



North Carolina
State Health Plan

FOR TEACHERS AND STATE EMPLOYEES

A Division of the Department of State Treasurer

State Health Plan for Teachers and State Employees

**Consumer-Directed Health Plan
(CDHP)**

Benefits Booklet

January 1 – December 31, 2016



NCHEALTH
Smart

An initiative of the State Health Plan



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State Health Plan

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Consumer-Directed Health Plan (CDHP) Benefits Booklet

January 1 – December 31, 2016

Dear Member,

Welcome to the *State Health Plan for Teachers and State Employees*. To assist you in understanding your health care benefits, we have created the State Health Plan Benefits Booklet. This is your personal *member* guide with valuable information at your fingertips.

The Benefits Booklet will guide you through your plan information with ease. To help you locate what you need quickly, we have outlined the most commonly used sections below:

- Quick Reference – easy access to the information that is most frequently needed.
- CDHP Summary of Benefits – detailed information about your Consumer-Directed Health Plan (CDHP).
- How the CDHP Works – Important information about using your plan with your Health Reimbursement Account (HRA).
- *Covered Services* – information about your benefits, and exclusions and limitations.
- When Coverage Begins and Ends – information about your rights to Eligibility and COBRA continuation coverage, which is a temporary extension of coverage under the Plan.
- Value-Added Programs – information about discounts on certain *non-covered services* such as laser eye surgery and hearing aids.
- Privacy Notice – describes how medical information about you may be used and disclosed and how you can get access to this information.

For your convenience, we have additional ways for you to access your *member* information. Our website, www.shpnc.org, offers a variety of health-related resources – including online forms, search tools to help you find a *doctor*, and general information about your plan. Additionally, our prompt and knowledgeable Customer Service department is just a phone call away at **888-234-2416**.

We are happy to have you as a *member* of the State Health Plan.

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Quick Reference – Toll Free Phone Numbers, Websites and Addresses

Quick Reference – Toll Free Phone Numbers, Websites and Addresses

SERVICES AND INFORMATION

State Health Plan Website www.shpnc.org	To obtain information on Pharmacy benefits, search for a provider, obtain claim forms, obtain "proof of coverage" portability certificates, NC HealthSmart and more.
Blue Connect® www.shpnc.org	To enroll in a safe, secure customer service website in order to: Check claim status, verify benefits and eligibility, check your HRA balance, change your address or request a new <i>Identification Card (ID card)</i> . (Note: Blue Connect formerly known as My Member Services.)
State Health Plan Customer Service 888-234-2416 8 a.m.-6 p.m., Monday-Friday, except holidays	For questions regarding your benefits, claim inquiries and new <i>ID card</i> requests.
State Health Plan Eligibility and Enrollment Center 855-859-0966 8 a.m.-5 p.m., Monday-Friday, except holidays	For questions regarding <i>member</i> eligibility and enrollment.
COBRA Administration and Individual Billing Services Customer Service 877-679-6272 8 a.m.-5 p.m., Monday-Friday, except holidays	For questions relating to premium payments for Retirees/COBRA/Surviving Spouses.
Express Scripts Customer Service 800-336-5933 24 hours a day, 7 days per week, except for Thanksgiving and Christmas day	For questions regarding your <i>prescription</i> benefits, to obtain a preferred drug list, information on <i>prior authorizations</i> , refills, and more.
Accredo Specialty Pharmacy 877-988-0059	For information regarding the specialty pharmacy services offered or to obtain <i>specialty medications</i> .
NC HealthSmart To speak with a Health Coach: 800-817-7044 Monday-Friday 8:30 a.m.-11 p.m. Saturday 9 a.m.-2 p.m. www.shpnc.org click on NC HealthSmart	For information on wellness, disease prevention and chronic illness management for you and your family. Coaches are available to assist <i>members</i> with complex medical needs, multiple hospitalizations and who are expecting a baby.
24hr Nurseline Available 7 days a week 800-817-7044	Quick answers to medical concerns.
NC Tobacco Use Quitline (QuitlineNC) 800-QUIT-NOW (800-784-8669) 8 a.m.-3 a.m., 7 days per week	For tobacco cessation assistance including obtaining nicotine replacement therapy.

Quick Reference – Toll Free Phone Numbers, Websites and Addresses

BlueCard® PPO Program To find a participating provider outside of North
800-810-2583 (Inside USA) Carolina and worldwide.
804-673-1177 (Call collect outside USA)

PRIOR AUTHORIZATION (CERTIFICATION)

Certification To request *prior authorization (certification)* for
800-672-7897 certain *out-of-network* or out-of-state services.

Express Scripts - Prior Authorization Number To initiate a *prior authorization* request for
800-417-1764 a *prescription drug*.

Mental Health Case Manager: For mental health and *chemical dependency prior*
800-367-6143 *review* and *certification* available 24 hours a day, 7
days per week.

Mental Health TTY (Teletypewriter) Services for the speech and hearing impaired are
866-835-2755 available.

CLAIMS FILING

Medical Claims Filing Mail completed medical claims to:
State Health Plan
c/o BCBSNC
PO Box 30087
Durham, NC 27702

Prescription Drug Claims Filing Mail completed *prescription drug*
claim forms to:
Express Scripts, Inc.
ATTN: Direct Claims
P.O. Box 2824
Clinton, IA 52733-2824

APPEALS

Medical and Pharmacy Appeals See "*Appeals Correspondence*" in "What If You
888-234-2416 Disagree With A Decision?"

Mental Health Appeals See "*Appeals Correspondence*" in "What If You
800-367-6143 Disagree With A Decision?"

ADDITIONAL RESOURCES

N.C. Department of State Treasurer If you are a benefit recipient (*Retirees,*
Retirement System Division Beneficiaries, Disability recipients) and you have
325 North Salisbury Street questions about your retirement benefits.
Raleigh, NC 27603-1385
919-733-4191 or 877-733-4191 toll-free
www.myncretirement.com

Quick Reference – Toll Free Phone Numbers, Websites and Addresses

NC HealthSmart Kidney Disease Specialty Case Managers are available to assist
Care Management *members* with Chronic Kidney Disease (CKD) and
800-817-7044 End Stage Renal Disease (ESRD).

VALUE-ADDED PROGRAMS

Not all plans have access to Value-Added programs. These programs are not covered benefits and are outside of the Plan. To see if you are eligible for these programs, talk to your *Health Benefits Administrator*. BCBSNC does not accept claims or reimburse for these goods or services and MEMBERS are responsible for paying all bills. The *Health Benefits Administrator* and BCBSNC may change or discontinue these programs at any time.

TruHearingSM For information about discounts on hearing aids,
1-877-343-0745 call or visit mybcbsnc.com.
1-800-975-2674
(TTY toll-free)

Blue365TM Health and wellness information support and
1-855-511-2583 services, and special MEMBER savings available
8 a.m. - 6 p.m. Monday-Friday, except holidays 365 days a year.

Davis Vision[®] For information about discounts on corrective laser
1-888-897-9350 eye surgery, call or visit mybcbsnc.com.
8 a.m. - 11 p.m. Monday-Friday
9 a.m. - 4 p.m. Saturday
12 p.m. - 4 p.m. Sunday

Tips for Getting the Most out of Your Health Care Benefits

Tips for Getting the Most out of Your Health Care Benefits

Understand your health care plan

The more you know about your benefits, the easier it will be to take control of your health. Let the *State Health Plan* help you understand your plan and use it effectively through our customer friendly website (www.shpnc.org), toll free Customer Service line (888-234-2416), and your benefits booklet.

Manage your out-of-pocket costs by managing the locations in which you receive care

Generally speaking, care received in a *doctor's* office is the most cost effective for you, followed by *hospital outpatient* services. *Hospital* and *emergency* room services often bear the highest cost. In addition, remember that *in-network* care (services from a Blue Options participating *provider* who agrees to charge specified rates) will cost you less than similar care provided by an *out-of-network provider*. You should ask the receptionist whether the *provider's* office is *hospital* owned or operated, or provides *hospital* based services. This may subject your *medical services* to the *Outpatient Services* benefit, which requires *deductibles* and *coinsurance*. Know what your financial responsibility is before receiving care.

Save on prescription drugs

Print out the preferred drug list and take it with you when visiting your *doctor*. Ask your *doctor* to authorize a *generic* substitute whenever a *generic* is available. You will save money using *generics* since they typically have the lowest *coinsurance*. When there is more than one *brand name* drug available for your medical condition, it is suggested that you ask your physician to prescribe a drug in Tier 2.

Pick a Primary Care Provider

While your health benefit plan does NOT require you to have a *Primary Care Provider*, we strongly urge you to select and use one. A *Primary Care Provider* informs you of your health care options, documents your care, and maintains your records for you. In addition, they save you time and unnecessary additional costs by recommending appropriate *specialists*, coordinating your care with them, and informing them of things such as your medical history and potential drug interactions.

Take charge of your health

NC HealthSmart — is a health resource for you and your family. Use a full range of tools to help maintain/improve your health and ensure the best outcomes for chronic conditions. NC HealthSmart offers tools and qualified staff to work with you to maximize your health resources and your interactions with your *provider* including:

- Health Coaches - Available Monday-Friday 8:30 a.m.-11 p.m., Saturday 9a.m.-2p.m. to provide support on wellness and health management
- Personal Health Portal- Find personalized information, prevention tips, lifestyle change suggestions and healthy living ideas for your health and wellness to make the information work for your life
- Worksite Wellness Programs - Tap into wellness choices at work! Stay healthy at home and at work
- Case and Disease Management Services- Get assistance with chronic conditions such as diabetes, with Chronic Kidney Disease (CKD), or End Stage Renal Disease (ESRD), multiple hospitalizations or a sudden catastrophic event

Member Rights and Responsibilities

Member Rights and Responsibilities

As a State Health Plan member, you have the right to:

- Receive, upon request, information about your health benefit plan including its services and *doctors*, a benefits booklet, benefit summary and directory of *in-network* providers
- Receive courteous service from the State Health Plan and its representatives
- Receive considerate and respectful care from your *in-network providers*
- Receive the reasons for the denial of a requested treatment or health care service, including (upon request) an explanation of the Utilization Management criteria and treatment protocol used to reach the decision
- Receive (upon request) information on the procedure and medical criteria used to determine whether a procedure, treatment, facility, equipment, drug or device is investigational, *experimental* or requires prior approval
- Receive accurate, reader friendly information to help you make informed decisions about your health care
- Expect that measures will be taken to ensure the confidentiality of your health care information
- File a *grievance* and expect a fair and efficient *appeals* process for resolving any differences you may have with the coverage determination of your health benefit plan
- Be treated with respect and recognition of your dignity and right to privacy
- Voice complaints or *appeals* about the organization or the care it provides
- Make recommendations regarding the organization's members' rights and responsibilities policies

As a State Health Plan member, you have the responsibility to:

- Present your *ID card* each time you receive services
- Give your *doctor* permission to ask for medical records from other *doctors* you have seen. You will be asked to sign a transfer of medical records authorization form
- Read your benefits booklet and all other member materials
- Call State Health Plan Customer Service if you have a question or do not understand the material provided by them
- Follow the course of treatment prescribed by your *doctor*. If you choose not to comply, tell your *doctor*
- Provide complete information about any illness, accident or health care issues to the State Health Plan or its representatives and providers
- Make and keep appointments for non-*emergency* medical care. If it is necessary to cancel an appointment, give the *doctor's* office adequate notice
- Ensure any advance *certifications* have been received for out-of-network services (see "Prospective Reviews" section for information on *certifications*)
- File claims for out-of-network services in a complete and timely manner
- Participate in understanding your health problems and the medical decisions regarding your health care
- Be considerate and courteous to Blue Options providers, their staff and State Health Plan representatives

Member Rights and Responsibilities

- Notify your employer and the *State Health Plan* if you have any other group coverage or become eligible for Medicare
- Notify your employer and the *State Health Plan* of any changes regarding *dependents* as soon as possible
- Notify your employer and the *State Health Plan* if you have a change in marital status as soon as possible
- Use *Blue Connect* to manage claims and related benefit issues
- Protect your *ID card* from unauthorized use
- Notify your employing unit and the *State Health Plan* of any address or phone number changes

Important Notices

Important Notices

According to the applicable provisions and limitations of North Carolina General Statutes Chapter 135, the State of North Carolina provides health care benefits to North Carolina teachers, state *employees*, retirees, members of boards and commissions, and their eligible *dependents*, as well as others eligible such as *employees* of certain counties and municipalities, firemen, rescue squad or *emergency* medical workers, members of the North Carolina Army and Air National Guard, and their eligible *dependents*. These provisions authorize the offering of an optional health plan, which is being offered in the form of a Consumer-Directed Health Plan (CDHP) and which is outlined in this booklet.

The information contained in this booklet is supported by medical policies which are used as guides to make coverage determinations.

For specific detailed information, or medical policies, please call Customer Service at 888-234-2416, or visit the State Health Plan website at www.shpnc.org. To obtain a copy of the General Statutes visit the North Carolina General Assembly at www.ncga.state.nc.us and search for Article 3B in Chapter 135.

Benefits Booklet

This benefits booklet describes the State Health Plan for Teachers and State *Employees* Consumer-Directed Health Plan (CDHP) known as your health benefit plan. Blue Cross and Blue Shield of North Carolina provides administrative services only and does not assume any financial risk or obligation with respect to claims.

Please read this benefits booklet carefully so that you will understand your benefits. Your *doctor* or medical professional is not responsible for explaining your benefits to you.

The benefit plan described in this booklet is subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). A summary of benefits, conditions, limitations and exclusions is set forth in this benefits booklet for easy reference.

If any information in this booklet conflicts with North Carolina state law or it conflicts with medical policies adopted under your health benefit plan, North Carolina law will prevail, followed by medical policies. If any of the Blue Cross and Blue Shield of North Carolina medical policies conflict with the State Health Plan medical policies, the State Health Plan medical policies will be applied.

Notice Regarding Wellness Incentives

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all *employees*. A reasonable alternative to smoking status (participation in a smoking cessation program) has been provided to you. If your physician recommends a different alternative because he believes the program we make available is not medically appropriate, that recommendation may be accommodated to enable you to achieve the reward. Contact us at 855-859-0966 to make an accommodation request.

Introduction to the Consumer-Directed Health Plan

Introduction to the Consumer-Directed Health Plan

Welcome to the State Health Plan's Consumer-Directed Health Plan (CDHP), also referred to in this benefits booklet simply as your health benefit plan, or the CDHP. Your health benefit plan is offered under a Blue Options Plan administered by Blue Cross Blue Shield of North Carolina (BCBSNC).

The State Health Plan has contracted with BCBSNC to use its Blue Options network. As a member of the CDHP, you will enjoy quality health care from the Blue Options network of health care providers and easy access to specialists.

Aviso Para Miembros Que No Hablan Ingles

Este folleto de beneficios contiene un resumen en inglés de sus derechos y beneficios cubiertos por su Plan de beneficios de salud. Si usted tiene dificultad en entender alguna sección de este folleto, por favor llame al departamento de Atención al Cliente para recibir ayuda.

Consumer Directed Health Plan (CDHP) Summary of Benefits

Consumer-Directed Health Plan (CDHP) Summary of Benefits

The following is a summary of your Consumer-Directed Health Plan (CDHP) benefits. A more complete description of your benefits is found in "*Covered Services*." General exclusions may also apply. Please see "What is not Covered?" As you review the Summary of Benefits chart, keep in mind:

- This plan offers Wellness Premium Credits and Wellness Incentives to encourage decisions that are good for your health.
- There are no copayments with this plan.
- *Coinsurance* percentages shown in this section are the portion of the *allowed amount* that you pay.
- *Deductible* and *coinsurance* amounts are based on the *allowed amount*.
- Services applied to the *deductible* also count toward any visit or day maximums.
- If your benefit level for services includes *deductibles* and *coinsurance*, your provider may collect an estimated amount of these at the time you receive services.
- To receive *in-network* benefits, you must receive care from a Blue Options *in-network provider*. However, in an *emergency*, or when *in-network providers* are not reasonably available as determined by BCBSNC's access to care standards, you may also receive *in-network* benefits for care from an out-of-network provider. Please see "Out-of-Network Benefits" and "*Emergency and Urgent Care Services*" for additional information on *emergency* care. Access to care standards are available on our website at www.shpnc.org or by calling the State Health Plan Customer Service number given in "Whom Do I Call?"
- If you see an out-of-network provider, you will receive out-of-network benefits unless otherwise approved by the State Health Plan or its representative.
- Out-of-Network Labs: If your provider sends your lab work to an out-of-network lab for processing, your claims will no longer be paid at the in-network coinsurance. Your claims for these services will be paid at the appropriate out-of-network coinsurance. This may result in you having to pay more for out-of-network lab work. Talk to your provider to ensure they are using Blue Cross and Blue Shield of North Carolina in-network labs.
- To receive Wellness Premium Credits, you must choose which Wellness Activities you would like to participate in during Open Enrollment, Annual Enrollment or when enrolling within 30 days of a qualifying event.
- To receive Wellness Incentive credits into your Health Reimbursement Account (HRA), you must use the Primary Care Provider (PCP) on your member identification (ID) card, or you must receive care from a *Blue Options Designated provider*.
- Preventive Care is covered at 100% so long as utilization management requirements (if applicable) are met.

Please note the list of in-network providers may change from time to time, so please verify that the provider is still in the Blue Options or Blue Options Designated network before receiving care. A Provider locator is available through our website at www.shpnc.org or by calling State Health Plan Customer Service at the number given in "Whom Do I Call?"

Consumer Directed Health Plan (CDHP) Summary of Benefits

	<i>In-Network</i>	<i>Out-of-Network*</i>
<i>Lifetime Maximum, Deductible, and Total Out-Of-Pocket Maximum</i>		
<i>Lifetime Maximum</i>	Unlimited	Unlimited
Unlimited for all services, except where otherwise indicated or excluded.		
<i>Deductible</i>		
Individual, per <i>benefit period</i>	\$1,500	\$3,000
Family, per <i>benefit period</i>	\$4,500	\$9,000
Charges for the following do not apply to the <i>benefit period deductible</i> :		
<ul style="list-style-type: none"> • <i>Preventive Care</i> as defined by the <i>Affordable Care Act</i> • <i>CDHP Preventive Medications</i> • <i>In-Network</i> services do not apply to the <i>Out-of-Network deductible</i>. 		
<i>Total Out-of-Pocket Maximum</i>		
Individual, per <i>benefit period</i>	\$3,500	\$7,000
Family, per <i>benefit period</i>	\$10,500	\$21,000
Charges over <i>allowed amounts</i> and charges for <i>noncovered services</i> do not apply to the total out-of-pocket maximum. The total out-of-pocket maximum, which is the <i>deductible</i> plus the <i>coinsurance</i> you pay, is the total amount you will pay for <i>covered services</i> .		
<i>Preventive Care</i>		
Preventive Care Services	100%	65% after <i>deductible</i>
Available in an office-based, outpatient, or ambulatory surgical setting, or urgent care center. Services include: routine physical exams and screenings, well-baby care, well-child care, well-woman care, immunizations, nutritional counseling (regardless of diagnosis), gynecological exams, cervical cancer screening, ovarian cancer screening, mammograms (regardless of diagnosis), colorectal screening, bone mass measurement, prostate-specific antigen tests, and newborn hearing screening.		
This benefit is only for services that indicate a primary diagnosis of preventive or wellness. Please visit the Plan's website at www.shpnc.org for the most up-to-date information on preventive care covered under federal law.		
<i>Provider's Office</i>		
Office visits for the evaluation and treatment of obesity are limited to a combined in- and out-of-network maximum of four visits per <i>benefit period</i> . Any visits in excess of these <i>benefit period maximum</i> are not <i>covered services</i> .		
<i>Office Visit Services</i>		
This includes: office surgery, X-rays, diagnostic imaging and lab tests.		
<i>Primary Care Provider or Specialist</i>	15% after <i>deductible</i> \$25 added into your HRA when using <i>PCP</i> listed on <i>ID card</i> \$20 added into HRA when a <i>Blue Options Designated provider</i> is utilized	35% after <i>deductible</i>
<i>Therapy Services</i>		
<i>Short-Term Rehabilitative Therapies</i>	15% after <i>deductible</i>	35% after <i>deductible</i>
Short-Term Rehabilitative Therapies include chiropractic care, occupational therapy, and physical therapy. Combined in-and out-of-network benefit maximums apply to chiropractic services. There is a 30 visit limit per benefit year for chiropractic care which includes occupational therapy, and physical therapy visits. Any visits in excess of this benefit period maximum are not covered services.		

Consumer Directed Health Plan (CDHP) Summary of Benefits

Other Therapies	15% after <i>deductible</i>	35% after <i>deductible</i>
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Includes chemotherapy, dialysis and cardiac rehabilitation provided in the office.

