



North  
Carolina

Pending NC Department of Insurance Approval

[StudentBlueNC.com/#/Campbell](https://StudentBlueNC.com/#/Campbell)

# Student Blue<sup>SM</sup>

## Health Plan for Campbell University Graduate Students | 2025-2026



# Student Blue

## A healthy plan for a successful future

Campbell University selected Student Blue to provide you with quality health insurance coverage from Blue Cross and Blue Shield of North Carolina (Blue Cross NC). With Student Blue, you have low out-of-pocket costs and worldwide coverage.<sup>1</sup>

| Mandatory Hard Waiver | Fall Semester Effective Dates <sup>2</sup><br>8/1/2025–12/31/25 | Spring Semester Effective Dates <sup>2</sup><br>1/1/2026–7/31/2026 | Dependent Rates <sup>3,4</sup><br>Rates are additional to your student rate | Monthly <sup>5,6</sup> |
|-----------------------|-----------------------------------------------------------------|--------------------------------------------------------------------|-----------------------------------------------------------------------------|------------------------|
| Student Rate          | \$2,172.00*                                                     | \$3,041.00*                                                        | Add Spouse/Domestic Partner                                                 | \$434.34               |
|                       |                                                                 |                                                                    | Add Child                                                                   | \$347.42               |
|                       |                                                                 |                                                                    | Add Child(ren)                                                              | \$521.17               |
|                       |                                                                 |                                                                    | Add Family                                                                  | \$1,302.93             |

\* A portion of the Student Health Insurance premium rate is retained by Campbell University to pay for administrative costs.

## Benefit highlights

| Services                                                                                                                                                                                                                                                                                                                                                                                                                                             | In-Network                                                                                  | Out-of-Network                                                                                |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|
| All dollar amounts and percentages are what you, as a plan member, would pay.                                                                                                                                                                                                                                                                                                                                                                        |                                                                                             |                                                                                               |
| <b>Lifetime Maximum, Deductibles and Total Out-of-Pocket Maximums</b><br>The following deductibles and Total Out-of-Pocket Maximum also apply to Behavioral Health and Substance Use Services.                                                                                                                                                                                                                                                       |                                                                                             |                                                                                               |
| <b>Lifetime Maximum</b>                                                                                                                                                                                                                                                                                                                                                                                                                              | Unlimited                                                                                   | Unlimited                                                                                     |
| <b>Deductibles</b>                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                             |                                                                                               |
| Individual (per benefit period)                                                                                                                                                                                                                                                                                                                                                                                                                      | \$500                                                                                       | \$1,000                                                                                       |
| Family (per benefit period)                                                                                                                                                                                                                                                                                                                                                                                                                          | \$1,000                                                                                     | \$2,000                                                                                       |
| <b>Total Out-of-Pocket Maximum</b>                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                             |                                                                                               |
| Individual (per benefit period)                                                                                                                                                                                                                                                                                                                                                                                                                      | \$6,350                                                                                     | \$12,700                                                                                      |
| Family (per benefit period)                                                                                                                                                                                                                                                                                                                                                                                                                          | \$12,700                                                                                    | \$25,400                                                                                      |
| <b>Physician Office Services</b><br>(See “Outpatient Clinic Services” for outpatient clinic or hospital-based services.).                                                                                                                                                                                                                                                                                                                            |                                                                                             |                                                                                               |
| <b>Office Visits</b><br>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 Hospital Services.”                                                                                                                                                                                                         | <b>Primary Care Provider:</b><br>\$30 copayment<br><br><b>Specialist:</b><br>\$50 copayment | <b>Primary Care Provider and/or Specialist:</b><br>50% after deductible                       |
| <b>Preventive Care</b><br>This benefit is only for services that your provider indicates with a primary diagnosis of preventive or wellness care on the claim that is submitted to Blue Cross NC.<br>* Gynecological exams, cervical cancer screening, ovarian cancer screening, screening mammograms, colorectal screening, bone mass measurement, newborn hearing screening and prostate specific antigen tests (PSAs) are covered out-of-network. | <b>Primary Care Provider:</b><br>No charge<br><br><b>Specialist:</b><br>No charge           | <b>Primary Care Provider:</b><br>Not applicable*<br><br><b>Specialist:</b><br>Not applicable* |

