StudentBlue℠

BENEFIT Highlights

for Davidson College Students
Effective: 2020-2021

davidson.myahpcare.com

BlueCross BlueShield of North Carolina

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In the event of any inconsistency between information contained in this brochure and the member's benefit booklet, the benefit booklet shall govern.

Getting started with Student Blue

As you read this benefit booklet, keep in mind that any word you see in all capital letters (ALL CAPITAL LETTERS) is a defined term and appears in the "Glossary" at the end of this benefit booklet. The terms "we," "us" and "Blue Cross NC" 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.

This benefit booklet provides important information about your benefits and can help you understand how to maximize them. To help you become familiar with some common insurance terms concerning what you may owe after visiting your PROVIDER, see the chart below and the glossary and the following definitions:

+ **Copayment** – The fixed dollar amount you may pay for some COVERED SERVICES at the time you receive them, if this health benefit plan includes copayments. One copayment covers most services at a PROVIDER'S office. Copayments may also apply to URGENT CARE and EMERGENCY room services. Copayments are not credited to the BENEFIT PERIOD deductible; however, they are credited to the TOTAL OUT-OF-POCKET LIMIT.
+ **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 inpatient newborn care for well-baby, coinsurance, charges in excess of the ALLOWED AMOUNT, amounts exceeding any maximum or charges for non-covered services.
+ **Coinsurance** – The sharing of charges by Blue Cross NC and you for COVERED SERVICES after you have met your BENEFIT PERIOD deductible. This is stated as a percentage of the ALLOWED AMOUNT. The coinsurance listed is your share of the cost of a COVERED SERVICE.
+ **Total out-of-pocket limit** – The TOTAL OUT-OF-POCKET LIMIT is the dollar amount you pay for COVERED SERVICES in a BENEFIT PERIOD before Blue Cross NC pays 100% of COVERED SERVICES. It does not include charges over ALLOWED AMOUNTS, including any charges over the allowable cost difference between GENERIC and BRAND-NAME drugs, charges for non-covered services and premiums.

Essential health benefits

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 the 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 nonessential health benefits. This health benefit plan covers nonessential health benefits for routine adult eye exams.

Special notices

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.

Privacy notice: Blue Cross NC is committed to protecting the privacy of the medical information and other personal information we keep regarding our members. We call this information **Protected Health Information (PHI)** throughout this notice. We are required by law to maintain the privacy of your Protected Health Information. We are also required to give you this notice about our privacy practices, our legal duties and your rights concerning your PHI. We must follow the privacy practices that are described in this notice while it is in effect. **This notice is effective as of July 1, 2013**, and will remain in place until we replace it.

We reserve the right to change this notice and our privacy practices at any time, provided such changes are permitted by applicable law. We also reserve the right to make the changes in our privacy practices and the new notice effective for all PHI that we already have about you as well as for PHI that we may receive in the future. Before we make a material change in our privacy practices, we will update this notice and send the new notice to our health plan subscribers at the time of the change or as required by applicable law.

You may request a copy of this notice by calling the Customer Service number on the back of your identification card. You may also obtain a copy from our website ***BlueCrossNC.com***.

Special notices (continued)

For more information or questions about our privacy practices, please contact the Privacy Office by writing to P.O. Box 2291, Durham, NC 27702.

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

Eligibility

All eligible students enrolled at Davidson College are required to have health insurance coverage. Davidson College endorses a cost-effective Student Health Insurance Plan (SHIP) that covers additional health care expenses not included in the Student Health Fee. This plan is administered by Blue Cross NC.

+ All **full-time students** enrolled at Davidson College are automatically enrolled in this SHIP and the cost will be included on the fall tuition bill.
+ **Domestic students** may waive coverage by providing proof of comparable coverage. Students may complete an online waiver at ***davidson.myahpcare.com*** to opt out of the plan. Waivers must be submitted by August 3, 2020, for the Fall and December 1, 2020, for the Spring.
+ **International students** are not allowed to waive coverage unless they have coverage in the United States.
+ **Dependent coverage is not available**.

Multiple coverage

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

If you become eligible for Medicare, you should apply for and enroll in Medicare Part A and Part B, and use PROVIDERS who accept Medicare, in order to ensure that you receive full benefit coverage. Blue Cross NC will assume you have enrolled in Medicare and use PROVIDERS who accept Medicare once eligible for benefits thereunder. If you are covered under this health benefit plan and are eligible for Medicare, Blue Cross NC may take into account the benefits that you are eligible for under Medicare, regardless of whether you have actually enrolled for such coverage.

