

The following **equipment**:

- Devices and equipment used for environmental accommodation requiring vehicle and/or building modifications such as, but not limited to, chair lifts, stair lifts, home elevators, and ramps
- Air conditioners, furnaces, humidifiers, dehumidifiers, vacuum cleaners, electronic air filters and similar equipment
- Physical fitness equipment, hot tubs, Jacuzzis, heated spas, 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 this health benefit 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

Hearing aids or examinations for the fitting of hearing aids for MEMBERS age 22 and older

Hypnosis except when used for control of acute or chronic pain

I

WHAT IS NOT COVERED? (cont.)

Inpatient admissions primarily for the purpose of receiving diagnostic services or a physical examination. Inpatient admissions primarily for the purpose of receiving therapy services, except when the admission is a continuation of treatment following care at an inpatient facility for an illness or accident requiring therapy.

Inpatient confinements that are primarily intended as a change of environment

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

M

Services or supplies deemed not **MEDICALLY NECESSARY**

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, or services deemed not **MEDICALLY NECESSARY**, or elective termination of pregnancy if not specifically covered by your health benefit plan.

P

Body **piercing**

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

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

R

The following **residential care** services:

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

RESPITE CARE, whether in the home or in a facility or inpatient setting, except as specifically covered by this health benefit plan

S

Services or supplies that are:

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

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.

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

WHAT IS NOT COVERED? (cont.)

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.
- 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 a PRESCRIPTION, except for PRESCRIPTION prenatal vitamins or PRESCRIPTION vitamin B-12 injections for anemias, neuropathies or dementias secondary to a vitamin B-12 deficiency, or certain over-the-counter medications that may be available under your PREVENTIVE CARE benefits for certain individuals. For the most up-to-date list of PREVENTIVE CARE services that are covered under federal law, see the website at bcbsnc.com/preventive.

W

Wigs, hair pieces and hair implants for any reason.

WHEN COVERAGE BEGINS AND ENDS

Students may be required to participate in this health benefit plan, unless they have alternate approved coverage. See below for information about when participation is mandatory (hard waiver) and which of these rates apply.

The following students are **required** to participate in this health benefit plan, unless they have alternate approved coverage and waive this coverage by the waiver due date. These students have a hard waiver rate.

Undergraduate students, who are:

- Enrolled in a minimum of 6 semester credit hours, and
- Enrolled in a degree-seeking or diploma-seeking program, and
- Eligible to pay the institution's student health fee.

Graduate students, who are:

- Enrolled in a minimum of 1 semester credit hours and
- Enrolled in a degree-seeking or diploma-seeking program, and
- Eligible to pay the institution's student health fee.

In addition, the following students are **eligible** to enroll.

Undergraduate and graduate students who are not required to participate, and who are:

- Eligible to pay the student health fee, and
- Enrolled in a degree-seeking program, or enrolled in a minimum of 6 semester credit hours
- Voluntary rates apply.

International students in some non-immigrant visa categories have federal health insurance mandates and are eligible regardless of semester credit hours, if they are:

- Enrolled in a degree-seeking program
- Hard waiver rates apply

Distance education students, if they:

- Meet the semester credit hour thresholds for undergraduate or graduate students above, and
- Are enrolled in a degree-seeking or diploma-seeking program, and
- Reside in the state of North Carolina based upon the campus residency status
- Voluntary rates apply.

Student interns, co-ops, and student teachers, if they:

- Meet the semester credit hour thresholds for undergraduate or graduate students above, and
- Are enrolled in a degree-seeking program
- Hard waiver rates apply.

Students in non-degree programs, including student athletes who have graduated but are enrolled in post-baccalaureate studies, if:

- The program is sponsored by the campus, and
- Participants pay the student health fee, and
- All program participants are required by the campus to have health insurance
- Hard waiver rates apply.

Students studying abroad, who are:

- Enrolled in a degree-seeking or diploma-seeking program, and
- Enrolled in a minimum of 6 semester credit hours
- Hard waiver rates apply.

If you enroll during the Fall open enrollment period, your coverage begins on August 1, 2015. If you enroll during the Spring open enrollment period, your coverage begins on January 1, 2016. In order to be eligible for this coverage, a student must attend classes for the first 10 days of the enrollment period. There are no premium refunds except for students entering full-time active duty in any Armed Forces. Premiums for this health benefit plan will be on the tuition bill unless the student shows proof of other insurance coverage and waives coverage under this plan during the defined open enrollment period. Students may discontinue coverage at the end of any internal plan year coverage period (December 31 or July 31) if they (1) discontinue enrollment at University of North Carolina at Chapel Hill or (2) acquire health insurance coverage that meets University of North Carolina at Chapel Hill waiver requirements.

Coverage for Your DEPENDENTS

Dependents are not eligible under this health benefit plan. Coverage is only available for eligible SUBSCRIBERS.

Enrolling in this Health Benefit Plan

It is very important to enroll yourself when first eligible. Enrollment is only allowed during open enrollment periods. Open enrollment for students ends ten days after the start of classes for each semester.