Infertility Services

<i>Primary Care Provider or Specialist</i>	15% after <i>deductible</i>	35% after <i>deductible</i>
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Combined in- and out-of-network limit of 3 ovulation induction cycles and associated services per lifetime. Any services in excess of this lifetime limit are not *covered services*.

Urgent Care Centers and *Emergency Room*

Urgent Care Centers	15% after <i>deductible</i>	15% after <i>deductible</i>
<i>Emergency Room Visit</i>	15% after <i>deductible</i>	15% after <i>deductible</i>

Ambulatory Surgical Center

Ambulatory Surgical Services	15% after <i>deductible</i>	35% after <i>deductible</i>
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Outpatient

Outpatient Services	15% after <i>deductible</i>	35% after <i>deductible</i>
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Includes physician services, *hospital* and *hospital*-based outpatient clinic services, outpatient diagnostic services, and therapy services including short-term rehabilitative therapies, and other therapies including dialysis. See provider's office for visit maximums.

Inpatient

<i>Inpatient Services</i>	15% after <i>deductible</i> \$200 added into HRA when a Blue Options Designated <i>hospital</i> is utilized	35% after <i>deductible</i>
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Includes physician services, *hospital* and *hospital*-based services, and maternity delivery, prenatal and post-delivery care. If you are in a *hospital* as an *inpatient* at the time you begin a new *benefit period*, you may have to meet a new deductible for *covered services* from *doctors* or other professional providers.

Skilled Nursing Facility

	15% after <i>deductible</i>	35% after <i>deductible</i>
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Combined in- and out-of-network maximum of 100 days per *benefit period*. Services applied to the deductible count towards this day maximum. Any services in excess of this *benefit period maximum* are not *covered services*.

Other Services

	15% after <i>deductible</i>	15% after <i>deductible</i>
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Includes *ambulance*, *durable medical equipment*, *hospice* services, medical supplies, orthotic devices, private duty nursing, prosthetic appliances, and *home health care*. Orthotic devices for correction of positional plagiocephaly are limited to one per lifetime. Hearing aids are limited to one per hearing-impaired ear every 36 months for members under the age of 22. Any services in excess of these benefit period or lifetime maximums are not *covered services*.

Mental Health and Substance Abuse Services

Mental Health Office Services	15% after <i>deductible</i>	35% after <i>deductible</i>
Mental Health <i>Inpatient/Outpatient Services</i>	15% after <i>deductible</i>	35% after <i>deductible</i>
Substance Abuse Office Services	15% after <i>deductible</i>	35% after <i>deductible</i>
Substance Abuse <i>Inpatient/Outpatient Services</i>	15% after <i>deductible</i>	35% after <i>deductible</i>

Prescription Drugs

Prescription drug benefits are administered by Express Scripts. See "*Prescription Drug Coinsurance and Benefits*" in "*Covered Services*" for more information.

Consumer Directed Health Plan (CDHP) Summary of Benefits

	<i>In-Network</i>	<i>Out-of-Network*</i>
Prescription Drugs (<i>Generic, Brand-Name, and Specialty Drugs</i>) Diabetic Supplies	15% <i>coinsurance</i> after <i>deductible</i>	35% <i>coinsurance</i> after <i>deductible</i>
<i>Affordable Care Act Preventive Medications</i>	0% <i>coinsurance</i>	0% <i>coinsurance</i>
<i>CDHP Preventive Medications</i>	15% <i>coinsurance</i> , no <i>deductible</i> required	15% <i>coinsurance</i> , no <i>deductible</i> required

A list of *Affordable Care Act Preventive Medications* is on the Plan's website at www.shpnc.org.

A list of *CDHP Preventive Medications* is on the Plan's website at www.shpnc.org under Pharmacy Benefits.

NOTICE: All non-acute specialty drugs covered under the pharmacy benefit, excluding cancer medications, must be obtained through Accredo Specialty Pharmacy.

Certification Requirements

In-network providers outside of North Carolina, except for Veterans Affairs (VA) and military providers, are responsible for requesting prior review for inpatient facility services. For all other covered services received outside of North Carolina, you are responsible for ensuring that you or your provider requests prior review by the State Health Plan even if you see an in-network provider.

Certain services, regardless of the location, require prior review and *certification* in order to receive benefits. If you go to an *in-network provider* in North Carolina, your provider will request prior review when necessary. If you go to an out-of-network provider in North Carolina or to any provider outside of North Carolina, you are responsible for requesting or ensuring that your provider requests prior review. Failure to request prior review and receive *certification* will result in full denial of benefits. See "Covered Services" and "Prior Review (pre-service)" in "Utilization Management." The Plan delegates administration of your mental health and substance abuse benefits to the Plan's Mental Health Case Manager. Prior review and *certification* by the Plan's Mental Health Case Manager are required for *inpatient* and certain outpatient mental health and substance abuse services received from an *in-network provider*, except for *emergencies*. Please see the number in "Whom to Call?" For *certification* for certain *prescription drugs*, your physician may call Express Scripts at 800-417-1764 to initiate a *certification* request.

NOTICE: Your actual expenses for *covered services* may exceed the stated *coinsurance* amount because actual *provider* charges may not be used to determine the plan's and *member's* payment obligations. For *out-of-network* benefits, you may be required to pay for charges over the *allowed amount* in addition to any *deductible* and *coinsurance* amount.

Whom Do I Call?

State Health Plan Website

To obtain information on Pharmacy benefits, search for a *provider*, obtain claim forms, obtain "proof of coverage" portability certificates, NC HealthSmart and more, visit the *State Health Plan* website at:
www.shpnc.org

NC HealthSmart

For information on wellness, disease prevention and chronic illness management for you and your family.
NC HealthSmart Health Coach and 24hr Nurseline800-817-7044
QuitlineNC.....800-784-8669

Blue Connect®

To register for online services that will allow you to check claim status, verify benefits and eligibility, change your address, or request a new *ID card*, visit: **www.shpnc.org** and click **Blue Connect under Quick links**.

State Health Plan Customer Service

For questions relating to your benefits, claims inquiries, new *ID card* requests, or call:
State Health Plan Customer Service..... 888-234-2416

Eligibility and Enrollment Support Center

For questions related to eligibility and enrollment call.....855-859-0966

COBRA Administration and Individual Billing Services Customer Service

For questions relating to premium payments for *Retirees/COBRA/Surviving Spouses*.....877-679-6272

Mental Health and Chemical Dependency Services

The *Mental Health Case Manager* (MHCM) for the *State Health Plan* administers these benefits. You must contact this vendor directly in advance for *prior review* for certain services.
Mental Health Case Manager:.....800-367-6143

Pharmacy Benefit Manager

The current *Pharmacy Benefit Manager (PBM)* is:
Express Scripts.....800-336-5933
Express Scripts Prior Authorization.....800-417-1764
Accredo Specialty Pharmacy877-988-0059

For information regarding the specialty pharmacy services offered or to obtain *specialty medications*.

Out of North Carolina Care

For assistance in obtaining care outside of North Carolina, including outside of the U.S., visit the national BCBS website at www.bcbs.com or call:800-810-2583
BlueCard® (call collect outside USA).....804-673-1177

Prior Review

Some services require *prior review* and *certification* by the *State Health Plan* or its representative. The list of these services may change from time to time. Please visit our website at www.shpnc.org or call *State Health Plan* Customer Service at the number given above for current information about which services require *prior review*. See "Prospective Review/Prior Review" in "Utilization Management" for information about the review process. To request *prior review*, call:
Prior Review (Certification)800-672-7897

How the CDHP Works

The CDHP gives you the freedom to choose any provider — the main difference will be the cost to you depending on whether you see an *in-network* or out-of-network provider. There is also opportunity for additional contributions to your HRA by participating in wellness incentives.

Wellness Activities

During Open Enrollment, Annual Enrollment, or when enrolling within 30 days of being first eligible, you have the option to complete up to three wellness activities. Wellness premium credits lower your monthly *employee-only* premium. See Wellness Premium Credits below. You can do one, two, or all three activities. The more you complete, the lower your premium will be. The wellness activities are:

Wellness Activity #1: Quit Smoking

During Open Enrollment, Annual Enrollment or when enrolling within 30 days of being first eligible, you (and your spouse, if covered on the health plan) will need to attest that you do not smoke or will commit to a smoking cessation program by the start of the benefit year or, if enrolling during the benefit year, within 45 days of enrollment. You will need to log into your enrollment system to complete the attestation. Completing this attestation during enrollment will save you \$20 per month off of your *employee-only* premium.

Wellness Activity #2: Take a Health Assessment

During Open Enrollment, Annual Enrollment or when enrolling within 30 days of being first eligible, you will need to complete a brief confidential *Health Assessment*. The questions are regarding your overall health and lifestyle, your health history, work and daily life routines. You are asked to provide certain measures, such as your height and weight, blood pressure, total cholesterol, LDL (low-density lipoprotein), HDL (high-density lipoprotein), triglycerides, and blood sugar level. The *Health Assessment* is confidential. Federal law prohibits the Plan from using your personal health information to discriminate against you in any way or from giving this information to your employing agency/school or other unauthorized third party, except as allowed by law.

You can complete the *Health Assessment* through your enrollment system, online at www.shpnc.org by clicking Personal Health Portal or by phone at 800-817-7044. Completing the Health Assessment during enrollment will save you \$10 per month off of your *employee-only* premium per month.

Wellness Activity #3: Select a PCP

During Open Enrollment, Annual Enrollment or when enrolling within 30 days of being first eligible, you will need to select a Primary Care Provider (PCP) for yourself and any covered *dependents*. A PCP provides preventive care and guidance for maintaining a healthy lifestyle. Your PCP can be a general practitioner (family *doctor*), internist, obstetrician/gynecologist, pediatrician, nurse practitioner or physician's assistant.

You can select a PCP through your enrollment system. Selecting a Primary Care Provider (PCP) for you and your covered *dependents* will save you \$15 per month off of your *employee-only* premium. If the PCP that appears on your card is not available at the time of your appointment, you have the option to see another PCP within that practice at that selected location to receive the \$15 added to your HRA.

Understanding Your Share of the Cost

Wellness Incentives

In addition to the *Wellness Premium Credits*, you can also take advantage of additional *Wellness Incentives* that will add value to your HRA for various health care services you receive throughout the year.

Things you can do to reduce your costs	
Visit the <i>PCP</i> listed on your <i>ID card</i>	\$25 is added to your HRA
Visit a Blue Options Designated <i>specialist</i>	\$20 is added to your HRA
Receive <i>inpatient</i> care in a Blue Options Designated <i>hospital</i>	\$200 is added to your HRA

As a member of the CDHP Blue Options HRA plan, you enjoy quality health care from a network of health care providers and easy access to specialists. You also have the freedom to choose health care providers who do not participate in the Blue Options network – the main difference will be the cost to you. Benefits are available for service from an in- or out-of-network provider that is recognized as eligible. For a list of eligible providers, please visit the Plan’s website at www.shpnc.org or call Customer Service at the number listed in “Who to Call?” Here’s a look at how it works:

	<i>In-Network</i>	<i>Out-of-Network</i>
Type of Provider	<p><i>In-network providers</i> are health care professional and facilities that have contracted with BCBSNC, or a provider participating in the BlueCard program. Ancillary providers outside of North Carolina are considered <i>in-network</i> only if they contract directly with BCBSNC, even if they participate in the BlueCard program. <i>In-network providers</i> agree to limit charges for covered services to the <i>allowed amount</i>.</p> <p>Please note that <i>dentists</i> and orthodontists do not participate in the Blue Options <i>provider</i> network but there are a limited number of oral maxillofacial surgeons available <i>in-network</i>.</p> <p>The list of <i>in-network providers</i> may change from time to time. <i>In-network providers</i> are listed on the Plan’s website at www.shpnc.org or call Customer Service at the number listed in “Who to Call?”</p>	<p>Out-of-network providers are not designated as Blue Options providers by BCBSNC. Also see “Out-of-Network Benefit Exceptions.”</p>

Understanding Your Share of the Cost

<p><i>Allowed Amount vs. Billed Amount</i></p>	<p>If the billed amount for a covered service is greater than the <i>allowed amount</i>, you are not responsible for the difference. You only pay any applicable deductible, <i>coinsurance</i>, and noncovered expenses.</p>	<p>You may be responsible for paying any charges over the <i>allowed amount</i> in addition to any applicable deductible, <i>coinsurance</i>, noncovered expenses and <i>certification</i> penalty amounts, if any except for emergency services in the case of an emergency.</p>
<p>Referrals</p>	<p>The Plan does not require you to obtain any referrals.</p>	<p>The Plan does not require you to obtain any referrals.</p>
<p>After-hours Care</p>	<p>If you need <i>nonemergency services</i> after your provider’s office has closed, please call your provider’s office for their recorded instructions.</p>	
<p>Care Outside of North Carolina</p>	<p>Your <i>ID card</i> gives you access to participating providers outside the state of North Carolina through the BlueCard program, and benefits are provided at the <i>in-network</i> benefit level.</p>	<p>If you are in an area that has participating providers and you choose a provider outside the network, you will receive the lower out-of-network benefit. Also see “Out-of-Network Benefit Exceptions.”</p>
<p>Prior Review</p>	<p><i>In-network providers</i> in North Carolina will request prior review when necessary. If you receive services outside of North Carolina (even if you see an <i>in-network provider</i>), you are responsible for ensuring that you or your provider requests prior review.</p> <p>For <i>inpatient</i> or certain outpatient mental health and substance abuse services, either in or outside of North Carolina, contact Value Options to request prior review and receive <i>certification</i>.</p> <p>Prior review is not required for an <i>emergency</i> or for an <i>inpatient hospital</i> stay for 48 hours after a vaginal delivery or 96 hours after a cesarean section.</p>	<p>You are responsible for ensuring that you or your out-of-network provider requests prior review. Failure to request prior review and obtain <i>certification</i> will result in full denial of benefits. Prior review is not required for an <i>emergency</i> or for an <i>inpatient hospital</i> stay for 48 hours after a vaginal delivery or 96 hours after a cesarean section.</p>

Understanding Your Share of the Cost

Filing Claims	<i>In-network providers</i> in North Carolina are responsible for filing claims directly with BCBSNC.	You may have to pay the out-of-network provider in full and submit your own claim to BCBSNC. Mail claims in time to be received within 18 months of the date the service was provided. Claims not received within 18 months from the service date will not be covered, except in the absences of legal capacity of the member.
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Out-Of-Network Benefit Exceptions

In an *emergency*, in situations where *in-network providers* are not reasonably available as determined by BCBSNC’s access to care standards, or in continuity of care situations, out-of-network benefits will be paid at your *in-network* benefit level. However, you may be responsible for charges billed separately by the provider which are not eligible for additional reimbursement. If you are billed by the provider, you will be responsible for paying the bill and filing a claim with BCBSNC.

If you believe an *in-network provider* is not reasonably available, you can help assure that benefits are paid at the correct benefit level by calling Customer Service before receiving care from an out-of-network provider.

Carry Your Identification Card

Your *ID card* identifies you as a Blue Options CDHP member. Be sure to carry your *ID card* with you at all times and present it each time you seek health care. Each *dependent* will receive their own ID card. If you select a PCP for each family member upon enrollment, each family member’s *ID card* will have the selected PCP printed on the front of the ID card. Only subscribers and their enrolled eligible *dependents* may seek services with their card. The State Health Plan may consider unauthorized use of this card to be fraud. To find out how to report fraud go to “Report Suspected Abuse and Fraud” in the Contact Us section of the State Health Plan’s website at www.shpnc.org.

For *ID card* requests, please visit “Blue Connect” on the Plan’s website at www.shpnc.org or call Customer Service at the number listed in “Who Do I Call?”

Blue Options Designated Providers

This network of providers, which includes various providers and *hospitals* has been “designated” because they provide both quality and cost-effective care according to criteria set forth by Blue Cross and Blue Shield of North Carolina. To find a *Blue Options Designated provider*, visit the Plan’s website at www.shpnc.org and click on Find a *Doctor* or call 888-234-2416. If your *hospital* is not on the Blue Options Designated *Hospital* list, you can still select an *in-network hospital*, however, your *inpatient* copay would apply. If you select a *hospital* that is neither on the Blue Options Designated list or is *in-network*, you will be subject to out-of-network *hospital* charges.

The Role of A Primary Care Provider (PCP)

A Primary Care Provider (PCP) can help you manage your health and make decisions about your health care needs. It is important for you to maintain a relationship with a PCP. If you change PCPs, be sure to have your medical records transferred, especially immunization records, to provide your new *doctor* with your medical history. If you selected a PCP during enrollment, you may change your PCP at any time. You will receive a

Understanding Your Share of the Cost

new *ID card* which will include the PCP name on the ID card. PCPs are trained to deal with a broad range of health care issues and can help you to determine when you need a specialist.

A Primary Care Provider can practice:

- Family Practice/General Practice
- Internal Medicine
- Physician's Assistants
- Pediatrics
- Certified Nurse Practitioner
- Obstetrics & Gynecology

If your PCP or specialist leaves the Blue Options provider network and is currently treating you for an ongoing special condition that meets the continuity of care criteria, BCBSNC will notify you 30 days before the provider's termination, as long as BCBSNC receives timely notification from the provider.

You may be eligible to elect continuing coverage for a period of time if, at the time of the *provider's* termination, you meet the eligibility requirements. See Continuity Of Care in "*Utilization Management.*" Please contact the *State Health Plan* Customer Service at the number in "Whom Do I Call?" for additional information.

Understanding Your Share of the Cost

Understanding Your Share of the Cost

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

<i>Deductible</i>	The dollar amount you must incur for covered services in a benefit period before benefits are payable under the plan. The deductible does not include coinsurance, charges in excess of the allowed amount, amounts exceeding any maximum, or expenses for noncovered expenses. This plan has an embedded deductible which means you have an individual deductible and if dependents are covered, you also have a combined family deductible. You must meet your individual deductible before benefits are payable under the Plan. However, once the family deductible is met, it is met for all covered family members. Amounts applied to your out-of-network deductible are credited to your in-network deductible. However, amounts applied to your in-network deductible are not credited to your out-of-network deductible
<i>Coinsurance</i>	Your share of the cost of a covered health service, after you have met your <i>benefit period deductible</i> . This is stated as a percentage of the <i>allowed amount</i> .
Total out-of-pocket maximum	The total out-of-pocket maximum is the dollar amount you pay for covered services in a <i>benefit period</i> before the Plan pays 100%. Your total out-of-pocket maximum is determined by your type of coverage. The individual total out-of-pocket maximum applies if you selected <i>employee-only</i> coverage; otherwise, the family total out-of-pocket maximum applies. If one or more <i>dependents</i> are covered under the CDHP, all covered family members contribute to the same family out-of-pocket maximum. When either the family <i>in-network</i> or out-of-network total out-of-pocket maximum is met, the family total out-of-pocket maximum is met for all covered family members. Charges for <i>in-network</i> services apply to the <i>in-network</i> total out-of-pocket maximum. However, charges for out-of-network services apply to both the out-of-network and the <i>in-network</i> total out-of-pocket maximum,

Please note: The *deductible* and total out-of-pocket maximum amounts listed in the “Summary of Benefits” may be revised each year in accordance with Internal Revenue Service (IRS) rulings.

Important Information about Your Health Reimbursement Account (HRA)

Understanding the relationship between your health benefit plan and your Health Reimbursement Account (HRA)

With the CDHP, you are offered health coverage that is paired with a Health Reimbursement Account (HRA). You are provided with the necessary support in managing your HRA, managing the contributions that are made to your HRA, understanding how to make distributions from your HRA, and understanding what are considered qualified medical expenses. You can access these supports and manage your HRA by logging into Blue Connect which can be accessed on the Plan’s website at www.shpnc.org.

Amounts funded to your HRA

The balance placed in your HRA at the beginning of each benefit year is as follows:

Understanding Your Share of the Cost

- \$600 if you have employee/retiree only coverage
- \$1,200 if you have employee/retiree + 1 dependent coverage
- \$1,800 if you have employee/retiree + 2 or more dependent coverage

Any funds remaining in your HRA at the end of a benefit year will roll over and be added to the amounts above. The amounts above are pro-rated based on the date of hire if a member enrolls in the CDHP as a new employee.

You cannot take any remaining funds with you when you leave employment or your coverage ends.

If you work for an employer that offers Flexible Spending Accounts (FSAs), you can contribute to an FSA and enroll in the CDHP. However, any expense covered under the CDHP will be automatically reimbursed from your HRA if funds are available—even if you pay the expense with your FSA debit card.

To avoid using funds from your FSA and HRA for the same expense, be careful to use your FSA only after your HRA is depleted or for items that are not covered by the CDHP (such as eyeglasses). Once funds are reimbursed from your HRA, they cannot be redeposited.

Understand how to access your HRA funds

A claim for covered *medical services* will be automatically submitted each time you or your *dependents* use a medical benefit, and a check for out-of-pocket medical expenses will be issued directly to the *provider* if you have HRA funds available. For *prescription drugs*, you must pay in full for your *prescription*, a claim will be submitted by the pharmacy, and a check for the covered *prescription* will be sent directly to you if you have HRA funds available.