In other words, even if you have not enrolled in Medicare, Blue Cross NC may reduce your claim by the benefits that you are eligible for under Medicare, and then pay the remaining claim amount under the terms of this health benefit plan and in accordance with the Medicare Secondary Payer rules. As a result, your TOTAL OUT-OF-POCKET costs may be higher if you do not enroll in Medicare.

How to enroll

It is very important to enroll yourself when first eligible. Enrollment is only allowed during open enrollment periods.

Qualifying events

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 (1) the exhaustion of the COBRA continuation period, or (2) 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 (3) the termination of the other plan's coverage, or (4) the offered health benefit plan not providing benefits in your service area and no other health benefit plans are available, or (5) the termination of employer contributions toward the cost of the other plan's coverage, or (6) 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

How to enroll (continued)

+ You become eligible for premium assistance with respect to coverage under this health benefit plan under Medicaid or the CHIP and apply for coverage under this health benefit plan within 60 days

Premium payments
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.

There are no premium refunds except for students entering full-time active duty in any of the armed forces.

Reporting changes
Have you moved, added or changed other health coverage, changed your name or phone number? If so, visit our website at ***davidson.myahpcare.com*** to update your information or call Blue Cross NC Customer Service at **1-800-579-8022**. It will help us give you better service if we are kept informed of these changes.

When coverage begins and ends

Effective dates	Rates
Annual 08/01/2020 through 07/31/2021	$2,295
Spring/Summer 01/01/2021 through 07/31/2021	$1,338

Certificate of Creditable Coverage
Blue Cross NC, 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 Academic HealthPlans while you are still covered under this health benefit plan and up to 24 months following your termination.

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

MEMBER'S coverage terminates:

+ The date the health benefit plan ends
+ The date the student withdraws from school to enter the armed forces of any country
+ If the student withdraws within the first 30 days of the BENEFIT PERIOD. In this case, coverage will be terminated back to the effective date and premiums refunded. If the student withdraws after 30 days, no premium refund will be made.

An insured student's coverage will be terminated immediately by Blue Cross NC for the following reasons:

+ Fraud or intentional misrepresentation of a material fact by an insured student. 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.
+ An insured student has been convicted of (or a restraining order has been issued for) communicating threats of harm to Blue Cross NC personnel or property
+ An insured student permits the use of his or her or any other insured student's ID CARD by any other person not enrolled under this health benefit plan, or uses another person's ID CARD

Davidson Student Center

The College Student Health Center (CSHC) at your school provides access to medical care for all students. In order to make the most of your benefits, visit the CSHC first. With the exception of holiday periods, the CSHC handles routine medical care; a nurse is on duty or call 24 hours a day; and doctors see students daily by appointment. When necessary, college physicians refer students to area specialists.

You may also be responsible for requesting PRIOR REVIEW and receiving CERTIFICATION from Blue Cross NC when necessary. To request PRIOR REVIEW, call **1-800-579-8022**.

Schedule of benefits

The coinsurance amounts that appear on this benefit highlight represent member responsibility.

PHYSICIAN OFFICE SERVICES (See "Outpatient Clinic Services" for outpatient clinic or hospital-based services.)	If you visit your Student Health Center or doctor in the Student Blue network (in-network provider):	If you visit a doctor NOT in the Student Blue network (out-of-network provider)[1]:
Student Health Center (medical services)	No charge[2]	Not applicable
Lifetime Benefit Maximum	Unlimited	Unlimited
Deductibles		
Individual (per benefit period)	$300	$600
Out-of-pocket limits		
Individual (per benefit period)	$4,000	$8,000
Office Visits Includes office surgery, consultation, X-rays and labs and a benefit period maximum of four office visits for the evaluation and treatment of obesity in- and out-of-network. See "Inpatient and Outpatient Services."	**Primary Care Provider and/or Specialist:** 20% after deductible	**Primary Care Provider and/or Specialist:** 50% after deductible
Preventive Care (primary preventive diagnosis only) For the most updated list of general preventive/screenings, immunizations, well-baby/well-child care and women's preventive care services mandated under federal law, see our website at ***BlueCrossNC.com/Preventive***. Nutritional counseling is covered and available only in-network. *Colorectal screening, bone mass measurement, newborn hearing screening, prostate specific antigen tests (PSAs), gynecological exams, cervical cancer screening, ovarian cancer screening and screening mammograms are state-mandated and also covered out-of-network.	**Primary Care Provider and/or Specialist:** No charge	**Primary Care Provider and/or Specialist:** Not available*
Therapies Rehabilitative and habilitative therapies (maximums apply to home, office and outpatient settings) – physical/occupational: 30 visits per benefit period; speech therapy: 30 visits per benefit period; adaptive behavior treatment: not covered for students.	**Primary Care Provider and/or Specialist:** 20% after deductible	**Primary Care Provider and/or Specialist:** 50% after deductible
Urgent Care Centers and Emergency Room		
Urgent care centers	20% after deductible	20% after deductible
Emergency room visit (If admitted from the ER, inpatient hospital benefits apply. If held for observation, outpatient benefits apply. See "Inpatient and Outpatient Hospital Services.")	20% after deductible	20% after deductible
Ambulatory Surgical Center	20% after deductible	50% after deductible
Inpatient and Outpatient Hospital Services		
Hospital and hospital-based service	20% after deductible	50% after deductible
Hospital-based clinics (other than preventive services above)	20% after deductible	50% after deductible
Professional services	20% after deductible	50% after deductible
Outpatient diagnostic services		
Outpatient lab tests when performed alone (physician and hospital-based services)	No charge	30% after deductible