You may also apply for coverage within a 30-day period following any of the qualifying events listed below, unless otherwise noted. The following are considered qualifying events:

- You become eligible for coverage under this health benefit plan
- You lose coverage under another health benefit plan, and each of the following conditions is met:
 - you are otherwise eligible for coverage under this health benefit plan, and
 - you 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 lose coverage under another health benefit plan due to i) the exhaustion of the COBRA continuation period, or ii) the loss of eligibility for that coverage for reasons including, but not limited to, divorce, loss of DEPENDENT status, death of the employee, termination of employment, or reduction in the number of hours of employment, or iii) the termination of the other plan's coverage, or iv) the offered health benefit plan not providing benefits in your service area and no other health benefit plans are available, or v) the termination of employer contributions toward the cost of the other plan's coverage, or vi) the discontinuance of the health benefit plan to similarly situated individuals.
- You lose coverage due to loss of eligibility under Medicaid or the Children's Health Insurance Program (CHIP) and apply for coverage under this health benefit plan within 60 days
- You become eligible for premium assistance with respect to coverage under this health benefit plan under Medicaid or the Children's Health Insurance Program (CHIP) and apply for coverage under this health benefit plan within 60 days.

Types of Coverage

The type of coverage available:

- Student-only coverage - This health benefit plan covers only you

Multiple Coverage

When you enroll, you may be covered under only one health program offered or administered by BCBSNC. The total benefits paid or administered by BCBSNC will not be more than the ALLOWED AMOUNT. This health benefit plan is your primary coverage and BCBSNC does not coordinate benefit payments with any other health plan, except Medicare, when determining benefits under this health benefit plan.

Reporting Changes

Have you moved, added or changed other health coverage, changed your name or phone number? If so, visit our website at bcbsnc.com to update your information or call BCBSNC Customer Service at the number listed in "Who to Contact?" It will help us give you better service if we are kept informed of these changes.

Continuing Coverage

Under certain circumstances, your eligibility for coverage under this health benefit plan may end. You may have the option of purchasing an individual conversion policy.

When my Coverage Under this Health Benefit Plan Ends

If you are no longer eligible for coverage under this health benefit plan, you may transfer to individual conversion coverage. For continuous coverage, ensure that your premiums are paid during the continuation period. BCBSNC must be notified within 31 days of loss of eligibility. You must complete an Individual Enrollment Application and pay the applicable premium. Services during the 31-day conversion period will be covered only if the premium is received before the end of the 31-day period. Other options for enrollment in health insurance coverage may be available to you when your coverage in this health benefit plan ends, including, but not limited to, enrollment via the Health Insurance Marketplace.

Certificate of Creditable Coverage

BCBSNC or its designee will supply a Certificate of Creditable Coverage when your coverage under this health benefit plan ends. Keep the Certificate of Creditable Coverage in a safe place. You may request a Certificate of Creditable Coverage from BCBSNC while you are still covered under this health benefit plan and up to 24 months following your termination.

Termination of MEMBER Coverage

WHEN COVERAGE BEGINS AND ENDS *(cont.)*

A MEMBER'S termination shall be effective at 11:59 p.m. on the date that eligibility ends.

MEMBERS coverage terminates:

- The date the health benefit plan ends.

A MEMBER'S coverage will be terminated immediately by BCBSNC for the following reasons:

- Fraud or intentional misrepresentation of a material fact by a MEMBER. However, if such termination is made retroactively, including back to the EFFECTIVE DATE of your policy (called a rescission), you will be given 30 days advance written notice of this rescission.
- A MEMBER has been convicted of (or a restraining order has been issued for) communicating threats of harm to BCBSNC personnel or property
- A MEMBER permits the use of his or her or any other MEMBER'S ID CARD by any other person not enrolled under this health benefit plan, or uses another person's ID CARD.

UTILIZATION MANAGEMENT

To make sure you have access to high quality, cost-effective health care, BCBSNC has a UTILIZATION MANAGEMENT (UM) program. The UM program requires that certain health care services be reviewed and approved by BCBSNC in order to receive benefits. As part of this process, BCBSNC looks at whether health care services are MEDICALLY NECESSARY, provided in the proper setting and provided for a reasonable length of time. BCBSNC will honor a CERTIFICATION to cover medical services or supplies under this health benefit plan unless the CERTIFICATION was based on a material misrepresentation about your health condition or you were not eligible for these services under this health benefit plan due to termination of coverage (including your 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 BCBSNC'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 BCBSNC make a final determination of all ADVERSE BENEFIT DETERMINATIONS that were based upon MEDICAL NECESSITY
- Request a review of an ADVERSE BENEFIT DETERMINATION through our appeals process (see "What if You Disagree With our 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).

BCBSNC's Responsibilities

As part of all UM decisions, BCBSNC 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 we request 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 this health benefit plan.

In the event that BCBSNC does not receive sufficient information to approve coverage for a health care service within specified time frames, BCBSNC 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)

BCBSNC requires that certain health care services receive PRIOR REVIEW and CERTIFICATION as noted in "COVERED SERVICES." These types of reviews are called pre-service reviews. .

