

Benefit Booklet
For Students of
UNIVERSITY OF NORTH CAROLINA
for
DENTALBlue®



An Independent Licensee of the Blue Cross and Blue Shield Association

BENEFIT BOOKLET

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

Blue Cross and Blue Shield of North Carolina agrees to provide benefits to the qualified *subscribers* and eligible *dependents* who are listed on the Group Enrollment Application and who are accepted in accordance with the provisions of the *group contract* entered into between Blue Cross and Blue Shield of North Carolina and the *subscriber's group*. A summary of benefits, conditions, limitations, and exclusions is set forth in this Benefit Booklet for easy reference.

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



Attest:

A handwritten signature in cursive script, appearing to read "John Guay", written in black ink.

President

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

Secretary

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

***Pre-existing Condition* Limitations May Apply To Your Coverage. Please Read This Provision In This Benefit Booklet Entitled, "When Coverage Begins And Ends."**

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WELCOME TO DENTAL BLUE

Welcome to Blue Cross and Blue Shield of North Carolina's Dental Blue plan!

How To Use Your Dental Blue Benefit Booklet

This benefit booklet provides important information about your benefits and can help you understand how to maximize them.

If you are trying to determine whether coverage will be provided for a specific service, you may want to review all of the following:

- "Summary Of Benefits" to get an overview of your specific benefits, such as DEDUCTIBLE, COINSURANCE and maximum amounts
- "COVERED SERVICES" to get more detailed information about what is covered
- "What Is Not Covered?" to see exclusions from coverage.

If you still have questions, you can call the number listed on your ID CARD or in "Whom Do I Call?"

As you read this benefit booklet, keep in mind that any word you see in small capital letters (SMALL CAPITAL LETTERS) is a defined term and will appear in "Glossary" at the end of this benefit booklet. The terms "we," "us," and "BCBSNC" refer to Blue Cross and Blue Shield of North Carolina.

You will also want to review the following sections of this benefit booklet:

- "How Dental Blue Works" explains how to access your dental benefits
- "When Coverage Begins And Ends" tells you, among other things, how and when to enroll in this dental benefit plan
- "What If You Disagree With Our Decision?" explains the rights available to you when we make a decision regarding your coverage and you do not agree.

WHOM DO I CALL?

Web Site

To change your address, request new ID CARDS, get claim forms, we invite you to visit us here:

Web site.....**bcbsnc.com/student**

To view your claims or get benefit information, we invite you to visit us here:

Web site.....**bcbsnc.com/student**

Customer Service

For questions about your benefits or claims, claim form requests, to find a DENTIST, or to request pre-treatment estimates for services:.....1-800-305-6638 (toll free)

For questions about membership or to request a new ID CARD, claim form or benefit booklet:

.....1-800-579-8022 (toll free)

Or**email@studentbluenc.com**



SUMMARY OF BENEFITS

This section provides a summary of your Dental Blue benefits. A more complete description of your benefits is found in "COVERED SERVICES." Exclusions may also apply - please see "What Is Not Covered?" As you review the "Summary Of Benefits" chart, keep in mind:

- COINSURANCE percentages shown in this section are the portion of the ALLOWED AMOUNT that BCBSNC pays
- DEDUCTIBLE and COINSURANCE amounts are based on the ALLOWED AMOUNT

Please note: BCBSNC has contracted with certain PROVIDERS for DENTAL SERVICES. If you receive DENTAL SERVICES from PROVIDERS who have contracts with BCBSNC, you only pay the COINSURANCE amount and any applicable DEDUCTIBLE listed below. If you receive DENTAL SERVICES from PROVIDERS who do not contract with BCBSNC, in addition to the COINSURANCE and any DEDUCTIBLE listed below, you may be responsible for the difference between the PROVIDER'S actual charge and the ALLOWED AMOUNT. For a list of PROVIDERS who have contracted with BCBSNC, see our Web site at bcbsnc.com/student.

Benefit period - September 1, 2009 through August 31, 2010

	Benefits
<hr/>	
DENTAL SERVICES	
Diagnostic and Preventive Services	100%
Basic Services	80% after DEDUCTIBLE
Major Services	50% after DEDUCTIBLE
Individual Dental DEDUCTIBLE per BENEFIT PERIOD, includes basic and major services	\$50
Family Dental DEDUCTIBLE per BENEFIT PERIOD, includes basic and major services	\$150
BENEFIT PERIOD Maxium per individual, includes diagnostic and preventative, basic and major services	\$1,000
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HOW DENTAL BLUE WORKS

Dental Blue gives you the freedom to choose any PROVIDER. Please refer to "Summary Of Benefits" to see what DEDUCTIBLES or COINSURANCE will apply to your benefits. Also, see "Understanding Your Share Of The Cost" for an explanation of DEDUCTIBLES and COINSURANCE.

Prior to receiving services, you or your PROVIDER are encouraged to call BCBSNC Dental Blue Customer Service at the number given in "Whom Do I Call?" to obtain the criteria that BCBSNC uses to determine whether the recommended services are CLINICALLY NECESSARY and eligible for coverage. We encourage you to discuss the cost of services with your PROVIDER before receiving services so you will be aware of your total financial responsibility. You may be required to pay the difference between the PROVIDER'S actual charge and the BCBSNC ALLOWED AMOUNT if you receive DENTAL SERVICES from PROVIDERS who do not contract with BCBSNC.

Carry Your IDENTIFICATION CARD

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

If any information on your ID CARD is incorrect or if you need additional cards, please contact Dental Blue at email@studentbluenc.com or call the number listed in "Whom Do I Call?"

Making An Appointment

Call the PROVIDER'S office and identify yourself as a Dental Blue MEMBER. If you cannot keep an appointment, call the PROVIDER'S office as soon as possible. Charges for missed appointments, which PROVIDERS may require as part of their routine practice, are not covered.

How To File A Claim

If you choose contracting PROVIDERS, they will file claims for you. Otherwise, you may be responsible for paying for care at the time of service and filing claims for reimbursement. When you file a claim, mail the completed claim form to:

BCBSNC
Claims Unit
PO Box 2100
Winston Salem, NC 27102-2100

Mail claims in time to be received within 18 months of the date the service was provided. Claims not received within 18 months from the service date will not be covered, except in the absence of legal capacity of the MEMBER.