1 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 payment obligations for Blue Cross NC and its members.

2 Not all services rendered at the Student Health Center Service are covered by the plan. Please contact Blue Cross NC for more information.

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Schedule of benefits *(continued)*

PHYSICIAN OFFICE SERVICES (See "Outpatient Clinic Services" for outpatient clinic or hospital-based services.)	If you visit your Student Health Center or doctor in the Student Blue network (in-network provider):	If you visit a doctor NOT in the Student Blue network (out-of-network provider)[1]:
Outpatient lab tests when performed with another service		
Physician services	No charge	30% after deductible
Hospital and hospital-based services	20% after deductible	50% after deductible
Outpatient mammography	No charge	30% after deductible
Outpatient X-rays, ultrasounds and other diagnostic tests such as EEGs and EKGs	20% after deductible	50% after deductible
CT scans, MRIs, MRAs and PET scans in any location, including physician's office	20% after deductible	50% after deductible
Other Services		
Skilled nursing facility (60 days per benefit period)	20% after deductible	50% after deductible
Home health care, durable medical equipment and hospice	20% after deductible	50% after deductible
Ambulance	20% after deductible	20% after deductible
Maternity (maternity delivery includes prenatal and post-delivery care)		
Hospital services (delivery)	20% after deductible	50% after deductible
Professional services (delivery)	20% after deductible	50% after deductible
Transplants		
Hospital services	20% after deductible	50% after deductible
Professional services	20% after deductible	50% after deductible
Infertility services (combined in-network and out-of-network lifetime maximum of three ovulation induction cycles, with or without insemination, per member for infertility services, provided in all places of service)		
Primary Care Provider	20% after deductible	50% after deductible
Specialist	20% after deductible	50% after deductible
Hospital services	20% after deductible	50% after deductible
Inpatient and outpatient professional services	20% after deductible	50% after deductible
Mental Health and Substance Use Disorder Services		
Office visits	20% after deductible	50% after deductible
Inpatient/outpatient	20% after deductible	50% after deductible
Prescription Drugs*		
Tier 1	$4 copayment	$4 copayment
Tier 2	$25 copayment	$25 copayment
Tier 3	$35 copayment	$35 copayment
Tier 4	$75 copayment	$75 copayment
Tier 5	25% coinsurance	25% coinsurance
*Up to 30-day supply. 31–60 day supply is two copayments and 61–90 day supply is three copayments. MAC B pricing, enhanced formulary. Prior plan approval, step therapy and quantity limits may apply. Preventive over-the-counter medications and contraceptive drugs and devices as listed at ***BlueCrossNC.com/Preventive***. For each 30-day supply of a Tier 5 drug, you will pay a minimum of $100 in coinsurance, but not more than $200.		