Certain services require PRIOR REVIEW and CERTIFICATION by BCBSNC in order to receive benefits. IN-NETWORK PROVIDERS in North Carolina will request PRIOR REVIEW when necessary. IN-NETWORK inpatient FACILITIES outside of North Carolina will also request PRIOR REVIEW for you, except for Veterans' Affairs (VA) and military providers. If you go to any other PROVIDER outside of North Carolina or to an OUT-OF-NETWORK PROVIDER in North Carolina, you are responsible for ensuring that you or your PROVIDER requests PRIOR REVIEW by BCBSNC. BCBSNC delegates administration of your mental health and substance abuse benefits to Magellan Behavioral Health. Magellan Behavioral Health is not associated with BCBSNC. **Failure to request PRIOR REVIEW and receive CERTIFICATION may result in allowed charges being reduced or a full denial of benefits.**

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

General categories of services with this requirement are noted in "COVERED SERVICES." Please call the PRIOR REVIEW and CERTIFICATION 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.

UTILIZATION MANAGEMENT *(cont.)*

If you fail to follow the procedures for filing a request for CERTIFICATION, BCBSNC will notify you of the failure and the proper procedures to be followed in filing your request within five days of receiving the request.

BCBSNC will make a decision on your request for CERTIFICATION within a reasonable amount of time taking into account the medical circumstances. The decision will be made and communicated to you and your PROVIDER within three business days after BCBSNC receives all necessary information but no later than 15 days from the date BCBSNC received the request. BCBSNC may extend this period one time for up to 15 days if additional information is required and will notify you and your PROVIDER before the end of the initial 15-day period of the information needed and the date by which BCBSNC expects to make a decision. You will have 45 days to provide the requested information. As soon as BCBSNC receives all the requested information, or at the end of the 45 days, whichever is earlier, BCBSNC will make a decision within three business days. BCBSNC will 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 life, health, or ability to regain maximum function; or (ii) in the opinion of your PROVIDER, would subject you to severe pain that cannot be adequately managed without the requested care or treatment. BCBSNC will notify you and your PROVIDER of its decision as soon as possible, taking into account the medical circumstances. BCBSNC 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 BCBSNC needs more information to process your urgent review, BCBSNC will notify you and your PROVIDER of the information needed as soon as possible but no later than 24 hours after we receive your request. You will then be given a reasonable amount of time, but not less than 48 hours, to provide the requested information. As soon as BCBSNC receives the requested information, or at the end of the time period specified for you to provide the information, whichever is earlier, BCBSNC 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 BCBSNC Customer Service at the number given in "Who to Contact?"

Concurrent Reviews

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

If a request for an extension of treatment is non-urgent, a decision will be made and communicated to the requesting HOSPITAL or other facility within three (3) business days after receipt of all necessary clinical information, but no later than fifteen (15) days after we receive the request. In the event of an ADVERSE BENEFIT DETERMINATION, BCBSNC 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 BCBSNC receives the request. Written confirmation of the decision will also be sent to your home by U.S. mail. For concurrent reviews, BCBSNC will remain responsible for COVERED SERVICES you are receiving until you or your representatives have been notified of the ADVERSE BENEFIT DETERMINATION.

Urgent Concurrent Review

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

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

BCBSNC 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. BCBSNC will 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 BCBSNC received the request. In the event of an ADVERSE BENEFIT DETERMINATION, BCBSNC 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 health benefit plan. If more information is needed, before the end of the initial 30-day period, BCBSNC will notify you of the information needed. You will then have 90 days to provide the requested information. As soon as BCBSNC receives the requested information, or at the end of the 90 days, whichever is earlier, BCBSNC will make a decision within 15 days. Services that were approved in advance by BCBSNC will not be subject to denial for MEDICAL NECESSITY once the claim is received, unless the CERTIFICATION was based on a material misrepresentation about your health condition or you were not eligible for these services under this health benefit plan due to termination of coverage or nonpayment of premiums. All other services may be subject to retrospective review and could be denied for MEDICAL NECESSITY or for a benefit limitation or exclusion.

Care Management

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

To accomplish this, MEMBERS enrolled in or eligible for care management programs may be contacted by BCBSNC or by a representative of BCBSNC. BCBSNC is not obligated to 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 BCBSNC Customer Service.

In addition to our 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 BCBSNC criteria.

Continuity of Care

Continuity of care is a process that allows you to continue receiving care from an OUT-OF-NETWORK PROVIDER for an ongoing special condition at the IN-NETWORK benefit level when you or your GROUP changes health benefit plans or when your PROVIDER is no longer in the PPO network. If your PCP or SPECIALIST leaves our PROVIDER network and they are currently treating you for an ongoing special condition that meets our continuity of care criteria, BCBSNC will notify you 30 days before the PROVIDER'S termination, as long as BCBSNC receives timely notification from the PROVIDER. To be eligible for continuity of care, you must be actively being seen by an OUT-OF-NETWORK PROVIDER for an ongoing special condition and the PROVIDER must agree to abide by BCBSNC's requirements for continuity of care.

An ongoing special condition means:

- 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 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 your IN-NETWORK benefit. In these situations, benefits are based on the billed amount. However, you may be responsible for charges billed separately by the PROVIDER which are not eligible for additional reimbursement. Continuity of care will not be 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 the number listed in "Who to Contact?" for more information.