# Benefit highlights *(continued)*

| Services                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | In-Network                                                                                                                                                                                                                                                                                                                                   | Out-Of-Network                                                                                                                                                                                                                                                                                                                               |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| All dollar amounts and percentages are what you, as a plan member, would pay.                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                              |
| <b>Therapies</b><br>Rehabilitative therapy has a benefit period maximum of 30 visits for physical/occupational therapy (including chiropractic services), and 30 visits for speech therapy. Habilitative services has a benefit period maximum of 30 visits for physical/occupational therapy (including chiropractic services), and 30 visits for speech therapy.                                                                                                                          | <b>Primary Care Provider:</b><br>\$30 copayment<br><br><b>Specialist:</b><br>\$50 copayment                                                                                                                                                                                                                                                  | <b>Primary Care Provider and/or Specialist:</b><br>50% after deductible                                                                                                                                                                                                                                                                      |
| <b>Urgent Care Centers, Ambulance and Emergency Room</b><br>Urgent care centers<br>(Copayment waived if referred to emergency room)                                                                                                                                                                                                                                                                                                                                                         | \$75 copayment                                                                                                                                                                                                                                                                                                                               | \$150 copayment                                                                                                                                                                                                                                                                                                                              |
| <b>Ambulance</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 30% after deductible                                                                                                                                                                                                                                                                                                                         | 30% after deductible                                                                                                                                                                                                                                                                                                                         |
| <b>Emergency Room Visit</b><br>(Inpatient hospital benefits apply if admitted. If held for observation, outpatient benefits apply. See "Inpatient and Outpatient Hospital Services.")                                                                                                                                                                                                                                                                                                       | \$500 copayment                                                                                                                                                                                                                                                                                                                              | \$500 copayment                                                                                                                                                                                                                                                                                                                              |
| <b>Ambulatory Surgical Center</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 30% after deductible                                                                                                                                                                                                                                                                                                                         | 50% after deductible                                                                                                                                                                                                                                                                                                                         |
| <b>Inpatient and Outpatient Hospital Services</b><br>Hospital and hospital-based service<br>Outpatient clinic services (Other than preventive services above)<br>Professional services                                                                                                                                                                                                                                                                                                      | 30% after deductible<br>30% after deductible<br>30% after deductible                                                                                                                                                                                                                                                                         | 50% after deductible<br>50% after deductible<br>50% after deductible                                                                                                                                                                                                                                                                         |
| <b>Hospital and Professional</b><br>Outpatient lab tests<br>Outpatient diagnostic mammograms<br>Outpatient X-rays, ultrasounds and other diagnostic tests, such as EEGs<br>CT scans, MRIs, MRAs and PET scans in any location, including physician's office                                                                                                                                                                                                                                 | 30% after deductible<br>No charge<br>30% after deductible<br>30% after deductible                                                                                                                                                                                                                                                            | 50% after deductible<br>30% after deductible<br>50% after deductible<br>50% after deductible                                                                                                                                                                                                                                                 |
| <b>Other Services</b><br>Skilled nursing facility (60 days per benefit period)<br>Home health care, durable medical equipment and hospice<br>Maternity (maternity delivery includes prenatal and post-delivery care)<br>Hospital services (delivery)<br>Professional services (delivery)<br>Transplants<br>Hospital services<br>Professional services<br>Infertility services<br>Primary care provider<br>Specialist<br>Hospital services<br>Inpatient and outpatient professional services | 30% after deductible<br>30% after deductible<br>30% after deductible<br>30% after deductible<br>30% after deductible<br>30% after deductible<br>30% after deductible<br>30% after deductible<br>30% after deductible<br>30% after deductible<br>30% after deductible<br>30% after deductible<br>30% after deductible<br>30% after deductible | 50% after deductible<br>50% after deductible<br>50% after deductible<br>50% after deductible<br>50% after deductible<br>50% after deductible<br>50% after deductible<br>50% after deductible<br>50% after deductible<br>50% after deductible<br>50% after deductible<br>50% after deductible<br>50% after deductible<br>50% after deductible |
| <b>Mental health and Substance Use Disorder</b><br>Office visits<br>Inpatient/outpatient                                                                                                                                                                                                                                                                                                                                                                                                    | \$10 copayment<br>30% after deductible                                                                                                                                                                                                                                                                                                       | 50% after deductible<br>50% after deductible                                                                                                                                                                                                                                                                                                 |
| <b>Prescription Drugs</b><br>Other pharmacy<br>Up to 30 day supply. 31-60 day supply is two copayments, and 61-90 day supply is three copayments. There is \$100 per drug minimum and \$300 per drug maximum for each 30 day supply of Tier 5 drugs.                                                                                                                                                                                                                                        | <b>Tier 1:</b> \$20 copayment<br><b>Tier 2:</b> \$35 copayment<br><b>Tier 3:</b> \$45 copayment<br><b>Tier 4:</b> \$90 copayment<br><b>Tier 5:</b> 25% coinsurance                                                                                                                                                                           | Copayment + charge over in-network allowed amount                                                                                                                                                                                                                                                                                            |