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Schedule of benefits *(continued)*

PHYSICIAN OFFICE SERVICES (See "Outpatient Clinic Services" for outpatient clinic or hospital-based services.)	If you visit your Student Health Center or doctor in the Student Blue network (in-network provider):	If you visit a doctor NOT in the Student Blue network (out-of-network provider)[1]:
Pediatric Dental Services*		
Preventive services	No charge	30% after deductible
Basic and major	20% after deductible	50% after deductible
Orthodontic services (if medically necessary) * Pediatric dental is only available for members up through the end of the month they become age 19.	20% after deductible	50% after deductible
Pediatric Vision Benefit**		
Routine vision exam	No charge	Not covered
Frames and lenses or contact lenses ** Pediatric vision is only available for members up through the end of the month they become age 19.	20% after deductible	20% after deductible

Additional information about Student Blue

Benefit period
The period of time, usually 12 months as stated in the group contract, during which charges for covered services provided to a member must be incurred in order to be eligible for payment by Blue Cross NC. A charge shall be considered incurred on the date the service or supply was provided to a member.

Allowed amount
The maximum amount that Blue Cross NC determines is to be paid for covered services provided to a member.

Out-of-pocket limit
The dollar amount you pay for covered services in a benefit period before Blue Cross NC pays 100% of covered services. It includes deductible, coinsurance and copayments. It does not include charges over the allowed amount, premiums and charges for non-covered services.

Day and visit maximums
All day and visit maximums are on a combined in- and out-of-network basis.

Utilization management
To make sure you have access to high-quality, cost-effective health care, we manage utilization through a variety of programs including certification, transplant management, concurrent and retrospective review.

If you have a concern regarding the final determination of your care, you have the right to appeal the decision. If you would like a copy of a benefit booklet providing more information about our utilization management programs, call the toll-free number listed in your information packet.

Certification

Certification is a program designed to make sure that your care is given in a cost-effective setting and efficient manner.

If you need to be hospitalized, you must obtain certification. non-emergency and non-maternity hospital admissions must be certified prior to the hospitalization. If the admission is not certified, the claim will be denied.

For maternity admissions, your provider is not required to obtain certification from Blue Cross NC for prescribing a length of stay up to 48 hours for a normal vaginal delivery, or up to 96 hours for delivery by cesarean section. You or your provider must request certification for coverage for additional days, which will be given by Blue Cross NC if medically necessary.

PRIOR REVIEW and CERTIFICATION are required by Blue Cross NC for inpatient or certain outpatient services, such as partial hospitalization and intensive therapy, or services will not be covered.

In-network providers are responsible for obtaining certifications. The member will bear no financial penalties if the in-network provider fails to obtain the appropriate authorization. The member is responsible for obtaining certification for services rendered by an out-of-network or out-of-state provider.

Health and wellness program
Because we want to help you stay healthy, we offer many wellness benefits and services, including Health Line Blue℠ – our 24-hour nurse support line. We also provide wellness programs for prenatal care and for chronic condition management, plus a variety of health tools and trackers at ***BlueConnectNC.com***. We're making it easier than ever for you to take charge of your health.

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Certification requirements

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 Blue Cross NC. **Failure to request PRIOR REVIEW and receive CERTIFICATION will result in full denial of benefits**. See "COVERED SERVICES" and "PRIOR REVIEW (Pre-Service)" in "UTILIZATION MANAGEMENT" for additional information.

Blue Cross NC delegates PRIOR REVIEW and CERTIFICATION for particular benefits to other companies not associated with Blue Cross NC. Please see ***bcbsnc.com/content/services/medical-policy/index.htm*** for a detailed list of these companies and benefits. To request PRIOR REVIEW, please call **1-800-579-8022.**

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" and "Summary of benefits" and "What is not covered?" This health benefit plan does not cover services, supplies, drugs or charges for:

1. 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.
2. Conditions that federal, state or local law requires to be treated in a public facility.
3. 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.
4. Benefits that are provided by any governmental unit except as required by law.
5. Services that are ordered by a court that are otherwise excluded from benefits under this health benefit plan.
6. Any condition suffered as a result of any act of war or while on active or reserve military duty.
7. 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.
8. Services received in excess of any BENEFIT PERIOD MAXIMUM or LIFETIME MAXIMUM.
9. A benefit, drug, service or supply that is not specifically listed as covered in this benefit booklet.
10. Acupuncture and acupressure.
11. 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.
12. 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.
13. Alternative medicine services, which are unproven preventive or treatment modalities, also described as alternative, integrative or complementary medicine, whether performed by a physician or any OTHER PROVIDER.
14. Collection and storage of blood and stem cells taken from the umbilical cord and placenta for future use in fighting a disease.
15. Claims not submitted to Blue Cross NC within 18 months of the date the charge was INCURRED, except in the absence of legal capacity of the MEMBER.
16. Side effects and complications of non-covered services, except for EMERGENCY SERVICES in the case of an EMERGENCY.
17. Convenience items such as, but not limited to, devices and equipment used for environmental control, urinary incontinence devices (including bed-wetting alarms) and equipment, heating pads, hot water bottles, ice packs and personal hygiene items.
18. COSMETIC services, which include the removal of excess skin from the abdomen, arms or thighs, skin tag excisions, cryotherapy or chemical exfoliation for active acne and acne scarring, superficial dermabrasion,

What is not covered? (continued)

injection of dermal fillers, services for hair transplants, electrolysis 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.