Delegated UTILIZATION MANAGEMENT

BCBSNC 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 BCBSNC. Claims determinations and second level appeals, if eligible, are provided by BCBSNC.

Evaluating New Technology

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

WHAT IF YOU DISAGREE WITH OUR DECISION?

In addition to the UM program, BCBSNC offers an appeals process for our MEMBERS. If you want to appeal an ADVERSE BENEFIT DETERMINATION or have a GRIEVANCE, you have the right to request that BCBSNC 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, (including GRIEVANCES) relating 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:

- SUBSCRIBER'S ID number
- SUBSCRIBER'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 review, you may visit our website at **bcbsnc.com** or call BCBSNC Customer Service at the number listed in "Who to Contact?"

All correspondence related to a request for a review through BCBSNC's appeals process should be sent to:

BCBSNC
Customer Service
PO Box 30055
Durham, NC 27702-3055

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

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

In Person:

For the physical address for Health Insurance Smart NC, please visit the web-page:

http://www.ncdoi.com/Smart/Smart_Contacts.aspx .

Toll free: (855) 408-1212

www.ncdoi.com/Smart for External Review and Request Form

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 BCBSNC, 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, BCBSNC shall consult with a health care professional with an appropriate level of training and expertise in the field of medicine involved (as determined by BCBSNC) who was not involved in the initial claims denial and who is not a subordinate of any such individual.

Quality of Care Complaints

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

Internal Appeals

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

If you are dissatisfied with an ADVERSE BENEFIT DETERMINATION, or if you have a GRIEVANCE, you have the right to appeal (first level appeal). Within three business days after BCBSNC receives your appeal, BCBSNC will send you an acknowledgement letter which will include the name, address and telephone number of the appeals coordinator and instructions on how to submit written materials.

During the internal appeals process you may:

- request and receive from us all information that applies to your appeal
- provide and/or present written evidence and testimony
- receive, in advance, any new information that BCBSNC 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 the final ADVERSE BENEFIT DETERMINATION
- receive instructions on how to request an independent external review through NCDOI upon completion of this review if not satisfied with the decision (available for NONCERTIFICATIONS only).

BCBSNC asks that you send all of the written material you feel is necessary to make a decision. BCBSNC will use the material provided in the request for review, along with other available information, to reach a decision. For all ADVERSE BENEFIT DETERMINATIONS and GRIEVANCES, BCBSNC will send you notification in clear written terms within a reasonable time but no later than 30 days from the date BCBSNC received the appeal. You may then request all information that was relevant to the review.

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 life, health or ability to regain maximum function; or (ii) in the opinion of your PROVIDER, would subject you to severe pain that cannot be adequately managed without the requested care or treatment. An expedited review may be initiated by calling BCBSNC 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 standard appeal apply to an expedited review. BCBSNC will communicate the decision by phone to you and your PROVIDER as soon as possible, taking into account the medical circumstances, 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, BCBSNC will remain responsible for covered health care services you are receiving until you have been notified of the review decision.

Second Level Review (Limited GRIEVANCES Only)

If you are dissatisfied with the first level appeal described above, you have the right to a second level review for certain GRIEVANCES. Second level reviews are not allowed for benefits or services that are clearly excluded by this benefit booklet, quality of care complaints, or NONCERTIFICATIONS. Within ten business days after BCBSNC receives your request for a second level review, the following information will be given to you:

- Name, address and telephone number of the second level review coordinator
- Availability of Health Insurance Smart NC including address and telephone number
- A statement of your rights, including the right to:
 - request and receive from us all information that applies to your GRIEVANCE
 - participate in the second level review 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.

The second level review meeting, which will be conducted by a review panel coordinated by BCBSNC using external physicians and/or benefit experts, will be held within 45 days after BCBSNC receives a second level review request. 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 GRIEVANCE 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. This second level review is the last review available for GRIEVANCES.

External Review (Available only for NONCERTIFICATIONS)

Federal and state law provide 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,

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

arranging for an IRO to review your case once the NCDOI establishes that your request is complete and eligible for review. BCBSNC 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.

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

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

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

- completed BCBSNC'S appeals process and received a written determination on the appeal from BCBSNC, or
- filed an appeal and except to the extent that you have requested or agreed to a delay, have not received BCBSNC'S written decision on the appeal within 60 days of the date you can show that you submitted the request, or
- received written notification that BCBSNC has agreed to waive the requirement to exhaust the internal 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.

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 final ADVERSE BENEFIT DETERMINATION from BCBSNC.

Expedited External Review

An expedited external review may be available if the time required to complete either an expedited internal appeals review 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 BCBSNC and have filed a request with BCBSNC for an expedited appeal; or
- an appeal decision upholding an ADVERSE BENEFIT DETERMINATION (also known as a final internal ADVERSE BENEFIT DETERMINATION).

In addition, prior to your discharge from an inpatient facility, you may also request an expedited external review after receiving a 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:

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

(Mail)

North Carolina Department
of Insurance
Health Insurance Smart NC
1201 Mail Service Center
Raleigh, NC 27699-1201
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 .