**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 payment obligations for Blue Cross NC and its members.



**Visit** [StudentBlueNC.com/#/Campbell](https://StudentBlueNC.com/#/Campbell)  
**Connect** @BCBSNCStudent



## Health and wellness programs

Because we want to help you stay healthy, we offer a variety of wellness benefits and services. You can take advantage of Health Line Blue<sup>SM</sup>, our 24-hour health information service; a health topics library; asthma and diabetes management; and a prenatal program. You will also have access to online health and wellness information at [BlueCrossNC.com](https://BlueCrossNC.com). With our programs, you can get health advice any time you need it, so you can learn how to take charge of your health.

### What Is Not Covered

The following are summaries of some of the coverage restrictions. A full explanation and listing of restrictions will be found in your benefit booklet, which can be found at [StudentBlueNC.com/#/Campbell](https://StudentBlueNC.com/#/Campbell). Your health benefit plan does not cover services, supplies, drugs or charges that are:

- Not medically necessary
- For injury or illness resulting from an act of war
- For personal hygiene and convenience items
- For inpatient admissions that are primarily for diagnostic studies
- For palliative or cosmetic foot care
- For investigative or experimental purposes
- For cosmetic services or cosmetic surgery except as specifically covered by your health benefit plan
- For custodial care, domiciliary care or rest cures
- For treatment of obesity, except for surgical treatment of morbid obesity, or as specifically covered by your health benefit plan
- For reversal of sterilization
- For treatment of sexual dysfunction not related to organic disease
- For conception by artificial means or diagnosis and treatment of infertility
- For self-injectable drugs in the provider's office
- For vision care

The benefit highlights is a summary of Blue Options<sup>®</sup> benefits. This is meant only to be a summary. A final interpretation, and a complete listing of benefits and exclusions is found in and governed by the group contract and benefit booklet. You may preview the benefit booklet by accessing a copy of the Blue Options benefit booklet from your campus website.

### Important legal notices for students' Special Enrollment

Deductibles, coinsurance, limitations and exclusions apply to this coverage. Further details of coverage, limitations and exclusions will be provided in your benefit booklet.

If you are declining enrollment for yourself or your dependents (including your spouse/domestic partner) because of other health insurance, including Medicaid, Children's Health Insurance Program (CHIP) or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (other than Medicaid or CHIP), or if the employer stops contributing toward your or your dependents' other coverage and within 60 days after the loss of Medicaid or CHIP eligibility. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption or foster care, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption or foster care, except when adding a dependent child will not change your coverage type or premiums that are owed.

### For questions or to obtain more information, contact:

Blue Cross and Blue Shield of North Carolina  
P.O. Box 2073, Durham, NC 27702, or call 800-579-8022.

### Policy dates are 08/01/25 - 07/31/26

1 Worldwide through the GeoBlue<sup>®</sup> program. Blue Cross and Blue Shield Association Internal Data: [about.geo-blue.com/](https://about.geo-blue.com/) (Accessed October 2024).

2 Premium due for student coverage must be paid through the student's Campbell University account.

3 Premium due for dependent coverage is paid directly to Blue Cross and Blue Shield of North Carolina. At enrollment, you will receive an email advising of the current amount due and the date the initial draft will occur. Subsequent payments will be drafted on a monthly basis.

4 Dependent rate is an additional premium above the student premium and does not include the cost for student coverage.

5 All terminations will be effective the last day of the month. Requests for termination must be received at least 10 days prior to first day of the month that coverage is no longer desired. There are no refunds.

6 If you wish to pay annually, please contact Customer Service at 800-579-8022 to make arrangements.

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