Know how much you owe - using your HRA funds

When you receive *medical services*, it is recommended that you first use your HRA funds to pay for the services until your annual *deductible* has been met. For *employees* who have a Flexible Spending Account (FSA), this is very important. Since *providers* are instructed to process claims to the HRA first, if you use your FSA prior to exhausting funds from your HRA, it is likely that both accounts will be charged for the same service.

A final determination of how much you owe your *provider* cannot be calculated until your claim has been submitted to your health plan and appropriate benefits and negotiated prices have been applied for your *provider's* services. Please remember, when using *out-of-network providers*, you are responsible for the difference between the *allowed amount* and the *provider's* charge. It is important that you check each Explanation of Benefits (EOBs) to ensure that your *provider* has not collected too much from you.

Go Online! - My HRA Account

Go to www.shpnc.org and click Blue Connect to access your HRA Account online. This portal that provides access to your health plan claims information as well as your HRA fund balance, transactions, and, at your choosing, electronically request reimbursement for specific health plan claims.

Know who to contact

Make sure you take the time to understand your HRA and how to get the most out of it. For help in managing your HRA contact State Health Plan Customer Service at 888-234-2416.

Covered Services

The CDHP covers only those services that are medically necessary. Also keep in mind as you read this section:

Covered services described on the following pages are available at both the *in-network* and out-of-network benefit levels, when medically necessary, unless otherwise noted. If you have a question about whether a certain health care service is covered, and you cannot find the information in "Covered Services," see "Summary of Benefits" or call State Health Plan Customer Service at the number listed in "Whom Do I Call?"

Also keep in mind as you read this section:

- Certain services require prior review and *certification* in order for you to avoid a denial of your services. General categories or services are noted below requiring prior review. Please see "Prior Review/Pre-Service" in "Utilization Management" for information about the review process, and visit our website at www.shpnc.org or call Customer Service to ask whether a specific service requires prior review and *certification*.
- Exclusions and limitations may apply to your coverage. Service-specific exclusions are stated along with the benefit description in "Covered Services." Exclusions that apply to many services are listed in "What Is Not Covered?" To understand the exclusions and limitations that apply to each service, read "Covered Services," "Summary of Benefits" and "What Is Not Covered?"
- You may receive, upon request, information on the procedure and medical criteria used by the State Health Plan to determine whether a procedure, treatment, facility, equipment, drug or device is medically necessary and eligible for coverage, investigational or *experimental*, or requires prior review and *certification* by the State Health Plan. **The State Health Plan medical policies are guides considered when making coverage determinations. If you need more information on medical policies, see our website at www.shpnc.org, or call State Health Plan Customer Service at the number listed in "Whom Do I Call?"**

Office Services

If you select a PCP during enrollment, and you use the PCP printed on the front of your ID card, you will receive a \$15 credit added into your HRA each time you see that PCP. The care you receive as part of an office visit, electronic visit, or house call is covered, except as otherwise noted in this benefit booklet. Some providers may get ancillary services, such as laboratory services, medical equipment or supplies or specialty drugs from third parties. In these cases, you may be billed directly by the ancillary provider. Benefit payments for these services will be based on the type of ancillary provider, its network status, and how the services are billed.

Office Services Exclusions

- Certain self-injectable prescription drugs that can be self-administered. The list of these excluded drugs may change from time to time. See our website at www.shpnc.org under Pharmacy Benefits or call State Health Plan Customer Service for a list of these drugs excluded in the office.

Preventive Services

The Plan covers preventive care services that can help you stay safe and healthy.

Under federal law, you can receive certain covered preventive care services from an *in-network provider* in an office-based, outpatient, or ambulatory surgical setting, or urgent care center, at no cost to you. Please note, this benefit is only for services that indicate a primary diagnosis of preventive or wellness

Covered Services

and which are identified by recent federal legislation as being eligible. Services, such as diagnostic lab tests, that may be delivered with a preventive care service are not considered preventive care. These services and services that do not include a primary diagnosis of preventive or wellness will be subject to your *in-network* benefit level for the location where services are received. In addition, the Plan may use reasonable medical management to determine coverage limitations.

Please visit the Plan's website at www.shpnc.org or call Customer Service at the number in "Who Do I Call?" for the most up-to-date information on preventive care that is covered under federal law, including any limitations that may apply. Certain over-the-counter medications may also be available. These over-the-counter medications are covered only as indicated and when a provider's prescription is presented at the pharmacy.

Preventive care covered services include:

Nutritional Counseling

The Plan covers nutritional counseling visits, which may include counseling specific to achieving or maintaining a healthy weight.

Routine Physical Examinations and Screenings

Routine physical examinations and related diagnostic services and screenings are covered for members as recommended with an A or B rating by the United State Preventive Services Task Force (USPSTF).

Well-Baby and Well-Child Care

These services are covered for each member including periodic assessments as recommended by the Health Resources and Services Administration (HRSA).

Well-Woman Care

These services are covered for each female member, including periodic assessments, screenings, counseling, or support services, as recommended by the Health Resources and Services Administration (HRSA).

Contraceptive Methods

Contraceptive methods and procedures requiring a prescription and approved by the U.S. Food and Drug Administration are covered for each female member with reproductive capacity through age 50. This includes intrauterine devices, diaphragms and caps, injectable or transdermal contraceptives, intravaginal hormonal contraceptives, implanted hormonal contraceptives, certain *emergency* contraceptives and *generic* oral contraceptives. In addition, over-the-counter contraceptives are covered when a provider's prescription is presented at the pharmacy.

Contraceptive Methods Exclusions

- Male contraceptives

Immunizations

Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) are covered.

Immunizations Exclusion

- Immunizations required for occupational hazard or international travel, unless specifically covered by the Plan.

Covered Services

Bone Mass Measurement Services

The Plan covers on scientifically proven and approved bone mass measurement for the diagnosis and evaluation of osteoporosis or low bone mass during any 23-month period for certain qualified individuals only. Additional follow-up bone mass measurement tests will be covered if medically necessary. Please note that bone mass measurement tests will be covered under your diagnostic benefit (not your preventive care benefit) if the claim for these services indicates a primary diagnosis of something other than preventive or wellness. Your diagnostic benefit will be subject to your *in-network* benefit level for the location where services are received.

Qualified individuals include members who have any one of the following conditions:

- Estrogen-deficient and at clinical risk of osteoporosis or low bone mass
- Radiographic osteopenia anywhere in the skeleton
- Receiving long-term glucocorticoid (steroid) therapy
- Primary hyperparathyroidism
- Being monitored to assess the response or effect of commonly accepted osteoporosis drug therapies
- History of low-trauma fractures
- Other conditions, or receiving medical therapies known to cause osteoporosis or low bone mass.

Colorectal Screening

Colorectal cancer examinations and laboratory tests for cancer are covered for any symptomatic or asymptomatic member who is at least 50 years of age, or is less than 50 years of age and at high risk for colorectal cancer. Increased/high-risk individuals are those who have a higher potential of developing colon cancer because of a personal or family history of certain intestinal disorders. Some of these procedures are considered surgery, such as colonoscopy and sigmoidoscopy, and others are considered lab tests, such as hemoccult screenings. Please note that if lab work is done as a result of a colorectal screening exam, the lab work will be covered under your diagnostic benefit and not be considered preventive care. It will be subject to your *in-network* benefit level for the location where services are received.

Gynecological Exam and Cervical Cancer Screening

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

Newborn Hearing Screening

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

Ovarian Cancer Screening

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

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

Covered Services

Prostate Screening

One prostate-specific antigen (PSA) test or an equivalent serological test will be covered per male member per *benefit period*. Additional PSA tests will be covered if recommended by a *doctor*.

Screening Mammograms

The Plan provides coverage for one baseline mammogram for any female member between the ages of 35 and 39. Beginning at age 40, one screening mammogram will be covered per female member per *benefit period*, along with a *doctor's* interpretation of the results. More frequent or earlier mammograms will be covered as recommended by a *doctor* when a female member is considered at risk for breast cancer.

A female member is “at risk” if she:

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

Diagnostic Services

Diagnostic procedures such as laboratory studies, radiology services and other diagnostic testing, which may include electroencephalograms (EEGs), electrocardiograms (ECGs), Doppler scans and pulmonary function tests (PFTs), help your *doctor* find the cause and extent of your condition in order to plan for your care. Multiple radiology or imaging procedures on the same date of service and/or during the same patient encounter may not be eligible for separate reimbursement.

Certain diagnostic imaging procedures, such as CT scans, PET scans and MRIs, may require prior review and *certification* or services will not be covered.

Your *doctor* may refer you to a freestanding laboratory, radiology center, or a sample collection device for these procedures. Separate benefits for interpretation of diagnostic services by the attending *doctor* are not provided in addition to benefits for that *doctor's* medical or surgical service, except as otherwise determined by the Plan.

Out-of-Network Labs: If your provider sends your lab work to an out-of-network lab for processing, your claims will no longer be paid at the in-network coinsurance. Your claims for these services will be paid at the appropriate out-of-network coinsurance. This may result in you having to pay more for out-of-network lab work. Talk to your provider to ensure they are using Blue Cross and Blue Shield of North Carolina in-network labs.

Diagnostic Services Exclusion

- Lab test that are not ordered by your *doctor* or other provider.

Emergency Care

The Plan provides benefits for *emergency services*.

An *emergency* is the sudden or unexpected onset of a condition of such severity that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

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

Covered Services

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

What to do in an Emergency

In an *emergency*, you should seek care from an *emergency* room or other similar facility. If necessary and available, call 911 or use other community *emergency* resources to obtain assistance in handling life-threatening *emergencies*. Prior review is not required for *emergency services*. Your visit to the *emergency* room will be covered if your condition meets the definition of an *emergency*.

Benefits for services in the *emergency* room

Situation	Benefit
You go to the <i>emergency</i> room for a nonemergency condition.	This is covered as an outpatient service.
You go to an <i>in-network hospital emergency</i> room for an <i>emergency</i> condition.	Applicable <i>coinsurance</i> . Prior review and <i>certification</i> are not required.
You go to an out-of-network <i>hospital emergency</i> room for an <i>emergency</i> condition.	Benefits paid at the <i>in-network coinsurance</i> level and based on the billed amount. You may be responsible for your out-of-network <i>deductible</i> if applicable, and for charges billed separately which are not eligible for additional reimbursement. You may be required to pay the entire bill at the time of service and file a claim. Prior review and <i>certification</i> are not required.
You are held for observation.	Outpatient benefits may apply to all covered services received in the <i>emergency</i> room and during observation.
You are admitted to the <i>hospital</i> from the ER following <i>emergency services</i> .	<i>Inpatient hospital</i> benefits apply for all covered services received in the <i>emergency</i> room and during hospitalization. Prior review and <i>certification</i> are required for <i>inpatient</i> hospitalization and other selected services following <i>emergency services</i> (including screening and stabilization) in order to avoid a penalty. You may need to transfer to an <i>in-network hospital</i> once your condition is stabilized in order to continue receiving <i>in-network</i> benefits.
You get follow-up care (such as office visits or therapy) after you leave the ER or are discharged.	Use <i>in-network providers</i> to receive <i>in-network</i> benefits. Follow-up care related to the <i>emergency</i> condition is not considered an <i>emergency</i> .

Urgent Care

The Plan also provides benefits for urgent care services. When you need urgent care, you should call your PCP, a specialist or go to an urgent care provider.

Covered Services

Family Planning

Maternity Care

Maternity care includes prenatal care, labor and delivery, and post-delivery care, are available to all female members. However, maternity benefits for *dependent children* cover only the treatment for *complications of pregnancy*. Coverage for breastfeeding counseling and certain breast pumps for pregnant or postpartum members are covered under your preventive care benefit.

	Mom	Newborn	Payment
Prenatal care	Care related to the pregnancy before birth.		<i>Coinsurance</i> and any applicable <i>deductible</i> apply.
Labor & delivery services	No prior review required for <i>inpatient hospital</i> stay for 48 hours after a vaginal delivery or 96 hours after a cesarean section. Mothers choosing a shorter stay are eligible for a home health visit for post-delivery follow-up care if received within 72 hours of discharge.	No prior review required for <i>inpatient</i> well baby care for 48 hours after a vaginal delivery or 96 hours after a cesarean section. Benefits include newborn hearing screening ordered by a <i>doctor</i> to determine the presence of permanent hearing loss. (Please see preventive care in “Summary of Benefits.”)	<i>Deductible</i> and <i>coinsurance</i> apply. If adding the baby changes your policy from <i>employee</i> to family coverage, the <i>family benefit period deductible</i> applies.
Post-delivery services	All care for the mother after baby’s birth that is related to the pregnancy. In order to avoid a penalty, prior review and <i>certification</i> are required for <i>inpatient</i> stays extending beyond 48/96 hours.	After the first 48/96 hours, whether <i>inpatient</i> (sick baby) or outpatient (well baby), the newborn must be enrolled for coverage as a <i>dependent child</i> , according to the rules in “When Coverage Begins Ends.” For <i>inpatient</i> services following the first 48/96 hours, prior review and <i>certification</i> are required in order to avoid a penalty.	

Statement of Rights Under The Newborns' And Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in

Covered Services

connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your doctor, nurse midwife or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, group health plans and health insurance issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48 hour (or 96 hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a doctor or other health care provider obtain certification for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain certification. For information on certification, contact State Health Plan Customer Service at the number given in "Whom Do I Call?"

Complications of Pregnancy

Benefits for *complications of pregnancy* are available to all female members including female dependent children. Please see "Definitions" for an explanation of *complications of pregnancy*.

Complications of Abortion

Benefits for complications of abortion are available to all female subscribers and enrolled female spouses of subscribers.

Infertility Services

Benefits are provided for certain services related to the diagnosis, treatment and correction of any underlying causes of *infertility* for all members except *dependent children*.

See "Summary of Benefits" for limitations that may apply. For information about coverage of prescription drugs for *infertility*, see "Prescription Benefits."

Sexual Dysfunction Services

The Plan provides benefits for certain services related to the diagnosis, treatment and correction of any underlying causes of sexual dysfunction for all members.

Sexual Dysfunction Exclusion

Prescription drugs related to sexual dysfunction are not covered. See Prescription Drug Exclusions.

Sterilization

This benefit is available for all members. Sterilization includes female tubal occlusion and male vasectomy. Certain sterilization procedures for female members are covered under your preventive care benefit. Call Customer Service for information about procedures that are covered according to federal regulations and any limitations that may apply.

Family Planning Exclusions

- Artificial means of conception, including, but not limited to, artificial insemination, in vitro fertilization (IVF), ovum or embryo placement, intracytoplasmic sperm injection (ICSI), and gamete intrafallopian tube placement (GIFT) and associated services
- Donor eggs and sperm
- Surrogate mothers
- Care or treatment of the following:
 - Maternity for *dependent children*

Covered Services

- *Infertility* and sexual dysfunction services for *dependent children*
- Reversal of sterilization.
- Abortions except for when the pregnancy is the result of rape or incest or for female subscribers and enrolled spouses of the subscribers when the life of the mother would be endangered if the unborn child was carried to term.
- Benefits for *infertility* or reduced fertility that result from a prior sterilization procedure or when *infertility* or reduced fertility is the result of a normal physiological change such as menopause.
- Any drugs associated with artificial reproductive technology.
- Ovulation tests
- Blood typing for paternity testing
- Biopsy, oocyte polar body or embryo blastomere, microtechnique

Facility Services

Benefits are provided for:

- Outpatient services received in a *hospital*, a *hospital* based facility, nonhospital facility or a *hospital*-based or outpatient clinic.
- *Inpatient* services received in a *hospital* or nonhospital facility. You are considered an *inpatient* if you are admitted to the *hospital* or nonhospital facility as a registered bed patient for whom a room and board charge is made. Your *in-network provider* is required to use the Blue Options network *hospital* where he/she practices, unless that *hospital* cannot provide the services you need. If you are admitted before the *effective date*, benefits will not be available for services received prior to the *effective date*. Take home drugs are covered as part of your prescription drug benefit.

Prior review must be requested and *certification* must be obtained in advance for *inpatient* admissions to avoid a penalty, except for maternity deliveries and *emergencies*. See “Maternity Care,” if applicable and “Emergency Care.”

- Surgical services received in an *ambulatory surgical center*
- Covered services received in a skilled nursing facility, skilled nursing *facility services* are limited to a combined in- and out-of-network day maximum per *benefit period*.

Prior review must be requested and *certification* must be obtained in advance for payment of claims. Service for which prior authorization is not obtained will not be covered. See “Summary of Benefits.”

Other Services

Ambulance Services

The Plan covers services in a ground *ambulance* traveling:

- From a member’s home, scene of an accident, or site of an *emergency* to a *hospital*
- Between *hospitals*
- Between a *hospital* and a skilled nursing facility

When such a facility is the closest one that can provide covered services appropriate to the member’s condition. Benefits may also be provided for *ambulance* services from a *hospital* or skilled nursing facility to a member’s home when medically necessary.

- The plan covers services in an air *ambulance* traveling from the site of an *emergency* to a *hospital* when such a facility is the closest one that can provide covered services appropriate to the

Covered Services

member's condition. Air *ambulance* services are eligible for coverage only when ground transportation is not medically appropriate due to the severity of the illness, or the pick-up point is inaccessible by land.

- Non-emergency air *ambulance* services require prior review and *certification* or services will not be covered.

Ambulance Service Exclusion

- No benefits are provided primarily for the convenience of travel.

Bariatric Surgery

The Plan covers bariatric surgery when performed at a Blue Distinction Center (BDC). Surgeries performed at non-BDCs will not be a covered benefit and prior approval will not be granted to non-BDC facilities. Complications arising from surgeries performed at a non-BDC will be covered under *emergency services* criteria. Bariatric surgeries for which prior approval is not obtained will not be covered regardless of the facility's BDC status. For a listing of Blue Distinction Centers (BDC), visit the State Health Plan website at www.shpnc.org, Find a *Doctor* and select "Obesity Surgery Blue Distinction Center."

Bariatric Surgery Exclusion

- Services provided at non-Blue Distinction Center facilities.

Blood

The Plan covers the cost of transfusions of blood, plasma, blood plasma expanders and other fluids injected into the bloodstream. Benefits are provided for the cost of storing a member's own blood only when it is stored and used for a previously scheduled procedure.

Blood Exclusion

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

Clinical Trials

The Plan provides benefits for participation in clinical trials phases I, II, III, and IV. Coverage is provided only for medically necessary costs of health care services associated with the trials, and only to the extent such costs have not been or are not funded by other resources. The member must meet all protocol requirements and provide informed consent in order to participate. The trial must involve the treatment of cancer or a life-threatening medical condition with services that are medically indicated and preferable for that member compared to non-investigational alternatives. In addition, the trial must:

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

Clinical Trials Exclusions

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

Covered Services

Dental Treatment Covered Under Your Medical Benefit

The Plan provides benefits for services provided by a duly licensed *doctor*, *doctor* of dental surgery or *doctor* of dental medicine for diagnostic, therapeutic or surgical procedures, including oral surgery involving bones or joints of the jaw, when the procedure or dental treatment is related to one of the following conditions:

- Accidental injury of the sound teeth, jaw, cheeks, lips, tongue, roof and floor of the mouth
- *Congenital* deformity, including cleft lip and cleft palate
- Removal of:
 - tumors which are not related to teeth or associated dental procedures
 - cysts which are not related to teeth or associated dental procedures
 - exostoses for reasons other than preparation for dentures.

The Plan provides benefits for dental implants and related procedures, such as bone grafting associated with the above three conditions.

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

When any of the conditions listed above require surgical correction, benefits for surgery will be subject to medical necessity review to examine whether or not the condition resulted in functional impairment. Examples of functional impairment include an impairment that affects speech or the ability to eat, or injury to soft tissue of the mouth. In special cases, benefits are provided only for anesthesia and facility charges related to dental procedures performed in a *hospital* or *ambulatory surgical center*. This benefit is only available to *dependent children* below the age of nine years, persons with serious mental or physical conditions and persons with significant behavioral problems. The treating provider must certify that the patient's age, condition or problem requires hospitalization or general anesthesia in order to safely and effectively perform the procedure. Other dental services, including the charge for surgery, are not covered unless specifically covered by the Plan.

In addition, benefits will be provided if a member is treated in a *hospital* following accidental injury, and covered services such as oral surgery or reconstructive procedures are required at the same time as treatment for the bodily injury.

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

Prior review and *certification* are required for certain surgical procedures or services will not be covered, unless treatment is for an *emergency*.

Dental Treatment Excluded Under Your Medical Benefit

Treatment for the following conditions:

- Injury related to chewing or biting
- Preventive dental care, diagnosis or treatment of or related to teeth or gums
- Periodontal disease or cavities and disease due to infection or tumor

And except as specifically stated as covered, treatment such as:

- Dental implants or root canals
- Orthodontic braces
- Removal of teeth and intrabony cysts
- Procedures performed for the preparation of the mouth for dentures

Covered Services

- Crowns, bridges, dentures or in-mouth appliances.