Tel: (855) 408-1212

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

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

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

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

Please note that you may also provide this additional information to the NCDOI within the seven-day deadline rather than sending it directly to the IRO and BCBSNC. The NCDOI will forward this information to the IRO and BCBSNC within two 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 NCDOI received your external review request. If the IRO's decision is to reverse the ADVERSE BENEFIT DETERMINATION, BCBSNC will, within three business days (or, for an expedited review, within 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 BCBSNC at the time BCBSNC receives notice of the IRO's decision to reverse the ADVERSE BENEFIT DETERMINATION, BCBSNC will only provide coverage for those services or supplies you actually received or would have received prior to disenrollment if the service had not been noncertified when first requested.

The IRO's external review decision is binding on BCBSNC and you, except to the extent you may have other 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 only legally binding benefits are described in this benefit booklet, which is part of the CONTRACT between BCBSNC and the GROUP. The terms of your coverage cannot be changed or waived unless BCBSNC agrees in writing to the change.

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

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

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

Any amounts paid by BCBSNC for noncovered services or that are in excess of the benefit provided under your Student Blue coverage may be recovered by BCBSNC. BCBSNC may recover the amounts by deducting from a MEMBER'S future claims payments. This can result in a reduction or elimination of future claims payments. In addition, under certain circumstances, if BCBSNC pays the PROVIDER amounts that are your responsibility, such as DEDUCTIBLE, copayments or coinsurance, BCBSNC may collect such amounts directly from you. BCBSNC will recover amounts we have paid for work-related accidents, injuries, or illnesses covered under state workers' compensation laws upon final adjudication of the claim or an order of the applicable state agency approving a settlement agreement. It is the legal obligation of the MEMBER, the EMPLOYER or the workers' compensation insurer (whoever is responsible for payment of the medical expenses) to notify BCBSNC in writing that there has been a final adjudication or settlement.

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

BCBSNC's Disclosure of Protected Health Information (PHI)

At BCBSNC, we take your privacy seriously. We handle all PHI as required by state and federal laws and regulations and accreditation standards. We have developed a privacy notice that explains our procedures.

To obtain a copy of the privacy notice, contact BCBSNC at the number listed in "Who to Contact?"

Administrative Discretion

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

North Carolina PROVIDER Reimbursement

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

Some OUT-OF-NETWORK PROVIDERS have other agreements with BCBSNC that affect their reimbursement for COVERED SERVICES provided to Student Blue MEMBERS. These PROVIDERS agree not to bill MEMBERS for any charges higher than

ADDITIONAL TERMS OF YOUR COVERAGE (cont.)

their agreed upon, contracted amount. In these situations, MEMBERS will be responsible for the difference between the Student Blue ALLOWED AMOUNT and the contracted amount. OUT-OF-NETWORK PROVIDERS may bill you directly. If you are billed, you will be responsible for paying the bill and filing a claim with BCBSNC.

Services Received Outside of North Carolina

BCBSNC has a variety of relationships with other Blue Cross and/or Blue Shield licensees, generally referred to as "Inter-Plan Programs". As a MEMBER of BCBSNC, you have access to PROVIDERS outside the state of North Carolina. Your ID CARD tells PROVIDERS that you are a MEMBER of BCBSNC. While BCBSNC maintains its contractual obligation to provide benefits to MEMBERS for COVERED SERVICES, the Blue Cross and/or Blue Shield licensee in the state where you receive services ("Host Blue") is responsible for contracting with and generally handling all interactions with its participating PROVIDERS.

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

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

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

This "negotiated price" can be:

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

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

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

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

As an alternative to the BlueCard Program and depending on your geographic location, your claim may be processed through a Negotiated National Account Arrangement with a Host Blue. In these situations, the amount you pay for COVERED SERVICES will be calculated based on the negotiated price made available to BCBSNC by the Host Blue.

If you receive COVERED SERVICES from a non-participating PROVIDER outside the state of North Carolina, the amount you pay will generally be based on either the Host Blue's non-participating PROVIDER local payment or the pricing arrangements required by applicable state law. However, in certain situations, BCBSNC may use other payment bases, such as billed charges, to determine the amount BCBSNC will pay for COVERED SERVICES from a non-participating PROVIDER. In any of these situations, you may be liable for the difference between the non-participating PROVIDER'S billed amount and any payment BCBSNC would make for the COVERED SERVICES.

Travel Assistance Services

If you need assistance while traveling internationally, such as with lost travel documents, including passports or tickets, lost or stolen luggage, or need to make legal arrangements or obtain a legal advisor, call 1-855-577-7651 (within the United States) or 919 706-4525 (outside the United States).

Services Received Outside the United States

This plan provides benefits to MEMBERS outside the United States. For a complete list of medical assistance services, visit BCBSNC's website bcbsnc.com/unc or call 1-855-577-7651 (within the United States) or (919) 706-4525 (outside the United States). Please note that the list of these services may change from time to time. In order to receive IN-NETWORK benefits, you must receive outpatient or inpatient medical care from a HOSPITAL or PROVIDER that participates in the Blue Cross and Blue Shield worldwide PROVIDER network, except in an EMERGENCY.

Medical Evacuation

ADDITIONAL TERMS OF YOUR COVERAGE (cont.)