You may obtain a claim form by visiting Dental Blue's Web site at bcbnsnc.com/student, or calling the number listed in "Whom Do I Call?" For help filing a claim, contact Dental Blue or write to:

BCBSNC
Claims Unit
P.O. Box 2100
Winston Salem, NC 27102-2100

UNDERSTANDING YOUR SHARE OF THE COST

This section explains how you and BCBSNC share the cost of your dental care.

DEDUCTIBLES

A DEDUCTIBLE is the dollar amount you must incur for COVERED SERVICES in a BENEFIT PERIOD before benefits are payable by BCBSNC. Charges over the ALLOWED AMOUNT do not apply to your DEDUCTIBLE. If one or more DEPENDENTS are covered, you each have an individual DEDUCTIBLE and your family has a combined family DEDUCTIBLE. Refer to "Summary Of Benefits" for your DEDUCTIBLE amounts.

COINSURANCE

COINSURANCE is the sharing of charges by BCBSNC and the MEMBER for COVERED SERVICES, after you have satisfied your BENEFIT PERIOD DEDUCTIBLE.

Here is an example of what your costs could be for basic services from a PROVIDER who has a contract with BCBSNC, compared to a PROVIDER who does not contract with BCBSNC.

	Contracting	Not Contracting
A. Total Bill	\$550	\$550
B. ALLOWED AMOUNT	\$500	\$500
C. DEDUCTIBLE Amount	\$50	\$50
D. ALLOWED AMOUNT Minus DEDUCTIBLE (B-C)	\$450	\$450
E. Your COINSURANCE Amount (x% times D)	(20%) \$90	(20%) \$90
F. Amount You Owe Over ALLOWED AMOUNT	\$0 (charges limited to ALLOWED AMOUNT)	\$50 (difference between Total Bill and ALLOWED AMOUNT)
G. Total Amount You Owe (C+E+F)	\$140	\$190

COVERED SERVICES

Dental Blue covers only those services that are CLINICALLY NECESSARY.

Exclusions and limitations apply to your coverage. See "Benefits Limitations" and "What Is Not Covered?"

Your dental benefits provide coverage for diagnostic and preventive, basic, and major services. The chart below describes how your dental benefit plan works:

Type of Coverage	DEDUCTIBLE	WAITING PERIOD	BENEFIT PERIOD Maximum
Diagnostic and Preventive Services	no	no	yes
Basic Services	yes	no	yes
Major Services	yes	yes	yes

Diagnostic And Preventive Services

Many dental expenses result from problems that could have been prevented by regular checkups. Your dental plan helps you avoid such expenses by providing benefits for preventive services.

The following are COVERED SERVICES:

- Routine oral examinations (twice each BENEFIT PERIOD)
- Cleaning - prophylaxis, including scaling and polishing above the gum line (twice each BENEFIT PERIOD)
- X-rays
 - full-mouth or panoramic (limited to once every 36 months unless taken for diagnosis of third molars, cysts, or neoplasms)
 - supplemental bitewings - x-rays showing the back teeth (twice each BENEFIT PERIOD)
- Pulp-testing - evaluation of tooth nerve (limited to one charge per visit, regardless of the number of teeth tested)
- Topical fluoride application to prevent decay (twice each BENEFIT PERIOD, covered through age 18)
- Palliative EMERGENCY treatment for relief of pain only and EMERGENCY oral examinations, not including permanent restorations or services
- Sealants for first and second permanent molars for MEMBERS age 5 through 15 (one reapplication per tooth every 60 months).

Basic Services

The following are COVERED SERVICES:

- Routine fillings to restore diseased teeth
 - amalgam - a soft silver which hardens after it is packed into the cavity
 - composite resin or other tooth-colored filling materials
- Space maintainers - devices to keep space from closing after loss of a primary (baby) tooth so a permanent tooth will have room to grow (limited to DEPENDENTS through age 15)
- Simple extractions
- Oral surgery including surgical removal of teeth and maxillary or mandibular intrabony cysts and procedures performed for the preparation of the mouth for dentures
- Anesthesia when CLINICALLY NECESSARY and related to covered surgery
- Periapical x-ray of a tooth
- Stainless steel crowns

Major Services

A DENTIST may use an artificial device to restore your natural teeth or treat diseases of the gum and tissues around the teeth. Please note, treatment of crowns, bridges or gold restorations is deemed INCURRED when the tooth is prepared for the procedure.

The following are COVERED SERVICES:

COVERED SERVICES (cont.)

- Inlays - not part of a bridge (once every 60 months, covered only when a filling cannot restore the tooth)
- Onlays - not part of bridge (once every 60 months, covered only when a filling cannot restore the tooth)
- Full dentures (once every 60 months, no additional allowances for over-dentures or customized dentures)
- Partial dentures (once every 60 months, no additional allowances for precision or semi-precision attachments)
- Fixed bridges (once every 60 months)
- Denture relining done more than six months after the initial insertions (once each BENEFIT PERIOD)
- Fixed bridge and denture repairs (limited to repairs or adjustments done after 12 months following the initial insertion)
- Recementing of inlays, crowns and/or bridges
- Crowns not part of bridge (once every 60 months, covered only when a filling cannot restore the tooth)
- Endodontics - treatment of diseases of the nerve chamber and canals
 - pulpotomy - partial removal of a tooth's pulp and placement of medicament
 - root canal treatments
 - hemisection - dividing the crown and roots of a multi-rooted tooth
 - apicoectomy - removing the infected tip of the tooth's root.

Treatment of the diseases of the gums and bone surrounding the teeth is periodontics. The following are covered periodontal services:

- Gingival curettage - scraping or cleaning the inner gum tissues surrounding the teeth
- Gingivectomy and gingivoplasty - cutting out diseased or overgrown gum tissues around the teeth (once every 36 months per site or quadrant)
- Osseous surgery - removing or reshaping the bone around the teeth through an incision of the gum (once every 36 months per site or quadrant)
- Crown lengthening - reshaping the bone around the teeth to allow for proper prosthetic preparation (once every 36 months per site or quadrant)
- Mucogingivoplastic surgery - reconstructing the gum surface and mucous membrane
- Root planing and periodontal scaling - scraping to remove mineralized deposits and smooth rough, infected root surfaces (once per quadrant every 24 months)
- Periodontal maintenance (twice within 12 months)
- Periodontal exam and consultations (twice each BENEFIT PERIOD).