19. Custodial care designed essentially to assist an individual with activities of daily living, with or without routine nursing care and the supervisory care of a DOCTOR. While some skilled services may be provided, the patient does not require continuing skilled services 24 hours daily. The individual is not under specific medical, surgical or psychiatric treatment to reduce a physical or mental disability to the extent necessary to enable the patient to live outside either the institution or the home setting with substantial assistance and supervision, nor is there reasonable likelihood that the disability will be reduced to that level even with treatment. Custodial care includes, but is not limited to, help in walking, bathing, dressing, feeding, preparation of special diets and supervision over medications that could otherwise be self-administered. Such services and supplies are custodial as determined by Blue Cross NC without regard to the place of service or the PROVIDER prescribing or providing the services.
20. Dental care dentures, dental implants, oral orthotic devices, palatal expanders and orthodontics except as specifically covered by this health benefit plan.
21. DENTAL SERVICES provided in a HOSPITAL, except as described in your benefit booklet.
22. 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.
    + 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 (1) specifically listed as a covered drug in the FORMULARY and for which a written PRESCRIPTION is provided or (2) 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
23. Services primarily for EDUCATIONAL TREATMENT including, but not limited to, books, tapes, pamphlets, seminars, classroom, websites or computer programs, individual or group instruction and counseling, except as specifically covered by this health benefit plan.
24. 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, pool or memberships to health clubs.
    + Standing frames.
    + Personal computers.
25. 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.
26. Routine foot care that is palliative or COSMETIC.
27. Genetic testing, except for high-risk patients when the therapeutic or diagnostic course would be determined by the outcome of the testing.
28. Hearing aids or examinations for the fitting of hearing aids, including implantable bone-anchored hearing aids (BAHA) for MEMBERS ages 22 and older.
29. Hypnosis, except when used for control of acute or chronic pain.
30. 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.
31. Inpatient confinements that are primarily intended as a change of environment.

What is not covered? (continued)

32. 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.
33. Services or supplies deemed not MEDICALLY NECESSARY.
34. Services that would not be necessary if a non-covered 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.
35. Body piercing.
36. Care or services from a PROVIDER who:
    + Cannot legally provide or legally charge for the services or services are outside the scope of the PROVIDER'S license or certification.
    + Provides and bills for services from a licensed health care professional who is in training.
    + Is in a MEMBER'S immediate family.
    + Is not recognized by Blue Cross NC as an eligible PROVIDER.
37. 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 disorder and mental health treatment) or any similar facility or institution.
38. RESPITE CARE, whether in the home or in a facility or inpatient setting, except as specifically covered by this health benefit plan.
39. Services or supplies that are:
    + Not performed by or upon the direction of a DOCTOR or OTHER PROVIDER.
    + Available to a MEMBER without charge.
40. SEXUAL DYSFUNCTION unrelated to organic disease.
41. Shoe lifts, and shoes of any type unless part of a brace.
42. The following types of therapy:
    + Music therapy, remedial reading, recreational or activity therapy, all forms of special education and supplies or equipment used similarly.
    + Massage therapy.
43. Travel, whether or not recommended or prescribed by a DOCTOR or other licensed health care professional, except when approved in advance for transplants.
44. The following vision services:
    + Radial keratotomy and other refractive eye SURGERY, and related services to correct vision except for surgical correction of an eye injury. Also excluded are premium intraocular lenses or the services related to the insertion of premium lenses beyond what is required for insertion of conventional intraocular lenses, which are small, lightweight, clear disks that replace the distance-focusing power of the eye's natural crystalline lens.
    + Eyeglasses or contact lenses, except as specifically covered in "PROSTHETIC APPLIANCES" or "Pediatric Vision."
    + Orthoptics, vision training and low vision aids, except as specifically covered in "Pediatric Vision."
45. 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 ***BlueCrossNC.com/Preventive***.
46. Wigs, hair pieces and hair implants for any reason.