In the event of an unforeseen injury or illness where emergency evacuation is determined to be **MEDICALLY NECESSARY** for you to be transported under medical supervision to the nearest hospital or treatment facility for treatment, or to be returned to your place of residence for treatment, BCBSNC will arrange for and pay for reasonable expenses incurred for the transport up to the benefit maximum (see "Summary of Benefits"). Transportation shall be made via the most direct and economical route. Covered land or air transportation includes, but is not limited to, commercial stretcher, medical escort, or air ambulance.

Medical repatriation assistance is also provided if a student is incapable of traveling alone and needs ongoing medical assistance following hospitalization. A medical or non-medical escort will assist the student to return home or to campus.

Transport services, including proper medical supervision during transport, are only eligible for payment if arrangements are made through BCBSNC by calling 1-855-577-7651 (arrangements within the United States) or through BlueCard Worldwide by calling 1-800-810-2583 (international arrangements). If these services are not pre-approved and arranged in advance through BCBSNC or BlueCard Worldwide, services will not be covered. Medical services received prior to and after medical evacuation are subject to all coverage requirements and limitations under this health benefit plan. If you disagree with a medical necessity determination, see "What If You Disagree With Our Decision?" See limitations and exclusions below.

Repatriation of Mortal Remains

In the event of an injury or illness resulting in death, all reasonable expenses incurred for preparation and return of the remains to the country/state of residence will be covered up to the benefit maximum (see "Summary of Benefits"). Services are only eligible for payment if arrangements are made through BCBSNC by calling 1-855-577-7651 (arrangements within the United States) or through BlueCard Worldwide by calling 1-800-810-2583 (international arrangements). If services are not arranged through BCBSNC or BlueCard Worldwide these services will not be covered. See limitations and exclusions below.

Medical Evacuation/Repatriation of Mortal Remains Limitations and Exclusions

- BCBSNC shall not evacuate or repatriate you if such transport is not **MEDICALLY NECESSARY**, advisable, or permissible under current public health directives, or if the injury or illness can be treated locally.
- The MEMBER is financially responsible for any expenses for transport and associated medical supervision when services are not arranged through BCBSNC or BlueCard Worldwide.
- The MEMBER is financially responsible for any expenses related to a family member accompanying the MEMBER.
- All medical services received prior to and after transport are subject to other coverage terms and limitations provided for under this health benefit plan.
- BCBSNC will not cover the cost for any taxes, government fees, tips, or costs due to delay in transport.
- Claims where the MEMBER is traveling against medical advice or to obtain medical treatment, or has received a terminal prognosis.
- Claims incurred in the US, or the MEMBER'S country of domicile if not a US citizen.
- Any evacuation without prior approval.
- Claims where the MEMBER is traveling to a country or region against US State Department advice.
- Claims related to pregnancy, or the MEMBER'S use of alcohol or drugs
- The MEMBER engaging in military service of any kind
- The MEMBER engaging in any criminal act
- Any claim arising where the MEMBER has not followed the recommended inoculation requirements.

BCBSNC shall not be held responsible for failure to provide, or for delay in providing services when such failure or delay is caused by conditions beyond our control, including but not limited to flight conditions, labor disturbance and strike, rebellion or riot, civil commotion, war, or uprising, nuclear accidents, natural disasters, acts of God or when rendering service is prohibited by local law or regulations.

BCBSNC Contract

BCBSNC is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans, permitting BCBSNC to use the Blue Cross and Blue Shield service marks in the state of North Carolina. BCBSNC is not contracting as an agent of the Blue Cross and Blue Shield Association. This paragraph shall not create any additional obligations whatsoever on the part of BCBSNC other than those obligations created under other provisions of this health benefit plan.

Premium Payment

If premium payments are the responsibility of the SUBSCRIBER and are not received by BCBSNC within 30 days of the end of the last paid-through date, the MEMBER'S coverage will automatically terminate as of that date. If BCBSNC does not

ADDITIONAL TERMS OF YOUR COVERAGE *(cont.)*

exercise its right to automatically terminate on the 30th day, BCBSNC will retain the right to terminate immediately for nonpayment upon written notice to the GROUP.

Notice of Claim

BCBSNC will not be liable for payment of benefits unless proper notice is furnished to BCBSNC that COVERED SERVICES have been provided to a MEMBER. If the MEMBER files the claim, written notice must be given to BCBSNC within 18 months after the MEMBER incurs the COVERED SERVICE, except in the absence of legal capacity of the MEMBER. The notice must be on an approved claim form and include the data necessary for BCBSNC to determine benefits. Forms are available at bcbsnc.com/unc or by calling the number in "Who to Contact?"

Limitation of Actions

No legal action may be taken to recover benefits for sixty (60) days after the Notice of Claim has been given as specified above and until you have exhausted all administrative remedies, including following the appeals process. Please see "What If You Disagree With Our Decision?" for details regarding the appeals process. No legal action may be taken later than three years from the date services are INCURRED.