Alternate Course Of Treatment

In all cases involving services in which either you or your PROVIDER selects a course of treatment, benefits will be based on the procedures that are consistent with professional standards of dental practice for the dental condition.

Pre-Treatment Estimate Of Benefits

When the charges from a DENTIST for a proposed course of treatment are expected to be over \$250, a pre-treatment estimate of benefits is strongly recommended before any services are performed. You or your DENTIST can mail information to BCBSNC for a pre-treatment estimate of benefits. BCBSNC will provide information on the portion of the charges that will be allowed.

This chart lists documentation required for a pre-treatment estimate:

	Single Unit Fixed Restorations	Periodontics	Multiple Unit Fixed Restorations	Endodontics	Oral Surgery	Anesthesia
Description	- Crowns - Build-ups - Post and cores	- Root planing and osseous surgery	- Abutments - Pontics	Conventional endodontics on permanent teeth and retreatments	- Surgical extractions - Impactions	- General - IV sedation
Information Required for Claim Processing	Pre-operative x-ray(s)	- Pre-operative x-rays - Periodontal charting	Pre-operative x-rays (full arch)	Pre- and post-operative x-rays	Pre-operative x-ray(s)	- Type - Duration of agent

Please mail the information to:
BCBSNC
Claims Unit

PO Box 2100
Winston Salem, NC 27102-2100

When You File A Claim

In order to process your claim, BCBSNC may need information and require proof of the condition and treatment of your teeth or mouth. For example, BCBSNC may request your complete dental chart, including:

- Previous dental work
- Itemized bills
- Materials and treatment
- X-rays
- Lab report
- Casts, molds, photographs or study models.

Benefit Limitations

The following services are limited to benefits described below:

- Replacement of complete or partial dentures, fixed bridgework or crowns within 60 months of initial or supplemental placement.
- Denture relines for complete or partial conventional dentures are not covered for six months following the insertion of prosthesis. Tissue conditioning and soft and hard relines for immediate full and partial dentures are not covered for six months after insertion of the full or partial denture. After this specified WAITING PERIOD, relines are covered once every 12 months.
- One hard-tissue periodontal surgery and one soft-tissue periodontal surgery per surgical area are covered within a three-year period. This includes gingivectomy, gingivoplasty, gingival curettage (with or without a flap procedure), osseous surgery, pedicle grafts, and free soft tissue grafts.
- Osseous grafts, with or without resorbable or nonresorbable guided tissue replacement (GTR), are covered once every 36 months per quadrant or surgical site
- Retreatment of a previous root canal, unless the original root canal has been in place for at least 12 months
- Clinical situations that can be effectively treated by a more cost-effective, clinically acceptable, alternative procedure will be assigned a benefit based on the less costly procedure
- Full-mouth debridement is limited to once every 36 months.

WHAT IS NOT COVERED?

This section describes exclusions to your dental benefits, starting with general exclusions and then the remaining exclusions are listed in alphabetical order. In addition, limitations to certain benefits are described in "Benefit Limitations" on the previous page. Your dental benefit plan does not cover services, supplies, drugs or charges for:

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

Your dental benefit plan does not cover the following services, supplies, drugs or charges:

A

Acupuncture and acupressure

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

Costs in excess of the **ALLOWED AMOUNT**

Attachments to conventional removable prostheses or fixed bridgework, including semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature

B

Placement of fixed **bridgework** solely for the purpose of achieving periodontal stability

C

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

Services or supplies deemed not **CLINICALLY NECESSARY**

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

Treatment of **CONGENITAL malformations** of hard or soft tissue, including excision, except when procedures are performed in order to restore normal function to minor children with CONGENITAL defects and anomalies

Convenience items such as, but not limited to, devices and equipment used for environmental control, heating pads, hot water bottles, ice packs and personal hygiene items

COSMETIC or aesthetic services, except when procedures are performed in order to restore normal function to minor children with CONGENITAL defects and anomalies

WHAT IS NOT COVERED? (cont.)

Services received either before or after the **coverage period** of your dental 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, except as specifically covered by your dental benefit plan

D

Dental procedures not directly associated with dental disease

Placement of **dental implants**, implant-supported abutments and prostheses. Implant sites will be considered edentulous areas for claims processing purposes. This includes pharmacological regimens and restorative materials.

Drugs or medications, obtainable with or without a PRESCRIPTION, unless they are dispensed and utilized in the dental office during the patient visit

E

Services primarily for **educational** purposes including, but not limited to, books, tapes, pamphlets, seminars, classroom, Web or computer programs, individual or group instruction and counseling, except as specifically covered by your dental benefit plan

Equipment and devices used for environmental accommodation requiring vehicle and/or building modifications such as, but not limited to, chair lifts, stair lifts, home elevators, and ramps

EXPERIMENTAL procedures including pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics

F

Setting of **facial bony fractures** and any treatment associated with the dislocation of facial skeletal hard tissue

H

DENTAL SERVICES provided in a **HOSPITAL**

Hypnosis except when used for control of acute or chronic pain

I

Incision and drainage for an abscessed tooth if the tooth is removed on the same date of service

INVESTIGATIONAL services in nature or obsolete, including any service, drugs, procedure or treatment directly related to an INVESTIGATIONAL treatment

N

Treatment of malignant or benign **neoplasms**, cysts, or other pathology, except for excisional removal

Services that would not be necessary if a **noncovered service** had not been received, except for EMERGENCY SERVICES in the case of an EMERGENCY

O

Occlusal guards for any purpose other than control of habitual grinding

Orthodontic services

P

Fixed or removable **prosthodontic restoration** procedures for complete oral rehabilitation or reconstruction

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

WHAT IS NOT COVERED? (cont.)

- 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 dental care professional who is in training
- Is in a MEMBER'S immediate family

S

Services or supplies that are:

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

T

Temporomandibular joint (TMJ) treatment, either bilateral or unilateral

Travel, whether or not recommended or prescribed by a DOCTOR or other licensed dental care professional

V

Reconstruction of a patient's correct **vertical dimension of occlusion** (VDO), and related procedures

Vitamins, food supplements or replacements, nutritional or dietary supplements, formulas or special foods of any kind.