Diabetes Related Services

All medically necessary diabetes-related services, including equipment, supplies, medications and laboratory procedures are covered. Diabetic outpatient self-management training and educational services are also covered.

Covered Services

Diabetes Related Services Exclusions

- Diabetic shoes, including accessories and fittings and associated services and supplies
- Glasses

Durable Medical Equipment

Benefits are provided for *durable medical equipment* and supplies required for operation of equipment when prescribed by a *doctor*. Equipment may be purchased or rented at the discretion of the State Health Plan or its representative. The State Health Plan provides benefits for repair or replacement of the covered equipment. Benefits will end when it is determined that the equipment is no longer medically necessary. In order to receive the *in-network* benefit, *durable medical equipment* must be provided by a participating supplier. It is important that you or provider verify that the *durable medical equipment* supplier is an *in-network provider*. Most out-of-state suppliers are out-of-network providers. Certain *durable medical equipment* requires prior review and *certification* or services will not be covered.

Durable Medical Equipment Exclusions

- Appliances or devices that serve no medical purpose or that are primarily for comfort or convenience
- Repair or replacement of equipment due to abuse or desire for new equipment.
- Heel or elbow protectors
- Batteries
- Gravity assisted traction devices
- Wheelchair accessories of any kind, including trays, commode seats, narrowing devices, and roll-about chairs with castors 5 or greater, crutch and cane holders, cylinder tank carriers, arm troughs, IV hangers
- Immersion external heater for nebulizer
- Commode chairs, seat lifts, toilet rails, toilet benches
- Bath or shower chairs, wall or tub rails, tub stools or benches
- Mattresses, bed boards, rocking beds, pediatric cribs, bed safety frames or canopies or bed accessories of any type
- Patient lifts, seat lifts, standing frame/table systems

Hearing Aids

The Plan now provides coverage for medically necessary hearing aids and related services that are ordered by a *doctor* or an audiologist for each member under the age of 22. Benefits are provided for one hearing aid per hearing-impaired ear, and replacement hearing aids when alterations to an existing hearing aid are not adequate to meet the member's needs. This benefit is limited to once every 36 months. Reimbursement will be limited to the usual, customary and reasonable (UCR) amount and you may be billed by the provider for charges greater than the UCR reimbursement. Benefits are also provided for the evaluation, fitting, and adjustments of hearing aids or replacement of hearing aids, and for supplies, including ear molds.

Home Health Care

Home health care services are covered when ordered by a *doctor* for a member who is *homebound* due to illness or injury, and you need part-time or intermittent skilled nursing care from a registered nurse (RN) or licensed practical nurse (LPN) and/or other skilled care services like short-term rehabilitative therapies. Usually, a home health agency coordinates the services your *doctor* orders for you. Services from a home health aide may be eligible for coverage only when the care provided supports a skilled service being delivered in the home.

Covered Services

Home health care requires prior review and *certification* or services will not be covered.

Home Health Care Exclusions

- Dietitian services or meals
- Homemaker services, such as cooking and housekeeping
- Services that are provided by a close relative or a member of your household.

Home Infusion Therapy Services

Home infusion therapy is covered for the administration of prescription drugs directly into a body organ or cavity or via intravenous, intraspinal, intramuscular, subcutaneous or epidural routes, under a plan prescribed by a *doctor*. These services must be provided under the supervision of an RN or LPN. Home infusion therapy requires prior review and *certification* or services will not be covered.

Prior review and *certification* are required for certain home infusion therapy services or services will not be covered.

Hospice Services

Your coverage provides benefits for *hospice* services for care of a terminally ill member with a life expectancy of six months or less. Services are covered only as part of a licensed health care program centrally coordinated through an interdisciplinary team directed by a *doctor* that provides an integrated set of services and supplies designed to give comfort, pain relief and support to terminally ill patients and their families.

Hospice Services Exclusions

- Homemaker services, such as cooking, housekeeping, food or meals.

Lymphedema-Related Services

Coverage is provided for the diagnosis, evaluation, and treatment of lymphedema. These services must be provided by a licensed occupational or physical therapist or licensed nurse that has experience providing this treatment, or other licensed health care professional whose treatment of lymphedema is within their scope of practice. Benefits include medically necessary equipment, supplies and services such as complex decongestive therapy or self-management therapy and training. Gradient compression garments may be covered with a prescription and when custom-fit for the patient.

Lymphedema-Related Services Exclusion

- Over-the-counter compression or elastic knee-high or other stocking products.

Medical Supplies

Coverage is provided for medical supplies. Your benefits are based on where supplies are received, either as part of your medical supplies benefit or prescription drug benefit.

To obtain medical supplies and equipment, please find a provider on our website at www.shpnc.org or call Customer Service.

Medical Supplies Exclusion

- Medical supplies not ordered by a *doctor* for treatment of a specific diagnosis or procedure.
- Thermometers
- Gauze, tape, adhesive first-aid bandages
- Spirometers and all related accessories
- Lubricants for any purpose
- Chemical or antiseptic solutions for any purpose
- Mucus traps

Covered Services

- Pocket nebulizers
- Replacement bulbs or lamps for therapeutic light

Orthotic Devices

Orthotic devices, which are rigid or semi-rigid supportive devices that restrict or eliminate motion of a weak or diseased body part, are covered if medically necessary and prescribed by a provider. Foot orthotics may be covered only when custom molded to the patient. Orthotic devices for correction of positional plagiocephaly, including dynamic orthotic cranioplasty (DOC) bands and soft helmets, are subject to a benefit limit. Please see “Lifetime Maximums” in the "Summary of Benefits."

Orthotic Devices Exclusions

- Premolded foot orthotics
- Over-the-counter supportive devices
- Plastazote shoes or sandals

Private Duty Nursing

The Plan provides benefits for medically necessary private duty services of an RN or LPN when ordered by your *doctor* for a member who is receiving active care management. Private duty nursing provides more individual and continuous skilled care than can be provided in a skilled nursing visit through a home health agency.

Private duty nursing requires prior review and *certification* or services will not be covered.

Private Duty Nursing Exclusion

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

Prosthetic Appliances

The Plan provides benefits for the purchase, fitting, adjustments, repairs, and replacement of prosthetic appliances. The prosthetic appliances must replace all or part of a body part or its function. The type of prosthetic appliance will be based on the functional level of the member. Therapeutic contact lenses may be covered when used as a corneal bandage for a medical condition. Benefits include a one-time replacement of eyeglass or contact lenses due to a prescription change after cataract surgery.

Certain prosthetic appliances require prior review and *certification* or services will not be covered.

Prosthetic Appliances Exclusions

- Dental appliances except when medically necessary for the treatment of temporomandibular joint disease or obstructive sleep apnea
- *Cosmetic* improvements, such as implantation of hair follicles and skin tone enhancements
- Lenses for keratoconus or any other eye procedure except as specifically covered under the Plan.

Surgical Benefits

Surgical benefits by a professional or facility provider on an *inpatient* or outpatient basis, including pre-operative and post-operative care and care of complications, are covered. Surgical benefits include diagnostic surgery, such as biopsies, and reconstructive surgery performed to correct *congenital* defects that result in functional impairment of newborn, adoptive, and foster children.

Certain surgical procedures, including those that are potentially *cosmetic*, require prior review and *certification* or services will not be covered.

Covered Services

Multiple surgical procedures performed on the same date of service and/or during the same patient encounter, may not be eligible for separate reimbursement.

For information about coverage of multiple surgical procedures, please refer to the Blue Options reimbursement policies, which are on our website at www.shpnc.org, or call State Health Plan Customer Service at the number listed in "Whom Do I Call?"

Anesthesia

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

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

Mastectomy Benefits

Under the Women's Health and Cancer Rights Act of 1998, the Plan provides for the following services related to mastectomy surgery:

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

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

The benefits described above are subject to the same applicable *deductibles* and *coinsurance* and limitations as applied to other medical and surgical benefits provided under the Plan.

Temporomandibular Joint (TMJ) Services

The Plan provides benefits for services provided by a duly licensed *doctor*, *doctor of dental surgery*, or *doctor of dental medicine* for diagnostic, therapeutic or surgical procedures, including oral surgery involving bones or joints of the jaw, face or head when the procedure is related to TMJ disease.

Therapeutic benefits for TMJ disease include splinting and use of intra-oral prosthetic appliances to reposition the bones. Surgical benefits for TMJ disease are limited to surgery performed on the temporomandibular joint. If TMJ is caused by malocclusion, benefits are provided for surgical correction of the malocclusion when surgical management of the TMJ is medically necessary. Please have your provider contact the Plan before receiving surgical treatment for TMJ.

Prior review and *certification* are required for certain surgical procedures or these services will not be covered, unless treatment is for an *emergency*.

Temporomandibular Joint (TMJ) Services Exclusions

- Treatment for periodontal disease
- Dental implants or root canals
- Crowns and bridges
- Orthodontic braces
- Occlusal (bite) adjustments
- Extractions.

Covered Services

Therapies

The Plan provides coverage for the following therapy services to promote the recovery of a member from an illness, disease or injury when ordered by a *doctor* or other professional provider.

Short-Term Rehabilitative Therapies

The following therapies are covered only for treatment of conditions that are expected to result in significant clinical improvement in a member's condition:

- Occupational therapy and/or physical therapy up to a one-hour session per day
- Speech therapy.

Other Therapies

The Plan covers:

- Cardiac rehabilitation therapy
- Pulmonary and respiratory therapy
- Dialysis treatment
- Radiation therapy, including accelerated partial breast radiotherapy (breast brachytherapy).
- Breast brachytherapy is investigational but will be covered upon prior review and *certification*, based on meeting the American Society of Breast Surgeons (ASBS) criteria.
- Chemotherapy, including intravenous chemotherapy.

Chemotherapy benefits are based on where services are received. For chemotherapy received in conjunction with bone marrow or peripheral blood stem cell transplants, follow transplant guidelines described in "Transplants." Also see "Prescription Drug Benefits" regarding related covered prescription drugs.

Therapy Exclusions

- Applied Behavior Analysis (ABA) therapy except as specifically covered by your benefit plan
- Cognitive therapy
- *Speech therapy* for stammering, stuttering, or developmental delay
- *Treatment of speech, language, voice, communication and/or auditory processing disorder*
- Pulmonary rehabilitation group sessions
- Peripheral arterial disease rehabilitation
- Community or work integration training, work hardening or conditioning

Transplants

The Plan provides benefits for transplants, including *hospital* and professional services for covered transplant procedures. The Plan provides care management for transplant services and will help you find a *hospital* or Blue Distinction Centers for Transplants that provides the transplant services required. Travel and lodging expenses may be reimbursed based on guidelines that are available upon request from a transplant coordinator.

A transplant is the surgical transfer of a human organ, bone marrow, tissue, or peripheral blood stem cells taken from the body and returned or grafted into another area of the same body or into another body.

For a list of covered transplants, call Customer Service at the number listed in "Who Do I Call?" to speak with a transplant coordinator and request prior review. *Certification* must be obtained in advance for all transplant-related services in order to assure coverage of these services. Grafting procedures associated with reconstructive surgery are not considered transplants.

Covered Services

If a transplant is provided from a living donor to the recipient member who will receive the transplant:

- Benefits are provided for reasonable and necessary services related to the search for a donor up to a maximum of \$10,000 per transplant.
- Both the recipient and the donor are entitled to benefits of this coverage when the recipient is a member. Benefits provided to the donor will be charged against the recipient's coverage.

Some transplant services are investigational for some or all conditions or illnesses. Please see "Definitions" for an explanation of investigational.

Transplants Exclusions

- The purchase price of the organ or tissue if any organ or tissue is sold rather than donated to the recipient member
- The procurement of organs, tissue, bone marrow or peripheral blood stem cells or any other donor services if the recipient is not a member
- Transplants, including high dose chemotherapy, considered *experimental* or investigational
- Services for or related to the transplantation of animal or artificial organs or tissues.

Mental Health and Chemical Dependency Benefits

The Plan provides benefits for the treatment of mental illness and *chemical dependency* by a *hospital, doctor* or other provider.

Coverage for *in-network inpatient* and outpatient services is coordinated through your Mental Health Case Manager. The Plan delegates administration of these benefit to the Mental Health Case Manager. To understand more about when you need to contact the Mental Health Case Manager, see "How to Access Mental Health and *Chemical Dependency* Services."

Office Visit Services

The following professional services are covered when provided in an office setting:

- Evaluation and diagnosis
- Medically necessary biofeedback and neuropsychological testing
- Individual and family counseling
- Group therapy.

Outpatient Services

Covered outpatient treatment services when provided in a mental health or *chemical dependency* treatment facility include:

- Each service listed in the section under office visit services
- Partial-day/night hospitalization services (minimum of four hours per day and 20 hours per week)
- Intensive Outpatient Program services (less than four hours per day and minimum of nine hours per week).
- Certain *in-network* and out-of-network outpatient services, such as partial hospitalization and intensive therapy, require prior review and *certification* or services will not be covered. The timeframe for receiving prior review and treatment certification are set forth in the table below. The list of services that require prior review may change from time to time.

Inpatient Services

Covered *inpatient* treatment services also include:

- Each service listed under office visit services
- Semi-private room and board
- Detoxification to treat *chemical dependency*.

Covered Services

Applied Behavior Analysis

Coverage is provided for *Applied Behavior Analysis* when all of the following conditions are met:

- The *member* is younger than age 26, and
- Diagnosed with Autism Spectrum Disorder by a licensed physician (MD or DO) or a licensed doctoral level clinical psychologist (PhD or PsyD) utilizing results from a face-to-face evaluation and a clinically recognized, validated tool endorsed by the Mental Health Case Manager, and
- Treatment is determined by the Mental Health Case Manager to be medically necessary

Other than those listed in the second bullet above, no other providers are eligible for reimbursement of the diagnostic evaluation. Licensure of the MD, DO, PhD or PsyD must be in the state in which the diagnostic evaluation is performed.

The diagnostic evaluation does not require prior approval. However, the results of the diagnostic evaluation may be requested by the Mental Health Case Manager when authorization for ABA is requested.

Clinically recognized, validated tools endorsed by the Mental Health Case Manager can be found at <http://www.cdc.gov/ncbddd/autism/screening.html>.

ABA medical necessity criteria are available on the Mental Health Case Manager's web site at http://www.valueoptions.com/providers/Handbook/clinical_criteria.htm.

Prior approval by the Mental Health Case Manager is required for the initiation of ABA treatment services. ABA therapy for which prior approval is not obtained will not be covered.

Coverage for *Applied Behavior Analysis* is limited to a maximum of \$36,000 per benefit year and is only available in-network, both in-state and out-of-state.

Coverage of ABA services is limited to:

- Mental health providers who are currently licensed in the state in which services are delivered,
- and for whom ABA is within their scope of practice.

Or

- A psychiatrist or developmental pediatrician licensed as an MD or DO in the state in which services are delivered.

Board Certified Behavior Analysts (BCBAs) or Board Certified Assistant Behavior Analysts (BCaBAs) with no other current mental health license must be supervised by a licensed mental health provider, including but not limited to a psychiatrist, or a licensed developmental pediatrician. The licensed mental health provider, psychiatrist, or developmental pediatrician must submit both the request for authorization and the claim for payment. A provider in any state who ONLY holds a certification as a BCBA or BCaBA from the national Behavior Analyst Certification Board is not eligible for reimbursement by the State Health Plan even though they may be eligible for reimbursement in the state in which they practice.

Covered Services

Substance use providers who are licensed or certified by NC Substance Abuse Professional Practice Board, or by the state in which services are provided, and who do not also have a current mental health license in their state of practice, are not eligible for reimbursement of ABA services.

Applied Behavior Analysis Exclusions

Treatment for the following is not covered:

- *Members* with medical conditions or impairments that would prevent beneficial utilization of services
- *Members* requiring 24 hour medical/nursing monitoring or procedures provided in a hospital setting

ABA treatment will not be certified for the following services:

- Speech therapy
- Occupational therapy
- Vocational rehabilitation
- Supportive respite care
- Recreational therapy
- Orientation and mobility
- Respite Care
- Equine therapy/Hippotherapy
- Dolphin therapy
- Service Animals
- Other educational services

How to Access Mental Health and *Chemical Dependency* Services

When you need mental health or *chemical dependency* treatment, you should call a *Mental Health Case Manager* customer service representative at the number given in "Whom Do I Call?" available 24 hours a day, 7 days a week. The *Mental Health Case Manager* customer service representative will refer you to a list of *in-network providers* and will give you the information you need to receive services. Language services are available free of charge through your *Mental Health Case Manager*. Please let the Customer Service representative know if you need an interpreter to talk about your behavioral health benefits or help in translating any letters you receive from your *Mental Health Case Manager* regarding your care.

Certification for Inpatient and Outpatient Services

Prior to seeking care in an *inpatient* hospital, a Residential Treatment Center, partial day/night programs or intensive outpatient treatment programs, you or your *provider* must receive *certification* from the *Mental Health Case Manager*. In order to receive *in-network* benefits, you must go to a Blue OptionsSM network *provider*. You may want to check with your *in-network provider* to make sure that *certification* has been obtained for services. Your *in-network provider* is required to use the Blue OptionsSM network *hospital* where he/she practices, unless that *hospital* cannot provide the services needed.

If you choose to go to an *out-of-network provider* without obtaining *certification* for *inpatient* or *outpatient services*, or you go to any *provider* outside of North Carolina without obtaining *certification* for services, it will result in a full denial of your services.

Covered Services

If you receive *certification* for *out-of-network* services, the services will be considered at the *out-of-network* benefit level. However, if *in-network providers* are not available as determined by *BCBSNC's* access to care standards and *certification* is obtained, the *Mental Health Case Manager* will authorize the services to be covered at the *in-network* benefit level.

Emergency inpatient admissions do not require *certification* prior to the admission. However, you or your provider should notify the *Mental Health Case Manager* of your *inpatient* admissions. See table below for timeframes in order to meet the Plan's requirements for prior review and continuing treatment certifications of covered services.

You should work with your doctor or *other professional provider* to make sure that *certification* has been obtained for partial-day/night, intensive therapy, or *inpatient* services. See "*Utilization Management*." Contact the *Mental Health Case Manager* at the number given in "Whom Do I Call?" for *certification*.

Timeframe Requirements for Prior Review and Treatment Certification of Covered Services

Covered Service	Within Two (2) Business Days of Admission	Prior to Admission to the Program	Continuing Treatment Certifications*
Crisis Evaluation & Stabilization	X		X
Psychiatric Inpatient Hospital	X		X
Chemical Dependency Inpatient Hospital	X		X
Inpatient Medical Detoxification	X		X
Psychiatric Residential Treatment Center		X	X
Chemical Dependency Residential Treatment Center		X	X
Psychiatric Partial Hospitalization Program		X	X
Chemical Dependency Partial Hospitalization Program		X	X
Psychiatric Intensive Outpatient Program		X	X
Chemical Dependency Intensive Outpatient Program		X	X

**Continuing treatment certifications must be requested by the last date of any previously certified period. Otherwise, certification decisions by the Mental Health Case Manager are effective as of the date the request for certification is received by the Mental Health Case Manager.*

Covered Services

*The following notice applies only when you are responsible for obtaining *certification*. NOTICE: 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 plan's and *member's* payment obligations. For *out-of-network* benefits, you may be required to pay for charges over the *allowed amount* in addition to any *copayment* or *coinsurance* amount. In addition, certain services require *prior review* and *certification*. You are responsible for obtaining or having your *provider* obtain *certification* on your behalf if you go to an *out-of-network*, or out-of-state *provider*. Failure to obtain *certification* will result in a full denial of benefits.