SPECIAL PROGRAMS

Programs Outside Your Regular Benefits

BCBSNC may offer or provide programs that are outside your regular benefits. These offers or programs may be changed from time to time. Following are examples of programs that may be included outside your regular benefits:

- Discounts or promotional offers on goods and services from other companies including certain types of PROVIDERS
- Health and wellness programs
- 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
- Service programs for MEMBERS identified with complex health care needs, including a dedicated administrative contact, consolidated claims data information, and supportive gift items
- Rewards or drawings for gifts based on activities related to online tools
- Periodic drawings for gifts, which may include club memberships and trips to special events, based on submitting information
- Charitable donations made on your behalf by BCBSNC.

BCBSNC may not provide some or all of these items directly, but may instead arrange these for your convenience.

These discounts or promotional offers are outside your health plan benefits. BCBSNC is not liable for problems resulting from goods and services it does not provide directly, such as goods and services not being provided or being provided negligently. The gifts and charitable donations are also outside your health plan benefits. BCBSNC is not liable for third party providers' negligent provision of the gifts. BCBSNC may stop or change these programs at any time.

Health Information Services

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

GLOSSARY

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 and initial eligibility determinations are also included as an adverse benefit determination.

ALLOWED AMOUNT

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

AMBULATORY SURGICAL CENTER

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

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

ANCILLARY PROVIDER

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

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

BENEFIT PERIOD

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

BENEFIT PERIOD MAXIMUM

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

BIOLOGIC

A complex large molecule drug produced from protein or living organisms.

BIOSIMILAR

PRESCRIPTION DRUG products approved by the U.S. Food and Drug Administration (FDA) that are subsequent versions of previously approved BIOLOGIC drugs, also known as follow-on biologics. Biosimilar drugs are manufactured after the patent and exclusivity protection of the BIOLOGIC drug has expired.

BRAND NAME

The proprietary name of the PRESCRIPTION DRUG that the manufacturer owning the patent places upon a drug product or on its container, label or wrapping at the time of packaging. A brand-name drug has a trade name and is protected by a patent and can only be produced and sold by the manufacturer owning the patent. BCBSNC makes the final determination of the classification of brand-name drug products based on information provided by the manufacturer and other external classification sources such as the U.S. Food and Drug Administration (FDA) and nationally-recognized drug databases.

CERTIFICATION

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

CLINICALLY NECESSARY (or CLINICAL NECESSITY)

Those COVERED SERVICES, materials or supplies that are:

- a) Provided for the diagnosis, treatment, cure, or relief of a dental condition, illness, injury, or disease; and not for EXPERIMENTAL, INVESTIGATIONAL, or COSMETIC purposes, except as specifically covered by your dental benefit plan,
- b) Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a dental condition, illness, injury, disease, or its symptoms,
- c) Within generally accepted standards of dental care in the community, and
- d) Not solely for the convenience of the insured, the insured's family, or the PROVIDER.

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

COMPLICATIONS OF PREGNANCY

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

CONGENITAL

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

CONTRACT

The agreement between BCBSNC and the group. It includes the master group contract, the benefit booklet(s) and any exhibits or endorsements, the group enrollment application and medical questionnaire when applicable.

COSMETIC

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

COVERED SERVICE(S)

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

CREDITABLE COVERAGE

Accepted health insurance coverage carried prior to BCBSNC coverage can be group health insurance, employee welfare benefit plans 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.

DEDUCTIBLE

The specified dollar amount for certain COVERED SERVICES that the MEMBER must incur before benefits are payable for the remaining COVERED SERVICES. The deductible does not include copayments, coinsurance, charges in excess of the ALLOWED AMOUNT, amounts exceeding any maximum and expenses for noncovered services.

DENTAL SERVICE(S)

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

DENTIST

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

DOCTOR

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

DURABLE MEDICAL EQUIPMENT

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

EDUCATIONAL TREATMENT

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

EFFECTIVE DATE

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

EMERGENCY(IES)

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

EMERGENCY SERVICES

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

ESSENTIAL HEALTH BENEFITS

The core set of services that federal law requires to be included in this health benefit plan, and includes the following ten categories: (1) ambulatory patient services, (2) EMERGENCY SERVICES, (3) hospitalization, (4) maternity and newborn care, (5) mental health and substance abuse services, including behavioral health treatment, (6) PRESCRIPTION DRUGS, (7) REHABILITATIVE and HABILITATIVE SERVICES and devices, (8) laboratory services, (9) preventive and wellness services and chronic disease management, and (10) pediatric services, including oral and vision care. No annual or lifetime dollar limits can apply to essential health benefits.

EXPERIMENTAL

See Investigational.

FACILITY SERVICES

GLOSSARY (cont.)

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

FORMULARY

The list of outpatient PRESCRIPTION DRUGS insulin, and certain over-the-counter drugs that may be available to MEMBERS.

GENERIC

A PRESCRIPTION DRUG that has the same active ingredient as a BRAND-NAME drug, has the same dosage form and strength as the BRAND-NAME drug, and has the same mechanism of action in the body as the BRAND-NAME drug. The classification of a PRESCRIPTION DRUG as a generic is determined by BCBSNC based on commercially available data resources and other external classification sources, such as the U.S. Food and Drug Administration (FDA) and nationally recognized drug databases.