WHEN COVERAGE BEGINS AND ENDS

To be covered under this dental benefit plan:

- You must be a Teaching Assistant, Research Assistant, or Fellow and have paid the SHC fee, or
- You must be a Postdoc (code 27 or 28 and classified as temporary full-time), or
- You must be a registered student at the University of North Carolina who has paid the SHC fee

If you enroll during the Fall open enrollment period, your coverage begins on September 1, 2009.

There is no premium refunds except for students entering full-time active duty in any Armed Forces.

Eligible students must complete a new enrollment form in order to be covered for the following year.

Coverage For Your DEPENDENTS

For DEPENDENTS to be covered under this dental benefit plan, you must be covered and your DEPENDENT must be one of the following:

- Your spouse, under a legally valid, existing marriage between persons of the opposite sex
- Your same sex domestic partner, so long as you and your same sex domestic partner have attested to Dental Blue in writing to the following:
 1. That you and your same sex domestic partner are both mentally competent
 2. That you and your same sex domestic partner are both at least the age of consent for marriage in the state of North Carolina
 3. That you and your same sex domestic partner are not related by blood to a degree of closeness that would prohibit legal marriage in North Carolina
 4. That you and your same sex domestic partner are not married to anyone else
 5. That you and your same sex domestic partner are mutually responsible for the cost of basic living expenses as evidenced by joint home ownership, common investments, or some other similar evidence of financial interdependence
 6. That you and your same sex domestic partner live together and intend to do so permanently
 7. That you do not currently have a domestic partner covered under this dental benefit plan
 8. That you have not had a domestic partner covered under this dental benefit plan at any time within the past 12 months before adding this domestic partner unless the previous domestic partnership was terminated by death.

The conditions listed in 2-8 above must remain true and correct for your same sex domestic partner to remain an eligible DEPENDENT under the terms of this coverage.

- Your or your spouse's or your same sex domestic partner's unmarried DEPENDENT CHILDREN to the 1st day of the month following their 26th birthday, including newborn children from date of birth, stepchildren, adoptive children from date of placement for adoption and FOSTER CHILDREN from date of placement in the foster home
- An unmarried DEPENDENT CHILD who is either mentally retarded or physically handicapped and incapable of self-support may continue to be covered under the dental benefit plan regardless of age if the condition exists and coverage is in effect when the child reaches the age of 26. The handicap must be medically certified by the child's DOCTOR and may be verified annually by BCBSNC.

Enrolling In This Dental Benefit Plan

It is very important to enroll yourself or your DEPENDENTS when first eligible.

Adding Or Removing A DEPENDENT

Do you want to add or remove a DEPENDENT? You must notify Dental Blue and complete any required forms. To add a DEPENDENT, you must visit bcbsnc.com/student and complete the proper form within 30 days after the DEPENDENT becomes eligible. If you marry and want your spouse to be covered under this dental benefit plan, your spouse's coverage will be effective on the date of your marriage if you enroll your spouse within 30 days after your marriage.

If you are adding a newborn child, a child legally placed for adoption or a FOSTER CHILD, and adding the DEPENDENT CHILD would not change your coverage type or the premiums that are owed, the change will be effective on the date the child becomes eligible (the date of birth for a newborn, the date of placement for adoption for adoptive children, or the date of placement of a FOSTER CHILD in your home), if the birth or date of placement occurs after the coverage is effective. Notice is not required within 30 days after the child becomes eligible; however, it is important to provide notification as soon as possible.

WHEN COVERAGE BEGINS AND ENDS (cont.)

You may also remove DEPENDENTS from your coverage by writing Dental Blue and completing the proper form. DEPENDENTS must be removed from coverage when they are no longer eligible, such as when a child is no longer eligible due to age, marriage, or loss of full-time student status, or when a spouse is no longer eligible due to divorce or death.

Waiting Periods

You are a timely enrollee if you apply for dental coverage and/or add DEPENDENTS within a 30-day period of when you first become eligible for coverage under this dental benefit plan, or within 30 days following a qualifying event. Newborns added up to 30 days after their first birthday will have no WAITING PERIOD. Adoptive children, FOSTER CHILDREN and children who are added as a result of a court order are not subject to a WAITING PERIOD. For more information about enrolling DEPENDENTS, see "Adding Or Removing A Dependent." Once dental coverage has terminated, regardless of the reason, you may not re-enroll, unless a qualifying event occurs.

There is no WAITING PERIOD for members to receive benefits for diagnostic and preventive or basic services. However, there is a 6-month WAITING PERIOD for major services. WAITING PERIODS are waived for timely enrollees who can show proof of prior dental coverage. If a WAITING PERIOD applies, see the Dental Coverage chart in "COVERED SERVICES."

Types Of Coverage

These are the types of coverage available:

- Student-only coverage - The dental benefit plan covers only you
- Student-spouse coverage - The dental benefit plan covers you and your spouse or same sex domestic partner
- Student-children coverage - The dental benefit plan covers you and your DEPENDENT CHILDREN
- Family coverage - The dental benefit plan covers you, your spouse or same sex domestic partner and your DEPENDENT CHILDREN.

Reporting Changes

Have you moved, added or changed other dental coverage, changed your name or phone number? If so, contact Dental Blue at email@studentbluenc.com. It will help us give you better service if we are kept informed of these changes.

Termination Of MEMBER Coverage

A MEMBER'S termination shall be effective at 11:59 p.m. on the date that eligibility ends. **A MEMBER'S coverage will be terminated immediately by BCBSNC for the following reasons:**

- Fraud or material misrepresentation by the SUBSCRIBER or DEPENDENT
- A MEMBER has been convicted of (or a restraining order has been issued for) communicating threats of harm to BCBSNC personnel or property
- A MEMBER permits the use of his or her or any other MEMBER'S ID CARD by any other person not enrolled under this dental benefit plan, or uses another person's ID CARD.