Mental Health and Chemical Dependency Services Exclusions

- Care for conditions not classified as psychiatric, emotional, or substance abuse illnesses
- Psychoanalysis
- Counseling with relatives about a patient with mental illness, alcoholism, drug addiction or substance abuse
- *Inpatient* confinements that are primarily intended as a change of environment
- Mental health services received in residential treatment facilities when age 18 or older. Residential treatment facilities are covered for *chemical dependency*.
- Marriage Counseling
- *Inpatient* psychiatric care rendered in a *hospital* not accredited by JCAHO
- *Inpatient chemical dependency* care rendered in a facility which is not currently accredited by a national health care organization approved by the Mental Health Case Manager
- *Inpatient hospital* care for medical detoxification rendered in a facility which is not licensed as a *hospital* and accredited by a national health care organization approved by the Mental Health Case Manager
- Outdoor components of a residential *chemical dependency* treatment program, when such program is licensed as a *chemical dependency* treatment program in the state in which services are provided, are covered only if facility based services are available as a part of the same program
- Primary treatment of a psychiatric disorder in a residential treatment center (RTC) unless the RTC is licensed as a psychiatric RTC
- Primary treatment of a *chemical dependency* or substance abuse disorder in a residential treatment center (RTC) unless the RTC is licensed as a *chemical dependency* or substance abuse RTC
- Services by providers not currently licensed in the state in which services are provided
- Psychotherapy as part of artificial means of conception
- Psychological assessment and psychotherapy treatment in conjunction with proposed gender transformation
- Psychological testing for those persons with a *chemical dependency* diagnosis until 30 consecutive days of abstinence are obtained.
- Therapeutic boarding schools as a psychiatric residential treatment center (RTC) unless the program is licensed for psychiatric RTC in the state in which services are provided, has registered nurses who are present on-site 24-hours per day, and holds current national accreditation by a national health care accrediting body approved by the Mental Health Case Manager
- Therapeutic boarding schools as a *chemical dependency* or substance abuse residential treatment center (RTC) unless the program is licensed as a *chemical dependency* RTC in the state in which services are provided and has licensed supervision of all residents 24 hours per day, seven days per week

Covered Services

- Wilderness camps, wilderness “step-down” components of a residential program, and stand-alone outdoor treatment programs or outdoor “step-down” components of a residential program are not covered as a psychiatric RTC unless the program is licensed for psychiatric residential treatment in the state in which services are provided, has registered nurses who are present on-site 24-hours per day, and holds current national accreditation by a national health care accrediting body approved by the Mental Health Case Manager
- Wilderness camps and stand-alone outdoor treatment programs are not covered as *chemical dependency* or substance abuse RTC programs
- Academic education during residential treatment when charged separately
- Administrative psychiatric services (e.g., expert testimony, report writing, medical records review and maintenance, case management or case coordination, chart review, etc.)
- Consultation with a mental health professional for adjudication of marital, child support, and custody cases
- Evaluations, consultations, testing or therapy for educational, professional training, or for investigation purposes relating to employment, insurance, judicial or administrative proceedings
- Training analysis
- Treatment for personal or professional growth, development, training or professional *certification*
- Aversive Treatment
- Treatment programs based solely on the 12-step Model
- Erhard Seminar Training (EST) or similar motivational services
- Bioenergetic, carbon dioxide, confrontational, hyperbaric or normobaric oxygen, marathon, megavitamin, orthomolecular, primal, rebirthing, or sleep therapies
- Expressive therapies (art, poetry, movement, psychodrama), guided imagery, or stress and relaxation therapy when billed separately
- Telephonic crisis management as a separate charge
- Sedative action, electro stimulation therapy
- Z therapy, also known as “holding therapy”
- Narcotherapy with LSD
- Environmental ecology treatments
- Hemodialysis for schizophrenia
- Rolfing
- Sensitivity training
- Room and Board costs for patients admitted to a partial *hospital* or intensive outpatient program are not covered.
- Intensive in-home services less than two hours per day
- Private duty nursing
- Therapeutic family, foster or home care
- L-tryptophan and vitamins, except thiamine injections on admission for alcoholism when there is a diagnosed nutritional deficiency
- Travel time necessary for service delivery
- Behavioral health; long term care residential (non-acute care in a residential treatment program where stay is typically longer than 30 days), with room and board, per diem
- Community or work integration training, work hardening or conditioning
- Family psychotherapy without patient present

Covered Services

Prescription Drug Benefits

A Pharmacy Benefit Manager (PBM), manages administration of the prescription drug benefit.

Prescription drugs are subject to the *benefit period deductible* and both *deductible* and *coinsurance* amounts apply to the out-of-pocket maximum.

After the out-of-pocket maximum is reached, the health benefit plan pays 100% of allowed prescription drug charges.

A prescription cannot be refilled until three fourths (3/4) of the medication has been used as prescribed by your physician; exceptions may apply to certain prior authorized drugs.

Your prescription benefit covers federal legend prescription drugs, self-injectable medications, insulin and certain over-the-counter medications. See "Prescription Drug Benefits Exclusions" for those drugs that are not covered by your health benefit plan.

Some prescription drugs may require *certification*, also known as prior approval, or be subject to step therapy or formulary coverage review in order to be covered. It is very important to make sure that prior approval is received before going to the pharmacy.

Some prescription drugs may be subject to quantity limits based on criteria developed by the State Health Plan or its representative. Prior approval is required before excess quantities of these drugs will be covered. If you need quantities in excess of the limit for a drug that is subject to quantity limits, it is important to make sure your provider has received prior approval before going to the pharmacy. To get a list of prescription drugs that require prior approval to be covered or require approval for additional quantities, you may call Pharmacy Customer Service at the number listed in "Whom Do I Call?" or visit the State Health Plan website. The State Health Plan or its representative may change the list of these prescription drugs from time to time.

For *certification* of your prescription drugs, your physician may call the PBM's Prior Authorization number listed in "Whom Do I Call?" to initiate a *certification* request.

Using a Contracting Pharmacy

Most chain and independent pharmacies contract with the *PBM*. You may obtain information about which pharmacies are contracting by:

- Visiting the *State Health Plan's* website, or
- Calling the *PBM* at the number listed in "Whom Do I Call?"

When you use a pharmacy **not contracting with the *PBM***, you will be responsible for paying the total amount of the *prescription* at the time of purchase. You or the pharmacy will be required to file a paper claim with the *PBM* for reimbursement. You may obtain a claim form on the *State Health Plan's* website or by calling the *PBM*. **You are responsible for any amount above the *allowed amount* and your *coinsurance*.**

The convenience of mail order pharmacy is available for your maintenance medications by using the *PBM's* online pharmacy services, by telephone, or by completing a Mail Service Order Form and returning it with your original *prescription* and appropriate *coinsurance amount* to the *PBM*. You may obtain a Mail Service Order Form on the *State Health Plan's* website or by calling the *PBM* at the number in "Whom Do I Call?" To learn how to register for the *PBM's* online pharmacy services, visit the *State Health Plan's* website at www.shpnc.org.

You may use a credit card for *coinsurance amounts* for telephone or online refills.

Covered Services

Affordable Care Act Preventive Medications

Some medications that are identified by the *Affordable Care Act* are covered to *members* on this plan at 100%. *Members* must meet certain criteria for these medications to be covered at 100% and a *PCP* must write a *prescription* for the drug to be filled at a participating pharmacy counter in order for the *prescription* to be covered at a \$0 cost-share.

Keep in mind that your *provider* must write a *prescription* and it must be filled at a participating pharmacy. Additionally, there may be some *prescription drugs* that are administered by a *provider* in a medical office that may be limited to coverage under your medical benefit.

CDHP Preventive Medications

Some preventive medications that are identified by the *State Health Plan* under the CDHP, which are used to help prevent or manage certain health conditions, are covered without meeting a *deductible*. This list is subject to change. *Coinsurance* will still apply. The most up-to-date list of the *CDHP Preventive Medications* can be found at www.shpnc.org by clicking on Pharmacy Benefits and scrolling down to Consumer-Directed Health Plan.

Prescription Drug Exclusions

- Any *prescription drugs* not FDA approved
- Any *prescription drugs* that are not federal legend.
- Any *prescription drugs* not specifically covered by the *State Health Plan*
- Any *prescription drugs* prescribed for *sexual dysfunction*.
- Any *prescription drugs* prescribed for hair growth
- Any *prescription drugs* prescribed for *cosmetic* purposes
- Any *prescription drugs* prescribed in conjunction with artificial reproductive technology
- Any *prescription drug* in excess of the stated quantity limits
- Any *prescription drug* requiring *certification* if *certification* is not obtained
- Any drug that can be purchased over the counter without a *prescription*, even though a written *prescription* is provided, except for insulin and other approved over-the-counter drugs
- Any *compound drug* that contains an *investigational drug*.
- Any *compound drug* in which any active ingredient is not a covered *prescription drug* including bulk chemicals.
- Any *prescription drug* that has a therapeutic equivalent available over-the-counter as determined by the *State Health Plan*.
- Any *prescription* medical foods
- Any compound drug in which any active ingredient is for a non-FDA approved indication as determined by the dosage of the active ingredient, combination of active ingredients or route of administration.

Diabetic Testing Supplies

Diabetic testing supplies are covered under your medical and pharmacy benefit.

Tobacco Cessation Coverage

For information on the tobacco cessation coverage, please see the Tobacco Cessation Support section under “Special Programs.”

Specialty Pharmacy

Specialty and biosimilar medications are designated and classified by the Plan as medications that meet the following criteria and are listed on the Specialty Drug List, which is located on the Plan’s [website](#):

Covered Services

- Treats complex medical conditions(s)
- Requires frequent clinical monitoring, e.g. dosing adjustments
- Requires special patient education, training and/or coordination of care
- Generally prescribed by a specialist provider

If you use *specialty medications*, you must use the contracted specialty vendor for all non-acute *specialty medications* covered under the pharmacy benefit, excluding cancer medications. If you use a pharmacy other than the contracted vendor to purchase any non-acute *specialty medications*, you will be responsible for paying the total amount of the *prescription* at the time of purchase. For more information call the specialty pharmacy at the number listed in "Whom Do I Call?"

How to File a Claim for *Prescription Drugs*

When you use a pharmacy contracting with the *PBM*, present your *ID card* to the pharmacist and you will not be required to pay more than the appropriate *coinsurance amount* for each 30-day supply. The pharmacist will file the claim.

Covered Services

If you purchased *prescription drugs* from a pharmacy not contracted with the *PBM*, you will be responsible for the total amount of the *prescription* at the time of purchase. You will be reimbursed for your costs minus the applicable *coinsurance amounts* and charges in excess of the *allowed amount*. You will need to complete a *Prescription Drug Claim Form* for reimbursement and submit it to:

Express Scripts
ATTN: Direct Claims
PO Box 2824
Clinton, IA 52733-2824

If you are sending the original pharmacy receipts, a pharmacist's signature is not required. All receipts must contain the following information in order to process the claim:

- Date *prescription* filled
- Name and address of pharmacy
- *Doctor* name or *ID number*
- National Drug Code (NDC)
- Name of drug and strength
- Quantity and day supply
- *Prescription* number (Rx number)
- DAW (Dispense As Written)
- Amount paid

Complete a separate form for each family *member* and pharmacy.

Drug receipts from the label or bag should not be submitted. Claims will be returned if not properly completed. For information on how to properly submit a pharmacy claim, call Express Scripts Customer Service at the number given in "Whom Do I Call?"

Special Programs

NCHealthSmart - Your Resource for Better Health

NC HealthSmart, the *State Health Plan's* healthy living initiative, aims to empower *members* to reach their health goals. Whether a *member* is looking for ways to stay healthy or needs support to manage an ongoing health condition, NC HealthSmart can help.

Members eligible for NC HealthSmart services are *members* whose primary health coverage is through the *State Health Plan*. Eligibility and services may change from time to time. Check the *State Health Plan* website at www.shpnc.org and click on NC HealthSmart for the most current program information.

NC HealthSmart is voluntary. Eligible *members* can use the program at no charge. Federal law prohibits the *State Health Plan* from using your personal information to discriminate against you in any way or from giving this information to your employing agency/school or other unauthorized third party, unless required by law.

The program offers resources and programs at work, at home, and through your health care *provider*. The tools and services available through NC HealthSmart include the following:

Tobacco Cessation and Weight Management Programs

<p>Tobacco Cessation Support</p>	<p><i>Members</i> are encouraged to call a QuitlineNC Quit Coach®and/or their physician or behavioral health care <i>provider</i> about quitting tobacco use.</p> <p>Free Hotlines</p> <ul style="list-style-type: none"> • QuitlineNC.....800-QUIT-NOW (800-784-8669). Available 24 hours a day, 7 days a week, English Spanish-speaking. QuitlineNC telephonic support program is tailored to help all <i>members</i> stop using tobacco. Quit Coaches® assist with quitting, goal setting, medication questions and locating local tobacco cessation resources. They can mail educational materials, make follow-up support calls, and disseminate nicotine replacement therapy patches, gum or lozenges. <p>Nicotine Replacement Therapy Medications</p> <p>Over the counter, <i>generic</i> nicotine replacement therapy (NRT) patches,gum, or lozenges will be available through QuitlineNC at no additional charge to <i>members</i>. <i>Members</i> do not need a <i>prescription</i> to receive NRT from QuitlineNC, but do need to be enrolled in the multi-call program to be eligible.</p> <p>Prescription Medications</p> <p>Prescription generic extended-release bupropion 12 hour and brand Chantix (varenicline) will be covered at 100% for <i>members</i> ≥ 18 years with a written prescription. Chantix will be limited to a 6 month supply in 12 months. Other covered <i>prescription</i> medications and over the counter medications are available through the Pharmacy program. For a list of covered medications, please visit the Pharmacy section of the <i>State Health Plan</i> website at www.shpnc.org.</p> <p>Worksite Wellness Initiatives</p> <p>The NC HealthSmart Worksite Wellness Toolkit, available at www.shpnc.org, contains “Quit Now,” a guide which provides step-by-step instructions on setting up tobacco cessation educational campaigns and support systems. It also makes recommendations for environmental policy changes that may support <i>members</i> in quitting. Contact your <i>Health Benefits Representative</i> or Wellness Leader for more information.</p>
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<p>Weight Management Support</p>	<p>Tools and Resources</p> <ul style="list-style-type: none">• Nutrition Visits Please see “<i>Covered Services</i>” for additional information about nutrition counseling benefits for subscribers and covered <i>dependents</i>. For a listing of participating licensed dietitians, visit the <i>State Health Plan</i> website at www.shpnc.org and select “Find a <i>Doctor</i>.”• Weight Management Medications Talk to your physician about FDA- approved medications available to <i>members</i> for managing weight. For a list of covered medications, please visit the Pharmacy section of the <i>State Health Plan</i> website at www.shpnc.org.• Web-based Programs Eligible <i>members</i>* may access the NC HealthSmart Personal Health Portal’s interactive weight management and nutrition improvement programs at www.shpnc.org.• Support Line <i>Members</i> may contact the NC HealthSmart Health Coach at 800-817-7044 for one-on-one nutrition and weight management information, as well as motivational support.• Eat Smart, Move More, Weigh Less ESMMWL is a 15-week, live, interactive online weight management program proven to work. Members can enroll for \$30 and are reimbursed \$25 for attending 10 out of the 15 classes. To learn more about the program and enroll, visit www.esmmweighless.com.• Worksite Wellness Initiatives The NC HealthSmart Worksite Wellness Toolkit available online at www.shpnc.org contains the “Eat Smart” resource book, which provides organizations with instructions on creating nutrition and weight management programs, making environmental and policy changes that support healthy eating at the work place, and accessing ready-made posters, fliers, and other educational resources. Check with your <i>Health Benefits Representative</i> or Wellness Leader to see if the Eat Smart, Move More, Weigh Less program will be offered at your work place.
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Special Programs

<p>Health Coaching</p>	<p>Health Coaches are specially trained and licensed health care professionals (nurses, registered dieticians) who are available by phone; Monday – Friday 8:30 a.m. - 11 p.m., Saturday 9 a.m. - 2 p.m. to talk with you to help you manage your health. They can discuss a variety of lifestyle issues such as:</p> <ul style="list-style-type: none"> • Tobacco cessation • Nutrition and weight management • Exercise • Stress • Preventive Health <p>They can also provide:</p> <ul style="list-style-type: none"> • One-on-one goal setting, monitoring and support to help you increase your physical activity • One-on-one support for managing health conditions such as: <ul style="list-style-type: none"> • Asthma • Coronary Artery Disease • Back pain • Joint pain • Obesity / bariatric <i>surgery</i> • Hypertension • Migraine/other headache • Osteoporosis • End of life issues • Chronic Obstructive Pulmonary Disease (COPD) includes chronic bronchitis and Emphysema <ul style="list-style-type: none"> • Congestive Heart Failure (CHF) • Diabetes • Depression and stress • Acute respiratory conditions • General arthritis • TMJ syndrome • Stroke • Renal failure • Specialized support during your pregnancy • Recommend health education programs, tools, and videos • Printed health-related materials to your home
<p>Case Management</p>	<p>Case management services are offered to eligible <i>members</i> with complex medical needs. The program focuses on early identification of a <i>member's</i> need for assistance with multiple hospitalizations, a high risk pregnancy or a sudden catastrophic event. If you or a family <i>member</i> needs intensive case management support, please contact an NC HealthSmart Nurse Case Manager at 800-817-7044.</p> <p>Specialty Case Managers are available to assist <i>members</i> with Chronic Kidney Disease (CKD) and End Stage Renal Disease (ESRD). To contact a CKD/ESRD case manager, call 800-817-7044.</p>
<p>Maternity Coaching</p>	<p>Maternity coaching is available to eligible members who are expecting a baby. Members can work with a maternity coach over the phone, with the main goal being to help you and your baby be as healthy as possible. Call toll-free 800-817-7044 to learn more. Coaching is available:</p> <ul style="list-style-type: none"> • Monday-Friday, 8:30 a.m.-11 p.m. • Saturday, 9 a.m.-2 p.m. <p>The State Health Plan offers the Stork Rewards program designed to help all newly pregnant subscribers or covered spouses (dependent children are not eligible) achieve a healthy, full-term delivery through the use of maternity coaches. To qualify, members must enroll during their first trimester. Qualifying participants</p>

Special Programs

	<p>will receive an inpatient copayment incentive for delivery in a certified medical facility or birthing center when they:</p> <ul style="list-style-type: none"> • Call the NC HealthSmart toll-free number to complete an initial assessment with a maternity coach • Continue to engage with a maternity coach during each trimester <p>Visit www.shpnc.org and click NCHealthSmart for more information.</p>
Health Assessment (HA)	<p>The HA is a survey that identifies your personal health risks and provides you with a comprehensive personal action plan. You can complete the HA online at www.shpnc.org, by logging into your Personal Health Portal, or by calling a Health Coach at 800-817-7044.</p>
NC HealthSmart Personal Health Portal Website	<ul style="list-style-type: none"> • HA and personal action plan • Personal health record stores health information in one place • Symptom diary and medication list • Interactive tools and lifestyle programs for nutrition, physical activity and smoking cessation • Medical information library
Worksite Wellness	<p>The <i>State Health Plan</i> is committed to helping work places develop on-site wellness committees, lifestyle management activities, and “health-friendly” policies. The purpose is to encourage and support <i>members</i> trying to live healthy lifestyles. The NC HealthSmart Worksite Wellness Toolkit and Training 101 Toolbox are comprehensive collections of guidelines and ready-to-use materials to help worksites develop a worksite wellness committee and implement worksite wellness programs.</p> <p>For more information, contact NC.HealthSmart@nctreasurer.com.</p>

For more information on these programs or to obtain further information on NC HealthSmart, call 800-817-7044. If you have certain health conditions, the *State Health Plan* or its representative may call you to provide information about your condition, answer questions and tell you about resources available to you. Your participation is voluntary, and you have no obligation to talk about your condition. Your medical information is kept confidential.

Other Special Programs

The *State Health Plan* and *BCBSNC* may agree to add programs that are outside your regular benefits. These programs may be changed from time to time. The 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*
- Discounts or other savings on retail goods and services.

These discounts on goods and services may not be provided directly by the *State Health Plan*, but may instead be arranged for your convenience. These discounts are outside your health benefit plan's benefits. Neither the *State Health Plan* nor *BCBSNC* is liable for problems resulting from goods and services they do not provide directly, such as goods and services not being provided or being provided negligently. The *State Health Plan* or *BCBSNC* may stop or change these programs at any time.

What is not Covered?

Exclusions for a specific type of service are stated along with the benefit description in "*Covered Services*." Exclusions that apply to many services are listed in this section, starting with general exclusions and then the remaining exclusions are listed in alphabetical order. To understand all of the exclusions that apply, read "*Covered Services*," "Summary of Benefits" and "What Is Not Covered?" The 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 required 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 member, employer or carrier is liable or responsible for the specific medical charge (1) according to a final adjudication of the claim under a state's workers' compensation laws, or (2) by an order of a state Industrial Commission or other applicable regulatory agency approving a settlement agreement
- Basic life or work-related or medical disability examinations
- 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 plan
- Any condition suffered as a result of any act of war or while on active or reserve military duty
- Services in excess of any *benefit period maximum* or lifetime maximum
- Received prior to the *member's effective date*
- Received after the coverage termination date, regardless of when the treated condition occurred, and regardless of whether the care is a continuation of care received prior to the termination
- Received from 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 provided at request of patient in a location other than physician's office which are normally provided in the physician's office
- Day care services, chore services, attendant care services, homemaker services, companion care services, foster care services
- Telephone consultations or web-based, online or other electronic evaluations
- Camisoles, or other clothing, post-mastectomy
- Alternative therapy services
- Incontinence products (including briefs, diapers, underwear, underpads)
- Communication boards or alternative communication devices
- Safety equipment, devices or accessories, including but limited to helmets with face guards and soft interfaces and any type of restraints
- Athletic training evaluations or re-evaluations
- Audiometric testing of groups, Bekesy audiometry, ear protector attenuation measurements
- Massage therapy services, including but not limited to reflexology
- Childbirth preparation classes, including but not limited to Lamaze classes, childbirth refresher classes, cesarean birth classes, vaginal birth after cesarean classes, and infant safety classes including CPR by a non-physician provider
- Human breast milk processing, storage and distribution
- Medical testimony
- Genetic testing for amyotrophic lateral sclerosis (ALS)
- Hair analysis, excluding arsenic
- Low density lipoprotein (LDL) apheresis using heparin-induced extracorporeal LDL precipitation
- Bone density wrist or heel radiology testing
- Thermography or thermograph examination

What is not Covered?