BlueCard

Like all Blue Cross and Blue Shield licensees, we participate in a program called BlueCard. Whenever the covered person accesses health care services outside our service area, the claims for those services may be processed through BlueCard and presented to us for payment in conformity with network access rules of the BlueCard policies then in effect ("Policies").

Under BlueCard, when covered persons incur covered expenses within the geographic area served by an onsite Blue Cross and/or Blue Shield licensee ("Host Blue"), we will remain responsible to the covered person for fulfilling the policy's contract obligations. The Host Blue will only be responsible, in accordance with applicable BlueCard policies, if any, for providing such services as contracting with its participating providers and handling all interactions with its participating providers.

Summary of Benefits and Coverage

The Affordable Care Act requires all health insurers to provide consumers with a Summary of Benefits and Coverage (SBC). The SBC is a description of the benefits and health coverage offered by a particular health plan. The SBC is intended to provide clear, consistent descriptions that may make it easier for people to understand their health insurance coverage. The items in the SBC just represent an overview of coverage; they are not an exhaustive list of what is covered or excluded. The full terms of coverage are located in your insurance policy. To obtain an SBC for your policy, please visit ***davidson.myahpcare.com***.

Blue Cross NC online resources

Some things in life are totally out of our hands. But with Blue Cross NC, health care doesn't have to be one of them. That's because you have access to Blue Connect℠. Blue Connect is our enhanced online destination for member services. It offers a wealth of tools and information to easily manage your health and health care. It's fully customizable based on your unique needs and interests. You can still do everything that you did before – only better and more easily. It all starts on your Blue Connect home page, where you can:

+ Tap into up-to-date information on your health plan and benefits.
+ Customize features to show what means the most to you – everything from motivating wellness challenges and health tools to our exclusive member discount program, Student Blue365®.
+ Get relevant health tips and news so you don't have to do the research on your own.

Visit ***BlueConnectNC.com*** today. Then, enjoy the full experience anytime, anywhere.

Filing claims

IN-NETWORK PROVIDERS in North Carolina are responsible for filing claims directly with Blue Cross NC. 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 you as eligible for coverage.

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 refund you the difference. If you are unable to return to the pharmacy within 14 days, mail your claim in time for it to be received within 18 months of 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.

You may have to pay an OUT-OF-NETWORK PROVIDER in full and submit your own claim to Blue Cross NC. Mail your claim in time for it 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.

Glossary

A

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 Blue Cross NC determines is reasonable for COVERED SERVICES provided to a MEMBER. The allowed amount includes any Blue Cross NC payment to the PROVIDER, plus any deductible, coinsurance or copayment. For PROVIDERS that have entered into an agreement with Blue Cross NC, the allowed amount is the negotiated amount that the PROVIDER has agreed to accept as payment in full. Except as otherwise specified in "EMERGENCY CARE," for PROVIDERS that have not entered into an agreement with Blue Cross NC, the allowed amount will be the lesser of the PROVIDER'S billed charge or an amount based on an OUT-OF-NETWORK fee schedule established by Blue Cross NC that is applied to comparable PROVIDERS for similar services under a similar health benefit plan.

Where Blue Cross NC has not established an OUT-OF-NETWORK fee schedule amount for the billed service, the allowed amount will be the lesser of the PROVIDER'S billed charge or a charge established by Blue Cross NC using a methodology that is applied to comparable PROVIDERS who may have entered into an agreement with Blue Cross NC for similar services under a similar health benefit plan. Calculation of the allowed amount is based on several factors including Blue Cross NC's medical, payment and administrative guidelines. Under the guidelines, some procedures charged separately by the PROVIDER may be combined into one procedure for reimbursement purposes.

AMBULATORY SURGICAL CENTER
A NON-HOSPITAL FACILITY with an organized staff of DOCTORS, which is licensed or certified in the state where located, and which:

+ Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an outpatient basis
+ Provides nursing services and treatment by or under the supervision of DOCTORS whenever the patient is in the facility
+ Does not provide inpatient accommodations
+ 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:

+ For independent clinical laboratories, services are received in the state where the specimen is drawn
+ 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
+ For specialty pharmacies, services are received in the state where the ordering physician is located

B

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 Blue Cross NC. 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 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 have 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. Blue Cross NC 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 FDA and nationally recognized drug databases.

C

CERTIFICATION
The determination by Blue Cross NC that an admission, availability of care, continued stay, or other services, supplies or drugs have been reviewed and, based on the information provided, satisfy 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:

+ 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
+ Necessary for and appropriate to the diagnosis, treatment, cure or relief of a dental condition, illness, injury, disease or its symptoms
+ Within generally accepted standards of dental care in the community
+ Not solely for the convenience of the insured, the insured's family or the PROVIDER

For CLINICALLY NECESSARY services, 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.