UTILIZATION MANAGEMENT

BCBSNC has a UTILIZATION MANAGEMENT (UM) program which looks at whether DENTAL SERVICES are CLINICALLY NECESSARY, provided in the proper setting, and provided for a reasonable length of time.

Rights And Responsibilities Under The UM Program

Your MEMBER Rights

Under the UM program, you have the right to:

- A UM decision that is timely, meeting applicable state and federal time frames
- The reasons for BCBSNC's denial of a requested treatment or dental care service, including an explanation of the UM criteria and treatment protocol used to reach the decision
- Have a clinical director from BCBSNC make a final determination of all denials of service that were based upon CLINICAL NECESSITY
- Request a review of denial of benefit coverage through our GRIEVANCE process.
- Have an authorized representative pursue payment of a claim or make an appeal on your behalf.

An authorized representative may act on the MEMBER'S behalf with the MEMBER'S written consent. In the event you appoint an authorized representative, references to "you" under the "UTILIZATION MANAGEMENT" section mean "you or your authorized representative" (i.e., the authorized representative may pursue your rights and shall receive all notices and benefit determinations).

BCBSNC's Responsibilities

As part of all UM decisions, BCBSNC will:

- Limit what we request from you or your PROVIDER to information that is needed to review the service in question
- Request all information necessary to make the UM decision, including pertinent clinical information
- Provide you and your PROVIDER prompt notification of the UM decision consistent with North Carolina law and your dental benefit plan.

In the event BCBSNC does not receive sufficient information to approve coverage for a dental service within specified time frames, BCBSNC will notify you in writing that benefit coverage has been denied. The notice will explain how you may pursue a review of the UM decision.

Retrospective Reviews

BCBSNC reviews the coverage of DENTAL SERVICES after you receive them (retrospective reviews). Retrospective review may include a review to determine if services received in an EMERGENCY setting qualify as an EMERGENCY. BCBSNC will make all retrospective review decisions and notify you of its decision within a reasonable time but no later than 30 days from the date BCBSNC received the request. When the decision is to deny benefit coverage, BCBSNC will notify you and your PROVIDER in writing within five business days of the decision. All decisions will be based on CLINICAL NECESSITY and whether the service received was a benefit under this dental benefit plan. BCBSNC may take an extension of up to 15 days if additional information is needed. Before the end of the initial 30-day period, BCBSNC will notify you of the extension, the information needed, and the date by which BCBSNC expects to make a decision. You will then have 90 days to provide the requested information. As soon as BCBSNC receives the requested information, or at the end of the 90 days, whichever is earlier, BCBSNC will make a decision within 15 days

Evaluating New Technology

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

WHAT IF YOU DISAGREE WITH OUR DECISION?

In addition to the UM program, BCBSNC offers a GRIEVANCE procedure for our MEMBERS. GRIEVANCES include dissatisfaction with a claims denial or any of our decisions (including an appeal of a NONCERTIFICATION decision), policies or actions related to the availability, delivery or quality of DENTAL SERVICES.

If you have a GRIEVANCE, you have the right to request that BCBSNC review the decision through the GRIEVANCE process. The GRIEVANCE process is voluntary and may be requested by the MEMBER or an authorized representative acting on the MEMBER'S behalf with the MEMBER'S written consent. In the event you appoint an authorized representative, references to "you" under this section mean "you or your authorized representative" (i.e., the authorized representative may pursue your rights and shall receive all notices and benefit determinations).

Steps To Follow In The GRIEVANCE Process

For each step in this process, there are specified time frames for filing a GRIEVANCE and for notifying you or your PROVIDER of the decision. The review must be requested in writing, within 180 days of a denial of benefit coverage (the initial claim denial or the first level GRIEVANCE review decision). Any request for review should include:

- SUBSCRIBER'S ID number
- SUBSCRIBER'S name
- Any other information that may be helpful for the review.
- Patient's name
- The nature of the GRIEVANCE

To request a form to submit a request for review, you may contact Dental Blue at bcbsnc.com/student or call the number given in "Whom Do I Call?"

All correspondence related to a request for a review through BCBSNC's GRIEVANCE process should be sent to:
BCBSNC
Customer Service
PO Box 2291
Durham, NC 27702-2291

In addition, MEMBERS may also receive assistance with GRIEVANCES from the Managed Care Patient Assistance Program by contacting:

Managed Care Patient Assistance Program
Consumer Protection Division, Office of the Attorney General
9001 Mail Service Center
Raleigh, NC 27699-9001
Fax: 1-919-733-6276
Tel: 1-919-733-6272
Tel (toll free in NC): 1-866-867-6272
Email: MCPA @ncdoj.gov

First Level GRIEVANCE Review

BCBSNC will provide you with the name, address and phone number of the GRIEVANCE coordinator within three business days after receipt of a review request. BCBSNC will also give you instructions on how to submit written materials. For GRIEVANCES concerning quality of care, an acknowledgement will be sent by BCBSNC within five business days.

Although you are not allowed to attend a first level GRIEVANCE review, BCBSNC asks that you send all of the written material you feel is necessary to make a decision. BCBSNC will use the material provided in the request for review, along with other available information, to reach a decision. You will be notified in clear written terms of the decision, within a reasonable time but no later than 30 days from the date BCBSNC received the request. You may then request all information that was relevant to the review.

Second Level GRIEVANCE Review

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

- Name, address and telephone number of the GRIEVANCE coordinator
- A statement of your rights, including the right to:
 - request and receive from us all information that applies to your case
 - attend the second level GRIEVANCE review meeting
 - present your case to the review panel

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

- submit supporting material before and at the review meeting
- ask questions of any member of the review panel
- be assisted or represented by a person of your choosing, including a family member, a GROUP representative, or an attorney.

The second level review meeting, which will be conducted by a review panel coordinated by BCBSNC using external physicians and/or benefit experts, will be held within 45 days after BCBSNC receives a second level GRIEVANCE review request. You will receive notice of the meeting date and location at least 15 days before the meeting. You have the right to a full review of your GRIEVANCE even if you do not attend the meeting. A written decision will be issued to you within five business days of the review meeting.