GRIEVANCE

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

GROUP

University of North Carolina at Chapel Hill

HABILITATIVE SERVICES

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

HOMEBOUND

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

HOME HEALTH AGENCY

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

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

HOSPICE

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

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

HOSPITAL

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

IDENTIFICATION CARD (ID card)

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

INCURRED

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

INFERTILITY

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

IN-NETWORK

Designated as participating in the PPO network. BCBSNC's payment for IN-NETWORK COVERED SERVICES is described in this benefit booklet as IN-NETWORK benefits or IN-NETWORK benefit levels.

IN-NETWORK PROVIDER

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

INVESTIGATIONAL (EXPERIMENTAL)

The use of a service or supply including, but not limited to, treatment, procedure, facility, equipment, drug, or device that BCBSNC does not recognize as standard medical care of the condition, disease, illness, or injury being treated. The following criteria are the basis for BCBSNC'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 BCBSNC's evaluation of the therapeutic value of the service or supply
- c) There is inconclusive evidence that the service or supply has a beneficial effect on health outcomes
- d) The service or supply under consideration is not as beneficial as any established alternatives
- e) There is insufficient information or inconclusive scientific evidence that, when utilized in a non-investigational setting, the service or supply has a beneficial effect on health outcomes and is as beneficial as any established alternatives.

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

LICENSED PRACTICAL NURSE (LPN)

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

LIFETIME MAXIMUM

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

MEDICAL SUPPLIES

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

MEDICALLY NECESSARY (or MEDICAL NECESSITY)

Those COVERED SERVICES or supplies that are:

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

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

MEMBER

A SUBSCRIBER, who is currently enrolled in this health benefit plan and for whom premium is paid.

MENTAL ILLNESS

- a) 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

- b) 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
- c) a mental disorder defined in the current edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, Washington, DC ("DSM-V"). Those mental disorders coded in the DSM-V as substance-related disorders, those coded as SEXUAL DYSFUNCTION not due to organic disease, and those coded as "V" codes are not included in the definition of Mental Illness.

NONCERTIFICATION

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

NONHOSPITAL FACILITY

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

OFFICE VISIT

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

OTHER PROVIDER

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

OTHER THERAPY(IES)

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

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

OUT-OF-NETWORK

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

OUT-OF-NETWORK PROVIDER

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

OUT-OF-POCKET LIMIT

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

OUTPATIENT CLINIC(S)

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

POSITIONAL PLAGIOCEPHALY

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

PRESCRIPTION

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

PRESCRIPTION DRUG

A drug that has been approved by the U.S. Food and Drug Administration (FDA) and is required, prior to being dispensed or delivered, to be labeled "Caution: Federal law prohibits dispensing without PRESCRIPTION," or labeled in a similar manner, and is appropriate to be administered without the presence of a medical supervisor. Prescription drugs include:

- a) Insulin
- b) Self-administered injectable drugs
- c) Contraceptive devices
- d) Select diabetic supplies: insulin needles, syringes, glucose testing strips, ketone testing strips and tablets, lancets and lancet devices.

PREVENTIVE CARE

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

PRIMARY CARE PROVIDER (PCP)

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

PRIOR REVIEW

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

PROSTHETIC APPLIANCES

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

PROVIDER

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

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

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

RESIDENTIAL TREATMENT FACILITY

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

RESPITE CARE

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

RESTRICTED-ACCESS DRUGS

Covered PRESCRIPTION DRUGS or devices for which reimbursement by BCBSNC is conditioned on: (1) BCBSNC's giving CERTIFICATION to prescribe the drug or device or (2) the PROVIDER prescribing one or more alternative drugs or devices before prescribing the drug or device in question.

ROUTINE FOOT CARE

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

SEXUAL DYSFUNCTION

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

SKILLED NURSING FACILITY

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

SPECIALIST

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

SPECIALTY DRUG(S)

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

STABILIZE

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

SUBSCRIBER

An eligible student who has enrolled for coverage under this health benefit plan.

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 BCBSNC.

TIER 1 DRUGS

The PRESCRIPTION DRUG tier which consists of the lowest cost tier of PRESCRIPTION DRUGS, most are GENERIC.

TIER 2 DRUGS

The PRESCRIPTION DRUG tier which consists of medium-cost PRESCRIPTION DRUGS, most are GENERIC, and some BRAND-NAME PRESCRIPTION DRUGS.

TIER 3 or TIER 4 DRUGS

The PRESCRIPTION DRUG tier which consists of higher-cost PRESCRIPTION DRUGS, most are BRAND-NAME PRESCRIPTION DRUGS, and some SPECIALTY DRUGS.

TRANSPLANTS

The surgical transfer of a human organ or tissue taken from the body for grafting into another area of the same body or into another body; the removal and return into the same body or transfer into another body of bone marrow or peripheral blood stem cells. Grafting procedures associated with reconstructive surgery are not considered transplants.

URGENT CARE

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

UTILIZATION MANAGEMENT (UM)

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

WAITING PERIOD

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

University of North Carolina at Chapel Hill
012547 PPO1 08/01/15 09/10/15

Student BlueSM

University of North Carolina at Chapel Hill

Group Effective Date:
08/01/15



An Independent Licensee of the Blue Cross and Blue Shield Association