CLOSED FORMULARY
A list of prescription medications that are covered under the prescription benefit. PROVIDERS can prescribe from a list of GENERIC and BRAND-NAME medications from each therapeutic category. Medications not on the list must go through a non-formulary exception process for MEDICAL NECESSITY to be reimbursed under the PRESCRIPTION DRUG benefit.

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; immediate postpartum hemorrhage due to uterine atony; missed abortion; nephrosis; placenta previa; Rh sensitization; severe pre-eclampsia; trophoblastic disease; toxemia; retained placenta or uterine rupture occurring within 72 hours of delivery; or, the following conditions occurring within ten days of delivery: endometritis, mastitis, thrombophlebitis or urinary tract infection. 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 Blue Cross NC 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 Blue Cross NC 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.

D

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

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

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 of 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, and subject to any licensure or regulatory limitation as to location, manner or scope of practice. All services performed must be within the scope of license or certification to be eligible for reimbursement.

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

E

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:

+ Ambulatory patient services
+ EMERGENCY SERVICES
+ Hospitalization
+ Laboratory services
+ Maternity and newborn care
+ Mental health and substance disorder services, including behavioral health treatment
+ Pediatric services, including oral and vision care
+ PRESCRIPTION DRUG
+ Preventive and wellness services and chronic disease management
+ REHABILITATIVE THERAPY and HABILITATIVE SERVICES and devices

No annual or lifetime dollar limits can apply to essential health benefits.

EXPERIMENTAL
See "Investigational."

F

FACILITY SERVICES
COVERED SERVICES provided and billed by a HOSPITAL or NON-HOSPITAL 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.

G

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 Blue Cross NC based on commercially available data resources and other external classification sources, such as the 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 Blue Cross NC.

GROUP
Davidson College.

H

HABILITATIVE SERVICES
Health care services and devices 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.

HOME HEALTH AGENCY
A NON-HOSPITAL FACILITY which is primarily engaged in providing home health care services that are medical or therapeutic in nature, and which:

+ Provides skilled nursing and other services on a visiting basis in the MEMBER'S home
+ Is responsible for supervising the delivery of such services under a plan prescribed by a DOCTOR
+ Is accredited and licensed or certified in the state where located
+ Is certified for participation in the Medicare program
+ Is acceptable to Blue Cross NC

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.

HOSPICE
A NON-HOSPITAL FACILITY that provides medically related services to persons who are terminally ill, and which:

+ Is accredited, licensed or certified in the state where located
+ Is certified for participation in the Medicare program
+ Is acceptable to Blue Cross NC

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

I

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.

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

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

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.

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

+ Services or supplies requiring federal or other governmental body approval, such as drugs and devices that do not have unrestricted market approval from the 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.
+ There is insufficient or inconclusive scientific evidence in peer-reviewed medical literature to permit Blue Cross NC's evaluation of the therapeutic value of the service or supply.
+ There is inconclusive evidence that the service or supply has a beneficial effect on health outcomes.
+ The service or supply under consideration is not as beneficial as any established alternatives.
+ 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 Blue Cross NC after independent review of scientific data. Opinions of experts in a particular field and/or opinions and assessments of nationally recognized review organizations may also be considered by Blue Cross NC but are not determinative or conclusive.

L

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.

M

MEDICAL SUPPLIES
Health care materials that include ostomy, catheter, oxygen and diabetic supplies.

MEDICALLY NECESSARY (MEDICAL NECESSITY)
Those COVERED SERVICES or supplies that are:

+ 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, are not for EXPERIMENTAL, INVESTIGATIONAL or COSMETIC purposes
+ Necessary for and appropriate to the diagnosis, treatment, cure or relief of a health condition, illness, injury, disease or its symptoms
+ Within generally accepted standards of medical care in the community
+ Not solely for the convenience of the insured, the insured's family or the PROVIDER

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

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

MENTAL ILLNESS
A mental disorder defined in the current edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, Washington, D.C. ("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.