If you have insurance-related problems or questions at any stage in the review process, you may contact the North Carolina Department of Insurance for assistance. Inquiries may be directed by calling 1-800-546-5664 or by writing to the:
North Carolina Department of Insurance
1201 Mail Service Center
Raleigh, NC 27699-1201

ADDITIONAL TERMS OF YOUR COVERAGE

Benefits To Which MEMBERS Are Entitled

The only legally binding benefits are described in this benefit booklet, which is part of the CONTRACT between BCBSNC and the GROUP. The terms of your coverage cannot be changed or waived unless BCBSNC agrees in writing to the change.

The benefits described in this benefit booklet are provided only for MEMBERS. These benefits and the right to receive payment cannot be transferred to another person. At the option of BCBSNC, payment for services will be made to the PROVIDER of the services, or BCBSNC may choose to pay the SUBSCRIBER.

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

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

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

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

BCBSNC's Disclosure Of Protected Health Information (PHI)

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

To obtain a copy of the privacy notice, contact Dental Blue at the number listed in "Whom Do I Call?"

PROVIDER Reimbursement

Benefits are paid based on the ALLOWED AMOUNT. MEMBERS are responsible for any amounts over the ALLOWED AMOUNT if services are performed by a PROVIDER who does not contract with BCBSNC, i.e. DEDUCTIBLES, COINSURANCE and charges not covered by BCBSNC, such as amounts above benefit maximums. MEMBERS are responsible for the full cost of noncovered services. PROVIDERS who do not contract, with BCBSNC may bill you directly. If you are billed, you will be responsible for paying the bill and filing a claim with BCBSNC.

BCBSNC Contract

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

Notice Of Claim

BCBSNC will not be liable for payment of benefits unless proper notice is furnished to BCBSNC that COVERED SERVICES have been provided to a MEMBER. If the MEMBER files the claim, written notice must be given to BCBSNC within 18 months after the MEMBER incurs the COVERED SERVICE, except in the absence of legal capacity of the MEMBER. The notice must be on an approved claim form and include the data necessary for BCBSNC to determine benefits.

Limitation Of Actions

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



Programs Outside Your Regular Benefits

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

- Wellness programs, including discounts on goods and services from other companies including certain types of PROVIDERS
- Clinical Opportunities Notification Program involves the analysis of claims and subsequent notification to PROVIDERS suggesting consideration of certain patient-specific treatment options along with medical literature addressing these treatment options
- Opportunities to qualify for gift items (such as exercise equipment and clothing) based on submitting activity diaries that record wellness and exercise activities or preventive health behaviors
- Quarterly, semi-annual, and/or annual drawings for gifts, which may include club memberships and trips to special events, based on submitting activity diaries
- Charitable donations made on your behalf by BCBSNC
- Discounts or other savings on retail goods and services.

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

ALLOWED AMOUNT

The charge that BCBSNC determines is reasonable for COVERED SERVICES provided to a MEMBER. This may be established in accordance with an agreement between the PROVIDER and BCBSNC. In the case of PROVIDERS that have not entered into an agreement with BCBSNC, the allowed amount will be the lesser of the PROVIDER'S actual charge or a reasonable charge established by BCBSNC using a methodology that is applied to comparable PROVIDERS for similar services under a similar dental benefit plan. BCBSNC's methodology is based on several factors including BCBSNC's medical, payment and administrative guidelines. Some procedures charged separately by the PROVIDER may be combined into one procedure for reimbursement purposes.

BENEFIT PERIOD

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

BENEFIT PERIOD MAXIMUM

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

CERTIFICATION

The determination by BCBSNC that services materials or drugs have been reviewed and, based on the information provided, satisfy our requirements for CLINICALLY NECESSARY services and supplies, appropriateness, dental care setting, level of care and effectiveness.

CLINICALLY NECESSARY (or CLINICAL NECESSITY)

Those COVERED SERVICES, materials or supplies that are:

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

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

COINSURANCE

The sharing of charges by BCBSNC and the MEMBER for COVERED SERVICES received by a MEMBER, usually stated as a percentage of the ALLOWED AMOUNT.

CONGENITAL

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

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 dental benefit plan. Any services in excess of a BENEFIT PERIOD MAXIMUM are not COVERED SERVICES.

DEDUCTIBLE

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

DENTAL SERVICE(S)

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

DENTIST

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

DEPENDENT

A MEMBER other than the SUBSCRIBER as specified in "When Coverage Begins And Ends."

DEPENDENT CHILD(REN)

The covered child(ren) of a SUBSCRIBER or spouse or same sex domestic partner up to the maximum DEPENDENT age, as specified in "When Coverage Begins And Ends."

EFFECTIVE DATE

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

EMERGENCY

Dental condition or symptom resulting from a dental disease which arises suddenly and, in the judgment of a reasonable person, requires immediate care and treatment and such treatment is sought or received within 24-hours of onset.

EXPERIMENTAL

See Investigational.

FOSTER CHILD(REN)

Children under age 18 i) for whom a guardian has been appointed by a clerk of superior court of any county in North Carolina or ii) whose primary or sole custody has been assigned by order of a court with proper jurisdiction and who are residing with a person appointed as guardian or custodian for so long as the guardian or custodian has assumed the legal obligation for total or partial support of the children with the intent that the children reside with the guardian or custodian on more than a temporary or short-term basis.

GRIEVANCE

Grievances include dissatisfaction with a claims denial or any of our decisions (including an appeal of a NONCERTIFICATION decision), policies or actions related to the availability, delivery or quality of health care services.

GROUP

UNC-CH Dental

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, or a state tax-supported institution. All services performed must be within the scope of license or certification to be eligible for reimbursement.

IDENTIFICATION CARD (ID card)

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

INCURRED

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

INVESTIGATIONAL (EXPERIMENTAL)

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

- a) Services or supplies requiring federal or other governmental body approval, such as drugs and devices that do not have unrestricted market approval from the Food and Drug Administration (FDA) or final approval from any other governmental regulatory body for use in treatment of a specified condition. Any approval that is granted as an interim step in the regulatory process is not a substitute for final or unrestricted market approval.
- b) There is insufficient or inconclusive scientific evidence in peer-reviewed medical literature to permit BCBSNC's evaluation of the therapeutic value of the service or supply
- c) There is inconclusive evidence that the service or supply has a beneficial effect on health outcomes
- d) The service or supply under consideration is not as beneficial as any established alternatives
- e) There is insufficient information or inconclusive scientific evidence that, when utilized in a non-investigational setting, the service or supply has a beneficial effect on health outcomes and is as beneficial as any established alternatives.