- Transportation of portable X-ray equipment and personnel to home or nursing home, transportation of portable EKG to facility or other location
- Compression stockings, garter belts, except as specifically covered by your health benefit plan
- Hypothermia therapy
- Necropsies
- Telehealth services originating site facility fees
- Extracorporeal shockwave lithotripsy (ESWL) of gallbladder and other sites
- Emergency response systems
- Postural drainage boards and similar equipment
- Pacemaker monitors and external defibrillators with integrated electrocardiogram analysis

In addition, the Plan does not cover the following services, supplies, drugs or charges:

- A**
- Acupuncture and acupressure
 - Administrative charges billed by a provider, including charges for failure to keep a scheduled visit, completion of a claim form, obtaining medical records, late payments and telephone charges
 - Costs in excess of the *allowed amount* for services usually provided by one *doctor*, when those services are provided by multiple *doctors* or medical care provided by more than one *doctor* for treatment of the same condition
-

- B**
- **Body** piercing
 - Collection and storage of blood and stem cells taken from the umbilical cord and placenta for future use in fighting a disease
 - Blood pressure machines, cuffs or other blood pressure monitoring device
-

- C**
- **Claims** not submitted to the Plan within 18 months of the date the charge was *incurred*, except in the absence of legal capacity of the member
 - Side effects and **complications** of noncovered services, except for *emergency services* in the case of an *emergency*
 - **Convenience** items such as, but not limited to, devices and equipment used for environmental control, urinary incontinence devices (including bed wetting devices) and equipment, heating pads, hot water bottles, ice packs and personal hygiene items
 - **Cosmetic** services, which include the removal of excess skin from the abdomen, arms or thighs, and surgery for psychological or emotional reasons, except as specifically covered by the Plan
 - Services received either before or after the **coverage period** of the Plan, regardless of when the treated condition occurred, and regardless of whether the care is a continuation of care received prior to the termination
 - **Custodial care** designed essentially to assist an individual with activities of daily living, with or without routine nursing care and the supervisory care of a *doctor*. While some skilled nursing services may be provided, the patient does not require continuing skill services 24 hours daily. The individual is not under specific medical, surgical, or psychiatric treatment to reduce a physical or mental disability to the extent necessary to enable the patient to live outside either the institution or the home setting with substantial assistance and supervision, nor is there reasonable likelihood that the disability will be reduced to that level even with treatment. *Custodial care*
-

What is not Covered?

includes, but is not limited to, help in walking, bathing, dressing, feeding, preparation of special diets and supervision over medications that could otherwise be self-administered. Such services and supplies are custodial as determined by the Plan without regard to the place of service or the provider prescribing or providing the services.

D

- **Dental care**, dentures, dental implants, oral orthotic devices, palatal expanders and orthodontics except as specifically covered by the Plan.
 - **Dental services** provided in a *hospital*, except as specifically covered by the Plan.
 - Considered as evaluation and treatment of **developmental dysfunction** and/or learning disability.
 - The following drugs:
 - Injections by a health care professional of injectable prescription drugs which can be self-administered, unless medical supervision is required
 - Drugs associated with conception by artificial means.
 - For prescribed *sexual dysfunction* medications
 - Take home drugs furnished by a *hospital* or *nonhospital facility*
 - *Experimental* drugs or any drug not approved by the U.S. Food and Drug Administration (FDA) for the applicable diagnosis or treatment. However, this exclusion does not apply to prescription drugs used in covered phases II, III and IV clinical trials, or drugs approved by the FDA for treatment of cancer, if prescribed for the treatment of any type of cancer for which the drug has been proven as effective and accepted in any of the following:
 - The National Comprehensive Cancer Network Drugs & Biologics Compendium
 - The ThomsonMicromedex DrugDex
 - The Elsevier Gold Standard's Clinical Pharmacology
 - Any other authoritative compendia as recognized periodically by the United States Secretary of Health and Human Services.
-

E

- Services primarily for **educational** purposes including, but not limited to, evaluation, books, tapes, pamphlets, seminars, classroom, Web or computer programs, individual or group instruction, counseling, and vocational counseling, educational supplies such as books, tapes, and pamphlets for the patient's education at cost to physician or other qualified health care professional, educational services rendered to patients in a group setting by physician or other qualified health care professional, except as specifically covered by the Plan
 - For **educational** or achievement testing for the sole purpose of resolving educational performance questions
 - The following **equipment**:
 - Air conditioners, furnaces, humidifiers, vacuum cleaners, electronic air filters and similar equipment
 - Devices and equipment used for environmental accommodation requiring vehicle and/or building modifications such as, but not limited to, positioning seats, chair lifts, stair lifts, home elevators, and ramps
 - Physical fitness equipment, hot tubs, Jacuzzis, heated spas, whirlpools, pools or membership to health clubs
 - Personal computers
-

What is not Covered?

- Standing frames.
 - **Experimental** services including services whose efficacy has not been established by controlled clinical trials, or are not recommended as a preventive service by the U.S. Public Health Service except as specifically covered by the Plan
 - Routine **eye exams**. Fitting for eyewear, evaluations by ophthalmologist, keratomileusis, keratophakia, radial keratotomy and other refractive eye *surgery*, optokinetic nystagmus, optokinetic nystagmus, and related services to correct vision except for surgical correction of an eye injury. Also excluded are accommodating intraocular lenses or the services related to the insertion of accommodating intraocular lenses that are not required for insertion of standard intraocular lenses
 - **Eyeglasses** or contact lenses, except as specifically covered in "*Prosthetic Appliances*," and eye glass cases
-

F

- Routine **foot care** that is palliative or *cosmetic*
-

G

- **Genetic testing**, except for high risk patients when the therapeutic or diagnostic course would be determined by the outcome of testing
-

H

- Routine **hearing** examinations and hearing aids or examinations for the fitting of hearing aids except as specifically covered by the Plan
 - **Holistic or alternative medicine** services, which are unproven preventive or treatment modalities, generally described as alternative, integrative or complementary medicine, whether performed by a physician or any other provider, except as specifically covered by your health benefit plan
 - **Hypnosis** except when used for control of acute or chronic pain.
-

I

- **Inpatient admissions** primarily for the purpose of receiving diagnostic services or a physical examination. *Inpatient* admissions primarily for the purpose of receiving therapy services, except when the admission is a continuation of treatment following care at an *inpatient* facility for an illness or accident requiring therapy.
 - Services that are **investigational** in nature or obsolete, including any service, drugs, procedure or treatment directly related to an investigational treatment, except as specifically covered by the Plan.
-

L

- Services provided and billed by a **lactation** consultant, except when covered as preventive care.
-

M

- Services or supplies deemed not **medically necessary**.
-

N

- Services that would not be necessary if a **noncovered service** had not been received, except for *emergency services* in the case of an *emergency*. This includes any services, procedures or supplies associated with *cosmetic* services, investigational services, services deemed not medically necessary, or elective termination of pregnancy, if not specifically covered by the Plan.
-

What is not Covered?

- O**
- Any treatment or regimen, medical or surgical, for the purpose of reducing or controlling the weight of a member or for treatment of **obesity**, except for surgical treatment of morbid obesity, or as specifically covered by the Plan. Used to treat *Bariatric surgery*, except when provided at a Blue Distinction Center (BDC).
-

- P**
- Care or services from a **provider** who:
 - Cannot legally provide or legally charge for the services or services are outside the scope of the provider's license or *certification*
 - Provides and bills for services from a licensed health care professional who is in training
 - Is in a member's immediate family
 - Is not recognized by the Plan as an eligible provider
-

- R**
- The following **residential care** services:
 - Care in a self-care unit, apartment or similar facility operated by or connected with a hospital
 - Domiciliary care or rest cures, care provided and billed for by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility, home for the aged, infirmary, school infirmary, institution providing education in special environments, in residential treatment facilities (except for *chemical dependency* treatment) or any similar facility or institution.
 - **Respite care**, whether in the home or in a facility or *inpatient* setting, except as specifically covered by the Plan.
-

- S**
- **Services** or **supplies** that are:
 - Not performed by or upon the direction of a *doctor* or other provider
 - Available to a member with charge.
 - Treatment or studies leading to or in connection with **sex change or modifications** and related care.
 - **Sexual dysfunction** unrelated to organic disease.
 - **Shoe** lifts, shoe accessories, attachment, equipment, inserts and other modifications, and shoes of any type unless part of a brace, and except as specifically covered by your health benefit plan
 - Services, supplies, drugs or equipment used for the control or treatment of **stammering or stuttering**.
-

- T**
- The following types of **therapy**:
 - Applied Behavior Analysis (ABA) therapy except as specifically identified by the plan
 - Music therapy, remedial reading, recreational or activity therapy, all forms of special education and supplies or equipment used similarly
 - Maintenance therapy
 - Massage therapy
 - **Travel**, whether or not recommended or prescribed by a *doctor* or other licensed health care professional, except as specifically covered by the Plan.
-

- V**
- The following **vision** services:
 - Radial keratotomy and other refractive eye surgery, and related services to correct vision except for surgical correction of an eye injury. Also excluded are premium intraocular lenses or the services related to the insertion of premium lenses beyond what is required for insertion of conventional intraocular lenses, which are small, lightweight, clear disks that replace the distance-focusing power of the eye's natural crystalline lens.
 - Orthoptics **vision training**, and low **vision aids**.
-

What is not Covered?

- For over-the-counter and non-federal legend **Vitamins**, food supplements or replacements, nutritional or dietary supplements, formulas or special foods of any kind, except for prescription prenatal vitamins or prescription vitamin B-12 injections for anemias, neuropathies or dementias secondary to a vitamin B-12 deficiency, or certain over-the-counter medications that may be available under your preventive care benefits for certain individuals.
- **Wigs**, hairpieces and hair implants for any reason.

W

Utilization Management

To make sure you have access to high quality, cost effective health care, the *State Health Plan* has a *Utilization Management (UM)* program. The *UM* program requires that certain health care services be reviewed and approved by the *State Health Plan* or its representative in order to receive benefits. As part of this process, the *State Health Plan* determines whether health care services are *medically necessary*, provided in the proper setting and for a reasonable length of time. The *State Health Plan* will honor a *certification* to cover *medical services* or supplies under your health benefit plan unless the *certification* was based on a material misrepresentation about your health condition or you were not eligible for these services under your health benefit plan due to termination of coverage or nonpayment of premiums.

Rights and Responsibilities Under the UM Program

Your Member Rights

Under the *UM* program, you have the right to:

- A *UM* decision that is timely, meeting applicable federal time frames
- The reasons for denial of a requested treatment or health care service, including an explanation of the *UM* criteria and treatment protocol used to reach the decision
- Have a medical director from the *State Health Plan* or its representative make a review of all denials of service that were based upon *medical necessity*
- Request a review of denial of benefit coverage through the *grievance* process. See "What If You Disagree With A Decision?"
- Have an authorized representative pursue payment of a claim or make an *appeal* on your behalf.

An authorized representative may act on the *member's* behalf with the *member's* written consent. In the event you appoint an authorized representative, references to "you" under the "*Utilization Management*" section mean "you or your authorized representative" (i.e., the authorized representative may pursue your rights and will receive all notices and benefit determinations).

The State Health Plan's Responsibilities

As part of all *UM* decisions, the *State Health Plan* or its representative will:

- Provide you and your *provider* with a toll-free telephone number to call *UM* review staff when *certification* of a health care service is needed. See "Whom Do I Call?"
- Limit what the *State Health Plan* or its representative requests 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 your health benefit plan.

In the event the *State Health Plan* or its representative does not receive sufficient information to approve coverage for a health care service within specified time frames, your health benefit plan 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.

Prior Review (Pre-Service)

In-network providers outside of North Carolina, except for Veterans' Affairs (VA) and military providers, are responsible for requesting prior review for inpatient facility services. For all other covered services received outside of North Carolina, you are responsible for ensuring that you or your provider requests prior review by the State Health Plan even if you see an in-network provider.

The *State Health Plan* requires that certain health care services receive *prior review* as noted in "*Covered Services*." These types of reviews are called pre-service reviews. If neither you nor your *provider*

Utilization Management

requests *prior review* and receives *certification*, this will result in a complete denial of benefits. The list of services that require *prior review* may change from time to time.

General categories of services with this requirement are noted in “*Covered Services*.” You may also visit our website at www.shpnc.org or call Customer Service at the number listed in “Whom Do I Call?” for a detailed list of services.

If you fail to follow the procedures for filing a request, the Plan or its authorized representative will notify you of the failure and the proper procedures to be followed in filing your request within five days of receiving the request.

The *State Health Plan* or its representative will make a decision on your request for *certification* within a reasonable amount of time taking into account the medical circumstances. The decision will be made and communicated within three business days after the *State Health Plan* or its representative receives all necessary information, but no later than 15 days from the date your request has been received. If your request is incomplete, then within five days of receipt of your request, you and your *provider* will be notified of how to properly complete your request. The *State Health Plan* or its representative may also take an extension of up to 15 days, if additional information is needed. The *State Health Plan* or its representative will notify you and your *provider* before the end of the initial 15-day period of the information needed and the date by which the *State Health Plan* or its representative expects to make a decision. You will have 45 days to provide the requested information. As soon as the *State Health Plan* or its representative receives the requested information, or at the end of the 45 days, whichever is earlier, a decision will be made within three business days. The *State Health Plan* or its representative will notify you and your *provider* of an adverse benefit determination electronically or in writing.

Urgent Prior Review

You have a right to an urgent review when the regular time frames for a decision: (i) could seriously jeopardize your or your *dependent's* life, health, or ability to regain maximum function; or (ii) in the opinion of your *provider*, would subject you or your *dependent* to severe pain that cannot be adequately managed without the requested care or treatment. The *State Health Plan* or its representative will notify you and your *provider* of its decision as soon as possible, taking into account the medical circumstances. The *State Health Plan* or its representative will notify you and your *provider* of its decision within 72 hours after receiving the request. If the *State Health Plan* or its representative needs additional information to process your expedited review, they will notify you and your *provider* of the information needed as soon as possible but no later than 24 hours following the receipt of your request. You will then be given a reasonable amount of time, but not less than 48 hours, to provide the requested information. As soon as the *State Health Plan* or its representative receives the requested information, or at the end of the time period specified for you to provide the information, whichever is earlier, the *State Health Plan* or its representative will make a decision on your request within a reasonable time but no later than 48 hours.

An urgent review may be requested by calling State Health Plan Customer Service at the number listed in “Whom Do I Call?”

Concurrent Reviews

The *State Health Plan* or its representative will also review health care services at the time you receive them. These types of reviews are concurrent reviews.

If a request for an extension of treatment is non-urgent, a decision will be made and communicated to the requesting *hospital* or other facility within three business days after receipt of all necessary clinical information, but no later than 15 days after we receive the request.

Urgent Concurrent Review

If a request for an extension of treatment is urgent, and the request is received at least 24 hours before the expiration of a previously approved *inpatient* stay or course of treatment at the requesting *hospital*

Utilization Management

or other facility, a decision will be made and communicated to the requesting *hospital* or other facility as soon as possible, but no later than 24 hours after we receive the request.

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

In the event of an adverse determination, the Plan or its representative will notify you, your *hospital's* or other facility's UM department and your provider. Written confirmation of the decision will also be sent to your home by U.S. mail. For concurrent reviews, the Plan or its representative will remain responsible for covered services you are receiving until you or your representatives have been notified of the adverse benefit determination.

Retrospective Reviews (Post-Service)

The *State Health Plan* or its representative also reviews the coverage of health care 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*. The *State Health Plan* or its representative 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 the *State Health Plan* or its representative received the request. In the event of an adverse benefit determination, the Plan or its representative will notify you and your provider in writing within five business days of the decision. All decisions will be based on medical necessity and whether the service received was a benefit under the Plan. If more information is needed before the end of the initial 30-day period, the Plan or its representative will notify you of the information needed. You will then have 90 days to provide the requested information. As soon as the Plan or its representative receives the requested information, or at the end of the 90 days, whichever is earlier, the Plan or its representative will make a decision within 15 days. Services that were approved in advance by the Plan or its representative will not be subject to denial for medical necessity once the claim is received, **unless the certification was based on a material misrepresentation about your health condition or you were not eligible for these services under your health benefit plan due to termination of coverage or nonpayment of premiums**. All other services may be subject to retrospective review and could be denied for *medical necessity* or for a benefit limitation or exclusion.

Care Management

Members with complicated and/or chronic medical needs may be eligible for care management services. Care management, also known as case management, encourages *members* with complicated or chronic medical needs, their *providers*, and the *State Health Plan* or its representative to work together to identify the appropriate services to meet the individual's health needs and promote quality outcomes. To accomplish this, *members* enrolled in or eligible for care management programs may be contacted by the *State Health Plan* or by a representative of the *State Health Plan*. Care Management services are provided solely at the option of the *State Health Plan* or its representative, and the *State Health Plan* is not obligated to provide the same benefits or services to a *member* at a later date or to any other *member*. Information about these services can be obtained by calling *State Health Plan* Customer Service.

Continuity of Care

Utilization Management

Continuity of care is a process that allows you to continue receiving care from an *out-of-network provider* for an ongoing special condition at the *in-network* benefit level when you or your *employer* changes health benefit plans or when your *provider* is no longer in the Blue Options network. To be eligible for continuity of care, you must be actively being seen by an *out-of-network provider* for an ongoing special condition and the *provider* must agree to abide by the *State Health Plan's* or its representative's requirements for continuity of care.

An ongoing special condition means:

- In the case of an acute illness, a condition that is serious enough to require *medical care* or treatment to avoid a reasonable possibility of death or permanent harm;
- In the case of a chronic illness or condition, a disease or condition that is life-threatening, degenerative, or disabling, and requires *medical care* or treatment over a prolonged period of time;
- In the case of pregnancy, the second and third trimesters of pregnancy;
- In the case of a terminal illness, an individual has a medical prognosis that the *member's* life expectancy is six months or less.

The allowed transitional period shall extend up to 90 days, as determined by the *provider*, except in the cases of:

- Scheduled *surgery*, organ transplantation, or *inpatient* care which shall extend through the date of discharge and post discharge follow-up care or other *inpatient* care occurring within 90 days of the date of discharge; and
- Second trimester pregnancy which shall extend through the provision of 60 days of postpartum care; and
- Terminal illness which shall extend through the remainder of the individual's life with the respect to care directly related to the treatment of the terminal illness.

Continuity of care requests will be reviewed by a medical professional based on the information provided about specific medical conditions. Claims for approved continuity of care services will be paid at the *in-network* benefit level. Continuity of care will not be provided when the *provider's* contract was terminated for reasons relating to quality of care or fraud. Such a decision may not be reviewed on *appeal*. Please call *State Health Plan* Customer Service at the number listed in "Whom Do I Call?" for additional information.

Further Review of Utilization Management Decisions

If you receive a *noncertification* as part of the *prior review* process, you have the right to request that the *State Health Plan* or its representative review the decision through the *grievance* process. Refer to "What If You Disagree With A Decision?"

Delegated Utilization Management

For *UM* and the first level *grievance* review for *inpatient* and *outpatient* mental health and *chemical dependency* services, your *Mental Health Case Manager* is responsible. The Case Manager's decision making is based on the appropriateness of care and service as well as existence of coverage. Claim determinations and second level *grievance* reviews are provided by the *State Health Plan* or its representative. The Mental Health Case Manager does not reward *practitioners*, or other individuals, for issuing denials of coverage or service. Financial incentives are not given that would encourage decisions resulting in less care than needed.

Evaluating New Technology

In an effort to allow for continuous quality improvement, the *State Health Plan* or its representative has processes in place to evaluate new medical technology, procedures and equipment. These policies allow the *State Health Plan* or its representative to determine the best services and products to offer *members*. They also help the *State Health Plan* or its representative to keep pace with the ever-advancing medical field. Before implementing any new or revised policies, the *State Health Plan* or its representative

Utilization Management

reviews professionally supported scientific literature as well as state and federal guidelines, regulations, recommendations, and requirements. The *State Health Plan* or its representative then seeks additional input from *providers* who know the needs of the patients they serve.

What if you disagree with a Decision?