+ 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
+ When applied to a DEPENDENT CHILD, in accordance with North Carolina law, a mental condition, other than intellectual disability alone, that so impairs the DEPENDENT CHILD'S capacity to exercise age-adequate self-control or judgment in the conduct of his/her activities and social relationships so that he/she is in need of treatment

N

NON-CERTIFICATION
An ADVERSE BENEFIT DETERMINATION by Blue Cross NC that a service covered under this health benefit plan has been reviewed and does not meet Blue Cross NC's requirements for a 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 non-certification. A non-certification is not a decision based solely on the fact that the requested service is specifically excluded under your benefits.

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

O

OFFICE VISIT
Medical care, SURGERY, diagnostic services, REHABILITATIVE THERAPY, HABILITATIVE 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 who is acceptable to Blue Cross NC. Examples may include physician assistants (PAs), nurse practitioners (NPs) or certified registered nurse anesthetists (CRNAs). All services performed must be within the scope of license or certification to be eligible for reimbursement.

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

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

+ Cardiac rehabilitative therapy
+ Chemotherapy, including intravenous chemotherapy. Chemotherapy benefits are based on where services are received. For chemotherapy received in conjunction with bone marrow or peripheral blood stem cell transplants, follow transplant guidelines described in "Transplants." Also see "PRESCRIPTION DRUG benefits" regarding related covered PRESCRIPTION DRUGS.
+ Dialysis treatments (three treatments a week; more treatments are available if MEDICALLY NECESSARY)
+ Pulmonary therapy and respiratory therapy
+ Radiation therapy

OUT-OF-NETWORK
Not designated as participating in the network, and not certified in advance by Blue Cross NC 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 IN-NETWORK by Blue Cross NC.

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.

P

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 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.

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

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

PRIOR REVIEW
The consideration of benefits for an admission, availability of care, continued stay, or other services, supplies or drugs, based on the information provided and requirements for a determination of MEDICAL NECESSITY of services and supplies, appropriateness, health care setting or level of care and effectiveness. PRIOR REVIEW results in CERTIFICATION or NON-CERTIFICATION 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, NON-HOSPITAL FACILITY, DOCTOR or OTHER PROVIDER, accredited, licensed or certified where required in the state of practice, performing within the scope of license or certification. All services performed must be within the scope of license or certification to be eligible for reimbursement.

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

R

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 PROFESSIONAL PROVIDER to promote the recovery of the MEMBER from an illness, disease or injury when provided by a DOCTOR, OTHER PROFESSIONAL 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 including:

+ 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.
+ 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 Blue Cross NC is conditioned on: (1) Blue Cross NC'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.

S

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

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

SPECIALTY DRUG(S)
Those medications classified by Blue Cross NC 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 self-administered or PROVIDER-administered and 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:

+ The correction of fractures and dislocations
+ Usual and related pre-operative and post-operative care
+ Other procedures as reasonable and approved by Blue Cross NC

T

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 consist of medium-cost prescription drugs; most are GENERIC and some are BRAND-NAME prescription drugs.

TIER 3 or **TIER 4 DRUGS**
The PRESCRIPTION DRUG tiers which consist of higher-cost prescription drugs; most are BRAND-NAME prescription drugs and some are SPECIALTY DRUGS.

TIER 5 DRUGS
The PRESCRIPTION DRUG tier which consists of some of the highest-cost PRESCRIPTION DRUGS; most are SPECIALTY DRUGS.

TOTAL OUT-OF-POCKET LIMIT
The maximum amount listed in the "Summary of benefits" that is payable by the MEMBER in a BENEFIT PERIOD before Blue Cross NC pays 100% of COVERED SERVICES. It consists of the OUT-OF-POCKET expense (which is the annual maximum amount of coinsurance and any copayments) plus the deductible.

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.

U

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.

W

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.

The plan is underwritten by:
Blue Cross and Blue Shield of North Carolina

Submit all claims or inquiries to:
Blue Cross and Blue Shield of North Carolina
Student Blue
P.O. Box 2073
Durham, NC 27702

1-800-579-8022
email@studentbluenc.com

The plan is administered by:
Academic HealthPlans, Inc.
P.O. Box 1605
Colleyville, TX 76034-1605
For more information
davidson.myahpcare.com

In the event of any inconsistency between information contained in this brochure and the member's benefit booklet, the benefit booklet shall govern.

Blue365 offers access to savings on items that members may purchase directly from independent vendors, which are different from items that are covered under the policies with Blue Cross NC. Blue Cross and Blue Shield Association (BCBSA) may receive payments from Blue365 vendors. Neither Blue Cross NC nor BCBSA recommends, endorses, warrants or guarantees any specific Blue365 vendor or item. This program may be modified or discontinued at any time without prior notice.