If a service or supply meets one or more of the criteria, it is deemed investigational except for clinical trials as described under this dental benefit plan. Determinations are made solely by BCBSNC after independent review of scientific data. Opinions of experts in

a particular field and/or opinions and assessments of nationally recognized review organizations may also be considered by BCBSNC but are not determinative or conclusive.

MEMBER

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

PROVIDER

An individual or entity, 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.

SUBSCRIBER

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

UTILIZATION MANAGEMENT (UM)

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

WAITING PERIOD

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

PRIVACY NOTICE

NOTICE OF PRIVACY PRACTICES
of
BLUE CROSS AND BLUE SHIELD OF NORTH CAROLINA
AND
PARTNERS NATIONAL HEALTH PLANS OF NORTH CAROLINA, INC.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Our Responsibilities

We are 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** or "**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 took effect on April 14, 2003** and will remain in place until we replace it.

We reserve the right to change this notice and our privacy practices at any time. 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 within 60 days of the time we make the change.

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 Web site, www.bcbsnc.com. For more information or questions about our privacy practices please contact the Privacy Official by writing to P. O. Box 2291, Durham, NC 27702.

How We Use and Disclose Your Protected Health Information

We may use and disclose your protected health information as permitted by federal and state privacy laws and regulations. We have described below how we are most likely to use and disclose your protected health information under these laws and regulations. Generally, we will only use and disclose your PHI as authorized by you or as permitted or required by law. If you cease to be a member, we will no longer disclose your PHI, except as permitted or required by law.

The federal health care privacy regulations known as "HIPAA" generally do not take precedence over state or other applicable privacy laws that provide individuals greater privacy protections. As a result, when a state law requires us to impose stricter standards to protect your health information, we will follow the state law rather than the HIPAA Privacy Regulations. For example, where such laws have been enacted, we will follow more stringent state privacy laws that relate to uses and disclosures of the protected health information

PRIVACY NOTICE

concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing or reproductive rights.

We may use and disclose your PHI for the following purposes:

Payment. We may use and disclose your PHI for payment purposes or to otherwise fulfill our responsibilities for coverage and providing benefits as established under your policy. For example, we may use or disclose your PHI to pay claims from your health care providers for their services that are covered under your health plan, determine your eligibility for benefits, coordinate benefits, determine the medical necessity of the treatment that you received or plan to receive, obtain premiums, issue explanations of benefits to the person who subscribes to the health plan in which you participate, and other purposes related to payment.

Health Care Operations. We may use and disclose your PHI to support our business functions. These functions include, but are not limited to: quality assessment and improvement, reviewing the competence or qualifications of your health care provider and evaluating the performance of your health care provider, conducting training programs, accreditation, certification, licensing or credentialing activities, rating our risk and determining our premiums for your health plan, medical review, legal services and auditing, business management and general administrative activities, including activities relating to privacy, customer service and resolution of grievances, business planning and business development. For example, we may use or disclose your PHI: (i) to inform you about one of our disease management programs; (ii) to respond to a customer service inquiry from you; (iii) in connection with fraud and abuse investigations and compliance programs; or (iv) to survey you concerning how effectively we are providing services. We may also disclose your PHI to the North Carolina Department of Insurance during a review of our health insurance operations. We may also disclose your PHI to non-affiliated third parties where allowed by law and as necessary to help us fulfill our obligations to you.

Your Authorization. You may give us written authorization to use or disclose your PHI for any purpose. If you give us an authorization, you may revoke it at any time by giving us written notice. Your revocation will not affect any use or disclosures permitted by your authorization while it is in effect. Without your authorization, we may not use or disclose your PHI for any reason except as described in this notice.

Your Family and Friends. We may disclose PHI to a family member, a friend or other persons whom you indicate are involved in your care or payment for your care. We may use or disclose your name, location and general condition or death to notify or help with notification of a family member, your personal representative, or other persons involved in your care. If you are incapacitated or in an emergency, we may disclose your PHI to these persons if we determine that the disclosure is in your best interest. If you are present, we will give you the opportunity to object before we disclose your PHI to these persons.

Your Health Care Provider. We may use and disclose your PHI to assist health care providers in connection with their treatment or payment activities. For example, we may disclose your PHI when needed by a health care professional to render medical treatment to you.

Underwriting. We may receive your PHI for underwriting, premium rating or other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits. We will not use or further disclose this PHI for any other purpose, except as required by law, unless the contract of health insurance or health benefits is placed with us. If the contract is placed with us, we will only use or disclose your PHI as described in this notice.

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Business Associates. We may contract with individuals and entities called business associates to perform various functions on our behalf or to provide services to you. To perform these functions or services, business associates may receive, create, maintain, use or disclose your PHI, but only after the business associate has agreed in writing to safeguard your PHI. For example, we may disclose your PHI to a business associate who will administer your health plan's prescription benefits, or perform preenrollment medical screenings.

Required by Law and Law Enforcement. We may use or disclose your PHI when we are required to do so by state or federal law. We are required to disclose your PHI to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining our compliance with federal privacy laws. We may disclose your PHI in connection with legal proceedings such as in response to an order from a court or administrative tribunal, or in response to a subpoena. We may also disclose your PHI for law enforcement purposes.

Abuse or Neglect. We may disclose your PHI to a government authority that is authorized by law to receive reports of abuse, neglect or domestic violence.

Workers' Compensation. We may disclose your PHI to comply with workers' compensation laws and other similar laws that provide benefits for work-related injuries or illnesses.

Public Health and Safety, Health Oversight Activities. We may use or disclose your PHI for public health activities for the purpose of preventing or controlling disease, injury or disability. We may also disclose your PHI to a health oversight agency for activities authorized by law such as audits, investigations, inspections, licensure or disciplinary actions.

Research. We may disclose your PHI to researchers when an institutional review board or privacy board has reviewed the research proposal and established protocols to protect the privacy of your PHI. We may also make limited disclosures of your PHI for actuarial studies.

Marketing. We may use your PHI to contact you with information about our health-related products and services, product enhancements or upgrades, or about treatment alternatives that may be of interest to you.