In addition to the *UM* program, your health benefit plan offers a *grievance* procedure for *members*. *Grievances* include dissatisfaction with a claims denial or any decisions (including an *appeal* of a *noncertification* decision), policies or actions related to the availability, delivery or quality of health care services. If you have a *grievance*, you have the right to request that the *State Health Plan* or its representative review the decision through the *grievance* process. ***Grievances are not allowed for benefits or services that are clearly excluded by this benefits booklet or for deductibles, coinsurance or coinsurance maximum, as well as other aspects of coverage excluded from appeal by law.*** 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). 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.

In addition, *members* may also receive assistance with *grievances* from the Health Insurance Smart NC, a program offered by the North Carolina Department of Insurance by contacting:

NC Department of Insurance Health Insurance
Smart NC
1201 Mail Service Center
Raleigh, NC 27699-1201
(855) 408-1212

Steps To Follow In the Grievance Process

First Level Grievance Review

The review must be requested in writing, within 180 days of a denial of benefit coverage. To request a form to submit a first level *grievance* review, visit the *State Health Plan* website or call *State Health Plan* Customer Service at the number given in "Whom Do I Call?"

Any request for review should include:

- *Member's ID number*
- *Member's name*
- Any other information that may be helpful for the review.
- Patient's name
- The nature of the *grievance*

Although you are not allowed to participate in a first level *grievance* review, the *State Health Plan* or its representative asks that you send all of the written material you feel is necessary to make a decision. The *State Health Plan* or its representative 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 the *State Health Plan* or its representative received the request. You may then request, free of charge, 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. The request must be made in writing within 180 days of the first level *grievance* review decision. Within ten business days after the *State Health Plan* or its representative receives your request for a second level *grievance* review, the following information will be given to you:

What if you disagree with a Decision?

- Name, address and telephone number of the *grievance* coordinator
- A statement of your rights, including the right to:
 - request and receive from the *State Health Plan* or its representative all information that applies to your case
 - participate in the second level *grievance* review meeting
 - present your case to the review panel
 - submit supporting material before and during the review meeting
 - ask questions of any *member* of the review panel
 - be assisted or represented by a person of your choosing, including a family *member*, an *employer* representative, or an attorney.

The second level review meeting, which will be conducted by a review panel coordinated by the *State Health Plan* or its representative using external physicians and/or benefit experts, will be held within 45 days after the *State Health Plan* or its representative receives a second level *grievance* review request. You will receive notice of the meeting date and time at least 15 days before the meeting. You have the right to a full review of your *grievance* even if you do not participate in the meeting. A written decision will be issued to you within seven business days of the review meeting.

Expedited Review

You have the right to a more rapid or expedited review of a denial of coverage if a delay: (i) would reasonably appear to seriously jeopardize your or your *dependent's* life, health or ability to regain maximum function; or (ii) in the opinion of your *provider*, would subject you or your *dependent* to severe pain that cannot be adequately managed without the requested care or treatment. You can request an expedited second level review even if you did not request that the initial review be expedited. An expedited review may be initiated by calling *State Health Plan* Customer Service at the number listed in "Whom Do I Call?" An expedited review will take place in consultation with a medical *doctor*. All of the same conditions for a first level or second level *grievance* review apply to an expedited review. The *State Health Plan* or its representative will communicate the decision by phone to you and your *provider* as soon as possible, taking into account the medical circumstances, but no later than 72 hours after receiving the request. A written decision will be communicated within four days after receiving the request for the expedited *appeal*. Information initially given by telephone must also be given in writing.

After requesting an expedited review, the *State Health Plan* will remain responsible for covered health care services you are receiving until you have been notified of the review decision.

External Review

North Carolina law provides for review of *noncertification* decisions by an external, independent review organization (IRO). The North Carolina General Statute can be found at N.C.G.S. 58-50-80. The North Carolina Department of Insurance (NCDOI) administers this service at no charge to you, arranging for an IRO to review your case once the NCDOI establishes that your request is complete and eligible for review.

The *State Health Plan* will notify you of your right to request an external review each time you receive:

- a *noncertification* decision or,
- an *appeal* decision upholding a *noncertification* decision.

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

- your request is about a *medical necessity* determination that resulted in *noncertification*;
- you had coverage with the *State Health Plan* when the *noncertification* was issued;
- the service for which the *noncertification* was issued appears to be a *covered* service; and
- you have exhausted the *State Health Plan's* first and second level *grievance* process as described above.

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For a standard external review, you will have exhausted the internal *grievance* review process if you have:

- completed the *State Health Plan*'s first and second level *grievance* review and received a written second level determination from the *State Health Plan* or its representative, or
- filed a second level *grievance* and have not requested or agreed to a delay in the second level *grievance* process, but have not received the *State Health Plan*'s or its representative's written decision within 60 days from the date that you can demonstrate that an *appeal* was filed with *BCBSNC*, or received written notification that the *State Health Plan* or its representative has agreed to waive the requirement to exhaust the internal *appeal* and/or second level *grievance* process.

External reviews are performed on a standard or expedited basis, depending on which is requested and on whether medical circumstances meet the criteria for expedited review.

Standard External Review

For all requests for a standard external review, you must file your request with the NCDOI within 120 days of receiving one of the notices listed above. If the request for an external review is related to a retrospective *noncertification* (a *noncertification* which occurs after you have already received the services in question), the 60-day time limit for receiving the *State Health Plan*'s second level determination does not apply. You will not be eligible to request an external review until you have exhausted the internal *appeal* process and have received a written second level determination from the *State Health Plan* or its representative.

Expedited External review

An expedited external review may be available if the time required to complete either an expedited internal first or second level *grievance* review or standard external review would reasonably be expected to seriously jeopardize your life or health or to jeopardize your ability to regain maximum function. If you meet this requirement, you may make a written or verbal request to the NCDOI for an expedited external review, after you receive:

- a *noncertification* from the *State Health Plan* or its representative and have filed a request with the *State Health Plan* or its representative for an expedited first level *appeal*; or
- a first level *appeal* decision upholding a *noncertification* and have filed a request with the *State Health Plan* or its representative for an expedited second level *grievance* review; or
- a second level *grievance* review decision from the *State Health Plan* or its representative.

In addition, prior to your discharge from an *inpatient* facility, you may also request an expedited external review after receiving a first level *appeal* or second level *grievance* decision concerning a *noncertification* of the admission, availability of care, continued stay or *emergency* health care services.

If your request is not accepted for expedited review, the NCDOI may: (1) accept the case for standard external review if you have exhausted the internal *grievance* review process; or (2) require the completion of the internal *grievance* review process and another request for an external review. An expedited external review is not available for retrospective *noncertifications*.

When processing your request for external review, the NCDOI will require you to provide the NCDOI with a written, signed authorization for the release of any of your medical records that need to be reviewed for the purpose of reaching a decision on the external review. For further information about external review or to request an external review, contact the NCDOI at:

<u>Mail</u>	<u>In person</u>	<u>Web</u>
NC Department of Insurance Health Insurance Smart NC 1201 Mail Service Center Raleigh, NC 27699-1201 Fax: 919-807-6865	NC Department of Insurance Dobbs Building 430 N. Salisbury Street, 1 st Floor, Suite 101 Raleigh, NC 27603 Tel: 919-807-6860	www.ncdoi.com/Smart for external review information and request form

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Tel: (toll free in NC)
(855) 408-1212

The Health Insurance Smart NC Program provides consumer counseling on utilization review and *grievance* issues. Within ten business days (or, for an expedited review, within three business days) of receipt of your request for an external review, the NCDOI will notify you and your *provider* of whether your request is complete and whether it has been accepted. If the NCDOI notifies you that your request is incomplete, you must provide all requested, additional information to the NCDOI within 150 days of the written notice from the *State Health Plan* or its representative, upholding a *noncertification* (generally the notice of a second level *grievance* review decision), which initiated your request for an external review. If the NCDOI accepts your request, the acceptance notice will include: (i) name and contact information for the IRO assigned to your case; (ii) a copy of the information about your case that the *State Health Plan* or its representative has provided to the NCDOI; and (iii) a notification that you may submit additional written information and supporting documentation relevant to the initial *noncertification* to the assigned IRO within seven days after the receipt of the notice. It is presumed that you have received written notice two days after the notice was mailed. Within seven days of the *State Health Plan's* receipt of the acceptance notice (or, for an expedited review, within the same day), the *State Health Plan* or its representative shall provide the IRO and you, by the same or similar expeditious means of communication, the documents and any information considered in making the *noncertification appeal* decision or the second level *grievance* review decision. If you choose to provide any additional information to the IRO, you must also provide that same information to the *State Health Plan* at the same time and by the same means of communication (e.g., you must fax the information to BCBSNC if you faxed it to the IRO).

When sending additional information to the *State Health Plan*, send it to:

State Health Plan
c/o BCBSNC Appeals Department
P.O. Box 30055
Durham, NC 27702-3055

Please note that you may also provide this additional information to the NCDOI within the seven-day deadline rather than sending it directly to the IRO and the *State Health Plan*. The NCDOI will forward this information to the IRO and the *State Health Plan* within two business days of receiving the additional information.

The IRO will send you a written notice of its decision within 45 days (or, for an expedited review, within four business days) of the date the NCDOI received your external review request. If the IRO's decision is to reverse the *noncertification*, the *State Health Plan* will, within three business days (or, for an expedited review, within one day) of receiving notice of the IRO's decision, reverse the *noncertification* decision and provide coverage for the requested service or supply. If you are no longer covered by the *State Health Plan* at the time the *State Health Plan* receives notice of the IRO's decision to reverse the *noncertification*, the *State Health Plan* will only provide coverage for those services or supplies you actually received or would have received prior to disenrollment if the service had not been noncertified when first requested.

The IRO's external review decision is binding on the *State Health Plan* and you, except to the extent you may have other remedies available under applicable federal or state law. You may not file a subsequent request for an external review involving the same *noncertification* for which you have already received an external review decision.

Third Level Grievance Review

If you do not agree with the second level decision, you may be able to *appeal* this decision by filing a Petition for Contested Case Hearing with the North Carolina Office of Administrative Hearings (OAH). This *appeal* must be received and filed with OAH within sixty (60) days of the date of the second level decision. Your second level decision and North Carolina General Statute (NCGS) 135-48.24 identifies

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those *appeals* that may be filed at OAH, OAH's address, the time period for filing an *appeal*, and any applicable fees. N.C.G.S. 135-48.24, as well as all *State Health Plan* statutes and medical policies, can be found at www.shpnc.org. The OAH statute is found in the North Carolina General Statutes at Chapter 150B. Information is also available on OAH's website at www.oah.state.nc.us.

Appeals Correspondence

Correspondence related to a request for a review through the *grievance* process should be sent to:

Medical Appeals

State Health Plan
c/o BCBSNC Appeals Department
P.O. Box 30055
Durham, NC 27702-3055

Pharmacy Appeals

The *State Health Plan* or its representative is responsible for all first and second level *grievance* review of pharmacy benefits. Please forward *grievances* to:

State Health Plan
c/o BCBSNC Appeals Department
P.O. Box 30055
Durham, NC 27702-3055

Mental Health Appeals

Your *Mental Health Case Manager* is responsible for the first level grievance review for mental health and chemical dependency inpatient hospitalizations, residential treatment centers, partial day/night programs, and intensive outpatient program services. Please forward *grievances* to:

State Health Plan
c/o Mental Health Case Manager
P.O. Box 12438
Research Triangle Park, NC 27709
Attn: *Appeals*

For special handling (i.e., FedEx or UPS), send to:

State Health Plan
c/o Mental Health Case Manager
3800 Paramount Parkway, Suite 300
Morrisville, NC 27560-6901
Attn: *Appeals*

Second level *grievance* review is provided by the *State Health Plan* or its representative. Please forward second level *appeals* to:

State Health Plan
c/o BCBSNC Appeals Department
P.O. Box 30055
Durham, NC 27702-3055

Additional Terms of Your Coverage

Benefits to Which Members are Entitled

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 the *State Health Plan* or its representative, payment for services will be made to the *provider* of the services, or the *State Health Plan* or its representative may choose to pay the *subscriber*.

If a *member* resides with a custodial parent or legal guardian who is not the *subscriber*, the *State Health Plan* or its representative 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 *State Health Plan* or its representative chooses to make the payment to the *subscriber* or custodial parent or legal guardian, it is his or her responsibility to pay the *provider*.

Benefits for *covered services* specified in your health benefit plan will be provided only for services and supplies that are performed by a *provider* as specified in your health benefit plan and regularly included in the *allowed amount*. The *State Health Plan* or its representative establishes coverage determination guidelines that specify how services and supplies must be billed in order for payment to be made under your health benefit plan.

Any amounts paid by the *State Health Plan* for services not covered or that are in excess of the benefit provided under your health benefit plan coverage may be recovered by the *State Health Plan*. The *State Health Plan* or its representative may recover the amounts by deducting from a *member's* future claims payments or by collecting directly from the *member*. This can result in a reduction or elimination of future claims payments. Amounts paid by the *State Health Plan* for work related accidents, injuries, or illnesses covered under state workers' compensation laws will be recovered upon final adjudication of the claim or an order of the applicable state agency approving a settlement agreement. It is the legal obligation of the *member*, the employer or the workers' compensation insurer (whoever is responsible for payment of the medical expenses) to notify the *State Health Plan* or its representative 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.

Disclosure of Protected Health Information (PHI)

The *State Health Plan* and its representatives, takes your privacy seriously and handles all PHI as required by state and federal laws and regulations. The *State Health Plan* has developed a privacy notice that explains the procedures. The *State Health Plan* privacy notice is included in the back of this booklet or it can be found on the website at www.shpnc.org.

Administrative Discretion

The *State Health Plan* and its representatives have the authority to make reasonable determinations in the administration of coverage. These determinations will be final. Such determinations include decisions concerning coverage of services, care, treatment or supplies, and reasonableness of charges. Medical policies are guides considered when making coverage determinations.

Receiving Care When You Are Outside Of North Carolina

Your health benefit plan offers you the choice of receiving either *in-network* or *out-of-network* benefits while outside of North Carolina. Your *ID card* gives you access to participating *providers* outside the state of North Carolina through the BlueCard[®] CDHP program. When you use a *provider* participating in the local Blue Cross or Blue Shield Plan's *provider* network, you will receive the higher *in-network* benefit level. If you are in an area that has participating *providers* and you choose a *provider* outside the network, you will receive the lower *out-of-network* benefits. However, if participating *providers* through the BlueCard[®] CDHP program are not reasonably available to the *member* as determined by the access to care standards, which are available on our website at www.shpnc.org or by calling *State Health Plan* Customer Service at the number given in "Whom do I call?," your benefits will be paid at the *in-network* benefit level. In an *emergency*, you should seek care from an *emergency*

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room or other similar facility. If you go to an *emergency* room for treatment of an *emergency*, your benefit level will be the same, regardless of whether you use an *in-network* or *out-of-network provider*. If you receive services outside of North Carolina, either *in-network* or *out-of-network*, you are responsible for requesting or ensuring that your *provider* requests *prior review* by the *State Health Plan* or its representative for those services that require *prior review*. For a list of services that require *prior review*, visit the *State Health Plan* website at www.shpnc.org. Failure to request *prior review* and receive *certification* will result in a full denial of benefits. For exceptions to *prior review* requirements, see "*Emergency and Urgent Care Services*" and "Maternity Care" in "*Covered Services*."

To see if an *in-network provider* is available in your location within the USA, you should call the BlueCard® CDHP program number listed in "Whom Do I Call?" and on the back of your *ID card*. If you are traveling outside the USA, you should call collect the BlueCard® number that is listed in "Whom Do I Call?"

Mental Health and Chemical Dependency Services

Although *prior review* is not required in an *emergency*, you may contact the *Mental Health Case Manager* for assistance in locating a *provider*.

If you need urgent *inpatient* or *outpatient* mental health or *chemical dependency* services while outside North Carolina, contact Customer Service at the number listed in "Whom Do I Call?" for assistance in locating a *provider*. You must request *prior review* and receive *certification* from the *Mental Health Case Manager* for mental health and *chemical dependency* services other than *office visits* or in *emergencies*. BlueCard® CDHP does not provide *prior review* or *certification* for mental health and *chemical dependency* services. The numbers for *Mental Health Case Manager* are provided in "Whom Do I Call?" and on the back of your *ID card*. For more information on these services, see "*Covered Services*."

Provider Reimbursement

Services Received In North Carolina

Benefits for services provided by *in-network* and *out-of-network providers* are reimbursed as follows:

In-network providers— benefits are based on the lesser of the *allowed amount* or the *provider's* charge. *In-network providers* agree to limit charges for *covered services* to the *allowed amount*. However, *members* are responsible for any *deductibles*, *coinsurance* and charges not covered by the health benefit plan, such as amounts above benefit maximums. *Members* are responsible for the full cost of *noncovered services*.

In-network providers agree to bill the *State Health Plan* directly for any *covered services* provided to *members* so the *member* is not responsible for submitting claims. In some situations, an *out-of-network provider* may be designated to serve as an *in-network provider* for a specific service. In this situation, the *member* may be billed by the *provider*. If you are billed, you will be responsible for paying the bill and filing a claim. Whether the claim is filed by the *provider* or by the *member*, benefits will be at the *in-network* benefit level.

Out-of-network providers— benefits are paid based on the *allowed amount*. *Members* are responsible for any amounts over the *allowed amount*, *deductibles*, *coinsurance* and charges not covered by your health benefit plan, such as amounts above benefit maximums. *Members* are responsible for the full cost of *noncovered services*.

If you receive care from an *out-of-network provider* in an *emergency*, or *in-network providers* are not reasonably available as determined by the access to care standards which are available on our website at www.shpnc.org or by calling the *State Health Plan* Customer Service at the number listed in "Whom Do I Call?", your benefits will be paid at the *in-network* benefit level. Please see "*Out-of-Network Benefits*" and "*Emergency and Urgent Care Services*."

Some *out-of-network providers* have other agreements with BCBSNC that affect their reimbursement for *covered services* provided to *members*. These *providers* agree not to bill *members* for any charges higher than their agreed upon, contracted amount. In these situations, *members* will be responsible for the difference

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between the *allowed amount* and the contracted amount. *Out-of-network providers* may bill you directly. If you are billed, you will be responsible for paying the bill and filing a claim. See "How To File A Claim."

Right of Recovery/Subrogation Provision

Immediately upon paying or providing any benefit under your health benefit plan, the *State Health Plan* shall be subrogated to all rights of recovery a *member* has against any party potentially responsible for making any payment to a *member* due to a *member's* injuries or illness, to the full extent of benefits provided or to be provided by your health benefit plan.

In addition, if a *member* receives any payment from any potentially responsible party as a result of an injury or illness, the *State Health Plan* has the right to recover from, and be reimbursed by, the *member* for all amounts the *State Health Plan* has paid and will pay as a result of that injury or illness, up to and including the full amount the *member* receives from all potentially responsible parties. Further, the *State Health Plan* will automatically have a lien, to the extent of benefits advanced, upon any recovery whether by settlement, judgment or otherwise, that a *member* receives from a third party, the third party's insurer or any other source as a result of the *member's* injuries. The lien is in the amount of benefits paid by the *State Health Plan* for the treatment of the illness, injury or condition for which another party is responsible.

As used throughout this provision, the term responsible party means any party possibly responsible for making any payment to a *member* due to a *member's* injuries or illness or any insurance coverage. The *member* acknowledges that the *State Health Plan's* recovery rights are a first priority claim against all potentially responsible parties and are to be paid to the *State Health Plan* before any other claim for the *member's* damages. The *State Health Plan* shall be entitled to full reimbursement first from any potential responsible party payments, even if such payment to the *State Health Plan* will result in a recovery to the *member* which is insufficient to make the *member* whole or to compensate the *member* in part or in whole for the damages sustained. It is further understood that the *State Health Plan* will pay all fees associated with counsel it hires to represent its interests related to any recovery it may be entitled to, but it is agreed that the *State Health Plan* is not required to participate in or pay court costs or attorney fees to any attorney hired by the *member*.

The terms of this entire right of recovery provision shall apply and the *State Health Plan* is entitled to full recovery regardless of whether any liability for payment is admitted by any potentially responsible party and regardless of whether the settlement or judgment received by the *member* identifies the medical benefits the *State Health Plan* provided. The *State Health Plan* is entitled to recover from **any and all** settlements or judgments, even those designated as pain and suffering or non-economic damages only.

The *member* acknowledges that the *State Health Plan* delegates authority to assert and pursue the right of subrogation and/or reimbursement on behalf of the *State Health Plan*. The *member* shall fully cooperate with the *State Health Plan* or its representative's efforts to recover benefits paid by the *State Health Plan*. It is the duty of the *member* to notify the *State Health Plan* or its representative in writing of the *member's* intent to pursue a claim against any potentially responsible party, within 30 days of the date when any notice is given to any party, including an attorney, of the intention to pursue or investigate a claim to recover damages or obtain compensation due to injuries or illness sustained by the *member*. The *member* shall provide all information requested by the *State Health Plan* or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the *State Health Plan* may reasonably request.