Employer or Organization Sponsoring A Group Health Plan. We may disclose your PHI and the PHI of others enrolled in your group health plan to the employer or other organization that sponsors your group health plan. Please see your group health plan document for a full explanation of the limited uses and disclosures that the plan sponsor may make of your PHI in providing plan administration. We may also disclose summary information about the enrollees in your group health plan to the plan sponsor to use to obtain premium bids for the health insurance coverage offered through your group health plan or to decide whether to modify, amend or terminate your group health plan.

Death and Organ Donation. We may disclose the PHI of a deceased person to a coroner, medical examiner, funeral director, or organ procurement organization to assist them in performing their duties.

Military Activity, National Security, Protective Services. If you are or were in the armed forces, we may disclose your PHI to military command authorities. We may also disclose your PHI to authorized federal officials for conducting national security and intelligence activities, and for the protection of the President of the United States, other federal officials or foreign heads of state.

PRIVACY NOTICE

Correctional Institutions. If you are an inmate, we may disclose your PHI to a correctional institution or law enforcement official for: (i) providing health care to you; (ii) your health and safety and the health and safety of others, or (iii) the safety and security of the correctional institution

Information We Collect About You

In the normal course of our operations, we may collect information from: (i) **You** (through information you give us on your applications for insurance or on other forms, through telephone or in-person interviews with you, and through information you provide to an insurance agent or your employer such as your address, telephone number, or your health status, or other types of insurance coverage you have; (ii) **Your Transactions** with us, such as your claims history; (iii) **Other Insurance Companies** that currently insure you or that have insured you in the past, such as your claims history; (iv) **Your Employer**, such as information your employer receives from you for purposes of eligibility for insurance coverage; or (v) **Your Health Care Providers** who currently treat you or have treated you in the past, such as information about your health status.

Our Policies for Protecting Your Protected Health Information

We protect the PHI that we maintain about you by using physical, electronic, and administrative safeguards that meet or exceed applicable law. When our business activities require us to provide PHI to third parties, they must agree to follow appropriate standards of security and confidentiality regarding the PHI provided. Access to your PHI is also restricted to appropriate business purposes.

We have developed privacy policies to protect your PHI. All employees receive training on these policies and they must sign a privacy acknowledgment form, binding them to abide by our policies and procedures.

In addition to these safeguards, we have developed a variety of other protections, including: (i) using only aggregate or non-identifiable information for research or quality measurement purposes whenever possible; (ii) using confidentiality provisions in our contracts with third parties to protect the confidentiality of your personal information and restrict use and disclosure of this information. (iii) restricting access to personal information through internal procedures and pass code access to computer systems; and (iv) restricting access to personal information by physical security measures in certain areas of our business operations, including employee badges, and restricted business areas.

YOUR RIGHTS

The following is a list of your rights with respect to your PHI.

Right to Access, Inspect and Copy Your PHI. You have the right to see or get a copy of the PHI that we maintain about you. Your request must be in writing. You may visit our office to look at the PHI, or you may ask us to mail it to you. We will charge a reasonable fee to cover the cost of copying the information. We will contact you to review the fee and obtain your agreement to pay the charges. If you wish to access your PHI, please call the number on the back of your identification card and request an access to PHI form.

Right To Correct, Amend or Delete Your PHI. You have the right to ask us to correct, amend or delete your PHI. Your request must be in writing. We are not required to agree to make the correction, amendment or deletion. For example, we will not generally make a correction, amendment or deletion if we did not create

PRIVACY NOTICE

the PHI or if we believe that the PHI is correct. If we deny your request, we will provide you a written explanation. You have the right to file a statement explaining why you disagree with our decision and setting forth what you believe is the correct, relevant and fair information. We will file the statement with your PHI and we will provide it to anyone who receives any future disclosures of your PHI. If we accept your request to correct, amend or delete your PHI, we will make reasonable efforts to inform others, including people you name, of the amendment and include the changes in any future disclosures of your PHI. If you wish to correct or amend your PHI, please call the telephone number on the back of your identification card and request an amendment of PHI form.

Right to Request an Accounting of Disclosures. You have a right to receive a list of certain instances in which we or our business associates disclosed your PHI for purposes other than our treatment, payment or health care operations and certain other activities. You are entitled to this accounting of disclosures for the six years prior to the date you make the request, but not for disclosures made before April 14, 2003. We will provide you with the date on which we made a disclosure, the name of the person or entity that received your PHI, a description of the PHI that we disclosed, the reason for the disclosure, and certain other information. If you request this list more than once in a 12-month period, we may charge you a reasonable fee for preparing the list. Your request must be in writing and you may call the number on the back of your identification card and request an accounting of disclosures form.

Right to Request Restrictions. You have the right to ask us to place additional restrictions on our use or disclosure of your PHI for our treatment, payment and health care operations. *We are not required to agree to these restrictions.* In most instances, we will not agree to these restrictions unless you have requested Confidential Communications as described below.

Right to Confidential Communications. If you believe that a disclosure of your PHI could endanger you, you may ask us to communicate with you confidentially at a different location. For example, you may ask us to contact you at your work address or other place instead of your home address. You may call the number on the back of your identification card to request a confidential communications form. Once we have received your confidential communications request, we will only communicate with you as directed on the confidential communications form, and we will also terminate any prior authorizations that you have filed with us.

Right to File a Privacy Complaint. You may complain to us if you believe that we have violated your privacy rights. You may also file a complaint with us by contacting the Privacy Official, P.O. Box 2291, Durham, NC 27702-2291. You may also file a complaint with the Secretary of the U. S. Department of Health and Human Services in Washington, D.C. We will not take any action against you or in any other way retaliate against you for filing a complaint with the Secretary or with us.

Right to Obtain a Copy of this Privacy Notice. You have a right to request a copy of this notice at any time by calling the number on the back of your identification card or you may obtain a copy from our Web site. Even if you agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.



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JOHN DOE
CAMPUS HEALTH CB 7470
CHAPEL HILL NC 27599

DENTALBlue[®]

**Member Guide for
JOHN DOE**

UNIVERSITY OF NORTH CAROLINA

**Group Effective Date:
September 1, 2009**



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