The *member* shall do nothing to prejudice the *State Health Plan's* recovery rights as herein set forth. This includes, but is not limited to, refraining from entering into any settlement or recovery that attempts to reduce, waive, bar or exclude the full cost of all benefits provided by your health benefit plan as provided by law.

In the event that any claim is made that any part of this right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the *member* and the *State Health Plan* or its representative agree that the *State Health Plan* shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

The *member* agrees that any legal action or proceeding with respect to this provision may be brought in any court of competent jurisdiction as the *State Health Plan* may elect. Upon receiving benefits under your health benefit plan,

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the *member* hereby submits to each such jurisdiction, waiving whatever rights may correspond to the *member* by reason of the *member's* present or future domicile.

If any information in this booklet conflicts with North Carolina state law or it conflicts with medical policies adopted under your health benefit plan, North Carolina law and such medical policies will prevail.

Notice of Claim

Your health benefit plan will not be liable for payment of benefits unless proper notice is furnished to the *State Health Plan* or its representative that *covered services* have been provided to a *member*. If the *member* files the claim, written notice must be given to the *State Health Plan* or its designated representative within 18 months after the *member* incurs the *covered service*. The notice must be on an approved claim form and include the data necessary for the *State Health Plan* or its representative as specifically set out in this benefits booklet to determine benefits.

Limitations of Actions

No legal action may be taken to recover benefits for 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 a Decision?" for details regarding the *grievance* review process.

Coordination of Benefits (Overlapping Coverage)

If a *member* is also enrolled in another group health plan, the *State Health Plan* may coordinate benefits with the other plan. Coordination of benefits (COB) means that if a *member* is covered by more than one health benefit plan, benefits under one plan are determined before the benefits are determined under the second plan. The plan that determines benefits first is called the primary plan. The other plan is called the secondary plan. Benefits paid by the secondary plan may be reduced to avoid paying benefits between the two plans that are greater than the cost of the health care service.

The rules by which a plan is determined primary or secondary are listed below.

Order of Benefits Determination

Subscriber or Spouse:

- The health benefit plan covering a person as a *subscriber* is primary
- The health benefit plan covering a person as a *spouse* is secondary

Dependent Children:

- The health benefit plan that covers the child as a *dependent* of the parent whose birthday falls first during the year is primary
- The health benefit plan that covers the child as a *dependent* of the parent whose birthday falls later in the year is secondary
- If both parents have the same birthday, benefits under the plan that has covered the parent for a longer period of time shall be determined primary to the plan that has covered the other parent for a shorter period of time
- If the parents are divorced or separated, the following order of benefits determination is followed:
- Benefits under the health benefit plan that covers the child as a *dependent* of the parent with custody are determined primary to
- Benefits under the health benefit plan that covers the child as a *dependent* of the *spouse* of the parent with custody are determined primary to
- Benefits under the health benefit plan that covers the child as a *dependent* of the parent without custody.

NOTE: If there is a court order that requires a parent to assume financial responsibility for the child's health care coverage, and the *State Health Plan* or its representative has actual knowledge of those terms of the court order, benefits under that parent's health benefit plan are determined primary.

Other Rules

- For proper coordination of your benefits, you are required to notify the *State Health Plan* of Medicare eligibility immediately.
- The benefits of a plan that covers the person as an active *employee* (neither laid off nor retired) or as a *dependent* of an active *employee* are determined before those of a plan that covers that person as a laid-off or retired *employee* or as that *employee's dependent*. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
- The health benefit plan that has covered the person the longest will be primary if none of the rules listed above determine order of benefits payment
- If the other health benefit plan does not have rules that establish the same order of benefits as under this health benefit plan, the benefits under the other plan will be determined primary to the benefits under this health benefit plan.

Benefit Coordination

Active Members and Retirees Under Age 65

Please note that payment by the *State Health Plan* under your health benefit plan takes into account whether the *provider* is a participating *provider*. If the *State Health Plan* is the secondary plan, and you use a participating *provider*, your health benefit plan will coordinate up to the *allowed amount*. The participating *provider* has agreed to accept the *allowed amount* as payment in full. If your *provider* is a non-participating *provider* then the *State Health Plan* will coordinate up to the *allowed amount* but you will be responsible for the difference between the *allowed amount* determined by the *State Health Plan* and what the *provider* actually charges.

If a *member* has more than one plan for health benefit coverage, the *State Health Plan* or its representative may request information about the other plan from the *member*. A prompt reply will help the *State Health Plan* or its representative process payments quickly. There will be no payment until primary coverage is determined. It is important to remember that even when benefits are coordinated with other group health plans, including Medicare, benefits for services covered under your health benefit plan are still subject to program requirements, such as *certification* procedures.

The *State Health Plan* mails a Medicare eligibility letter prior to your 65th birthday, which asks that you confirm your eligibility for Medicare benefits. If you are actively employed, your *Health Benefits Representative (HBR)* will receive and forward to you the Medicare eligibility election form.

Medicare consists of two parts:

- Part A: Pays *inpatient hospital* bills and *skilled nursing facility* bills. It is normally provided at no charge to those eligible for Medicare.
- Part B: Pays *outpatient hospital, doctor* and other professional bills and requires a monthly payment from the person eligible for Medicare.

If you or your covered *dependent* are 65 and are not eligible for either part of Medicare, the *State Health Plan* requires written documentation from the Social Security Administration (SSA) explaining the reason for ineligibility. Benefits cannot be paid unless this documentation is received. An *employee, retiree, or dependent* who becomes eligible for Medicare may remain covered under the *State Health Plan*. For proper coordination, it is important to notify the *State Health Plan* of Medicare eligibility. If Medicare becomes your primary health coverage, you must elect Medicare Part B to maintain your same level of coverage.

When Coverage Begins and Ends

State Health Plan Benefit Coordination with Medicare

- If you are actively employed and eligible for Medicare, the *State Health Plan* is primary and Medicare is secondary for you and your *dependents*. The only exception is if you are Medicare primary due to End Stage Renal Disease (ESRD).
- If you are retired and eligible for Medicare, the *State Health Plan* becomes secondary coverage. Medicare is also primary and the *State Health Plan* is secondary for the following Medicare-eligible individuals:
 - *Retirees*, including the last month that a retiree is still covered by the active group prior to being enrolled by the Retirement System.
 - *Dependents of retirees* who also have Medicare.
 - *Disability retirees*.
 - *Dependents of disability retirees* who also have Medicare.
 - *Members* with End Stage Renal Disease (ESRD) following the 30-month *State Health Plan* primary period.
 - Individuals with “dual” Medicare entitlement. Dual entitlement occurs when Medicare is already paying as primary because of disability or age and the *member* also becomes eligible because of ESRD. In this case, the 30-month *State Health Plan* primary period is waived and Medicare continues paying as primary.
 - Individuals who have Medicare because of disability and who are not actively working or those who are *spouses* of non-working *employees* who also have Medicare.
 - Former *members* and/or Medicare-eligible *dependents* covered under COBRA.
 - Former *employees* who are receiving the reduction in force (RIF) health benefit continuation coverage.

All covered charges not paid by Medicare are subject to the terms and conditions of your health benefit plan, including the *benefit period deductible*, *coinsurance*, *copayment* and *certification* requirements. When the *State Health Plan* is secondary, the *State Health Plan* will pay up to the amount that would have been paid had the *State Health Plan* been primary.

Important Information about Medicare Part B

You must enroll in Medicare Part B in order to receive full benefit coverage when Medicare is primary. If you are covered under the *State Health Plan* as a *member* or a *dependent* of a *member*, and you are eligible for Medicare Part B, **your benefits under the *State Health Plan* will be paid as if you are enrolled for coverage under Medicare Part B, regardless of whether you have actually enrolled for such coverage.** In other words, even if you have not enrolled in Medicare Part B coverage, your health benefit plan will reduce your claim by the benefit that would have been available to you under Medicare Part B, and then pay the remaining claim amount under the terms of your health benefit plan. **As a result, you are responsible for the amount that would have been paid by Medicare Part B if you do not enroll in Medicare Part B.**

When Coverage Begins and Ends

Medicare as a Secondary Payer

The federal Medicare Secondary Payer (MSP) rules require that, for persons covered under both Medicare and a group health plan, Medicare must be the secondary payer in certain situations. This means that the group health plan must not take Medicare entitlement into account in determining whether these individuals are eligible to participate in the Plan, or in providing benefits under the Plan. If you or your covered Dependent is eligible for Medicare, the following MSP rules apply:

If your Employer has 20 or more Employees, either Medicare or the Plan can be chosen as the primary coverage for you, if you are an Employee who is eligible for Medicare because you are age 65 or older; and your covered spouse is age 65 or older, regardless of your age.

If Medicare is elected as primary coverage, the law does not permit the Company's medical plan to provide benefits supplementing Medicare. Therefore, if you or your Dependent wishes to elect Medicare as your primary coverage, *you must terminate participation in the Company's medical plan* and have Medicare as your only coverage. You should contact the Company if you wish to terminate your participation in the Plan and have Medicare provide your medical benefits. Otherwise, participation in the Company's medical plan will continue to provide your primary medical benefits, with Medicare providing supplemental coverage.

If your Employer has 100 or more Employees, medical benefits under the Plan will be paid before Medicare benefits for you and your covered Dependent who is under age 65; is eligible for Medicare because of disability; and is covered under the Plan because of your current employment status.

For all Employers, medical benefits under the Plan will be paid before Medicare benefits for you or any covered Dependent qualifying for Medicare due to end-stage renal disease. The Plan will remain the primary payer only during the first thirty (30) months after the earlier of: (1) the date renal dialysis treatments are begun; or (2) the date of Medicare entitlement following a kidney transplant.

If this Plan is the primary payer under the above rules, it will provide the same medical benefits that it provides for other Plan Participants who are not entitled to Medicare benefits.

If Medicare is the primary payer for you or any of your covered Dependents, medical benefits will be paid in accordance with the *Coordination of Benefits* provisions of the Plan.

Note: To protect your financial liability it is in your best interest to enroll in Medicare Part B as soon as you become eligible.

MEDICAID

If you or any of your covered Dependents qualify for coverage under Medicaid:

- Your medical benefits under this Plan will be paid before any Medicaid benefits are paid;
- Eligibility and benefits under this Plan are not affected by Medicaid eligibility; and
- Benefits for a Plan Participant who is also covered by Medicaid are subject to the state's rights to subrogation and reimbursement, if Medicaid benefits have been paid first for covered medical charges.

When Coverage Begins and Ends

Please review the information in this section for a general understanding of eligibility and enrollment guidelines. Eligibility for the North Carolina *State Health Plan* is defined in Article 3B in Chapter 135 of the North Carolina General Statutes. If this summary of eligibility conflicts with the General Statutes, the General Statutes prevail.

Eligibility

The following individuals are eligible for coverage under the *State Health Plan*:

- All permanent full-time teachers and state *employees* who are either (1) paid from general or special state funds or (2) paid from non-state funds and the employing unit has agreed to provide coverage.
- *Employees* of state agencies, departments, institutions, boards and commissions, not otherwise covered by the *State Health Plan*, who are employed in permanent job positions on a recurring basis and who work 30 or more hours per week for nine or more months per calendar year.
- Retired teachers and State *employees*, members of the General Assembly, and retired law enforcement officers who retired under the Law Enforcement Officers' Retirement System prior to January 1, 1985. A retiring *employee* must have completed at least five years of contributory retirement service and have been hired prior to October 1, 2006. *Employees* first hired on and after October 1, 2006, must have 20 or more years of retirement service credit.
- Surviving *spouses* of deceased active or retired (1) North Carolina teachers, (2) State *employees*, (3) *members* of the General Assembly who are receiving a survivor's alternate benefit under any of the state supported retirement programs, provided the death of the former *State Health Plan member* occurred prior to October 1, 1986.
- *Employees* of the General Assembly, not otherwise covered by this section, as determined by the Legislative Services Commission, except legislative pages and interns.
- *Members* of the General Assembly.
- *Employees* on official leave of absence while completing a full-time program in school administration in an approved program as a Principal Fellow.
- *Employees* formerly covered, other than retired *employees*, who have been employed for 12 or more months by an employing unit and whose jobs are eliminated because of a reduction in funds. Payment is limited to 12 months following separation from services because of job elimination.
- Former *employees* of a local school administrative unit who have completed a contract term of employment of 10 or 11 months and whose jobs are eliminated because of a reduction in funds. Payment is limited to 12 months following separation from services because of job elimination.
- *Employees* on approved leave of absence with pay, or receiving workers' compensation. If you are receiving workers compensation, but separated from service (i.e. no longer an employee, then you are no longer eligible for State Health Plan benefits
- *Employees* on approved leave under the Family and Medical Leave Act of 1993 (FMLA).
- Former *employees* who are receiving disability retirement benefits are eligible for the benefit provisions of the State Health Plan on the same basis as retired *employees*. Coverage for these people will cease, however, as of the end of the month in which the former *employee* is no longer eligible for disability retirement benefits.

The State of North Carolina shall pay fifty percent (50%) of the total noncontributory premiums for coverage under the *State Health Plan* for the following individuals:

- School *employees* in a job sharing position as described in G.S. 115C-326.5.
- Retired former *employees* with 10, but less than 20 years of retirement service who were first hired on or after October 1, 2006.

In addition, **by paying the full cost of coverage**, the following individuals may enroll in the *State Health Plan*:

- Former *members* of the General Assembly who enrolled before October 1, 1986.
- Former *members* of the General Assembly who are enrolled in the *State Health Plan* at termination of membership in the General Assembly and elect to continue coverage within 30 days of the end of their term of office.
- Surviving *spouses* of deceased *members* of the General Assembly who enrolled before October 1, 1986.

When Coverage Begins and Ends

- *Employees* of the General Assembly, not otherwise covered by this section, as determined by the Legislative Services Commission, except legislative pages and interns.
- Surviving *wives* of deceased former *members* of the General Assembly, if covered at the time of death of the former *member* of the General Assembly.
- All permanent part-time *employees* (designated as half-time or more) who are paid from general or state funds.
- Former *employees* with 5, but less than 10 years of retirement service who were first hired on or after October 1, 2006.
- *Wives* and eligible *dependent children* of enrolled teachers, State *employees*, *retirees* and former *members* of the General Assembly.
- Former *employees* whose jobs were eliminated because of reduction in funds beyond the initial 12-month separation period.
- Certain blind persons licensed by the state as operators (or former operators) of vending facilities under contract with the Department of Health and Human Services.
- Surviving *wives* of deceased *retirees* and surviving *wives* of deceased teachers, State *employees*, and *members* of the General Assembly if the *wife* was covered at the time of death and the death occurred after September 30, 1986.
- Certain surviving *dependent children* who are covered by the *State Health Plan* at the time of the *employee's* death are entitled to coverage as a surviving *dependent* or who were covered under the *State Health Plan* on September 30, 1986. In the absence of an eligible surviving parent, each child is eligible for *member only* (individual) coverage until attaining one of the usual *dependent children* ineligibility events. If a surviving child was certified and covered as an incapacitated *dependent*, the *dependent* is eligible for life, or until the *dependent* marries or ceases to be incapacitated. When coverage ceases for a surviving *dependent child*, he or she may be eligible for continuation coverage.
- The *wives* and eligible *dependent children* of former *employees* whose jobs were eliminated because of reduction in funds.
- An *employee* on official leave of absence without pay.
- An *employee* with less than five years of retirement membership services, who is on leave without pay due to illness or injury for up to 12 months.

Under certain conditions the following are eligible:

- Firemen, Rescue Squad or *Emergency Medical Workers* and *members* of the North Carolina Army and Air National Guard; *employees* of certain counties and municipalities; and charter schools; and their *dependents*.

Dependent Eligibility

For *dependents* to be covered under the *State Health Plan*, the *employee* or *retiree* must be covered and their *dependent* must be one of the following:

- *Spouse*
- A natural, legally adopted or *foster child* of the *subscriber* and/or *wife* up to the end of the month of their 26th birthday. *Dependent child* includes a child for whom the *subscriber* is a court-appointed guardian, and a stepchild of the *subscriber* who is married to the stepchild's natural parent. *Foster child* requires legal documentation.

Dependent child coverage may be extended beyond the 26th birthday under the following condition:

- The *dependent* is physically or mentally incapacitated to the extent that he or she is incapable of earning a living and such handicap developed or began to develop before the *dependent's* 26th birthday if the *dependent* was covered by the *State Health Plan*. When requesting extension of coverage, or for further information, *employees* should contact Customer Service at the number listed in "Whom Do I Call?"

The *State Health Plan* requires documentation to verify a *dependent's* eligibility to be covered as a *dependent*.

When Coverage Begins and Ends

No person shall be eligible for coverage as an *employee* or or retired *employee* or as a *dependent* of an *employee* or retired *employee* upon a finding by the Executive Administrator, Treasurer, or Board of Trustees or by a court of competent jurisdiction that the *employee* or *dependent* knowingly and willfully made or caused to be made a false statement or false representation of a material fact in a claim for reimbursement.

Enrolling in the Plan

It is very important that you apply for coverage and/or add *dependents* when you or your *dependents* are first eligible to enroll on the *State Health Plan*.

New *employees* who do not elect to enroll themselves or their *dependents* on the *State Health Plan* within 30 days of hire (first eligible) will not be allowed to enroll unless they experience a qualifying life event or enroll during Annual Enrollment.

Dual Enrollment

No person shall be eligible for coverage as an *employee* and as a *dependent* of an *employee* or retired *employee* at the same time, except when a *spouse* is eligible on a fully contributory basis. In addition, no person shall be eligible for coverage as a *dependent* of more than one *employee* or retired *employee* at the same time.

Timely Enrollees

You are a timely enrollee if you apply for coverage and/or add or remove *dependents* within a 30-day period following any of the qualified life events listed below.

- You are newly hired
- Your marital status changes due to marriage, death of a spouse, divorce, legal separation, or annulment
- You obtain a dependent through marriage, birth, adoption, placement in anticipation of adoption, or foster care placement of an eligible child
- You or your *dependents* experience an employment status change that results in the loss or gain of coverage, and each of the following conditions is met:
 - You and/or your *dependents* are otherwise eligible for coverage under the State Health Plan, and
 - You and/or your *dependents* were covered under another health benefit plan at the time this coverage was previously offered and you declined enrollment due to the other coverage, and
 - You and/or your *dependents* lose coverage under another health benefit plan due to i) the exhaustion of the COBRA continuation period, or ii) the loss of eligibility for that other coverage for reasons including, but not limited to, divorce, loss of dependent status, death of the *employee*, termination of employment, or reduction in the number of hours of employment, or iii) the termination of the other plan's coverage, or iv) the offered health benefit plan not providing benefits in your service area and no other health benefit plans are available, or v) the termination of employer contributions toward the cost of the other plan's coverage, or vi) meeting or exceeding the lifetime maximum, or vii) the discontinuance of the health benefit plan to similarly situated individuals.
- Your dependent ceases to be an eligible dependent (dependent child turns 26).
- You, your spouse, or your dependents commence or return from an unpaid leave of absence such as Family and Medical Leave or military leave.
- You receive a qualified medical child support order (as determined by the plan administrator) that requires the plan to provide coverage for your children.
- If you, your spouse or dependents experience a cost or coverage change under another group health plan for which an election change was permitted, you may make a corresponding election change under the Flex Plan (e.g. your spouse's employee significantly increases the cost of coverage and as a result, allows the spouse to change his/her election) (not applicable to the Health FSA).
- If you change employment status such that you are no longer expected to average 30 hours of service per week but you do not lose eligibility for coverage under the State Health Plan (e.g. you are in a stability period during which you qualify as full-time), you may still prospectively revoke your election provided

When Coverage Begins and Ends

that you certify that you have or will enroll yourself (and any other covered family members) in other coverage providing minimum essential coverage (e.g. the Marketplace) that is effective no later than the first day of the second month following the month that includes the date the original coverage is revoked

- You may prospectively revoke your State Health Plan election if you certify your intent to enroll yourself and any covered dependents in the Marketplace for coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked
- You or your dependents become Medicare eligible
- You or your dependents lose coverage due to loss of eligibility under Medicaid or the Children's Health Insurance Program (CHIP) and apply for coverage under this Plan within 60 days
- You or your dependents become eligible for premium assistance with respect to coverage under this Plan under Medicaid or CHIP and apply for coverage under this Plan within 60 days.

In addition, eligible surviving *spouses* and any eligible surviving *dependent child* of a deceased *retiree*, teacher, State *employee*, *member* of the General Assembly, former *member* of the General Assembly, or Disability Income Plan beneficiary are considered a timely enrollee if they were enrolled at the time of the *member's* death and elect to continue coverage within 90 days after the death of the former *State Health Plan member*.

Completion of the enrollment must occur within 30 days of employment or the qualifying life event (except as specifically described above. Members who do not enroll when first eligible must wait until the next annual enrollment period if they are still eligible. Proof of prior coverage, if applicable, must be returned to the *HBR* of the *employee's* employing unit. Retirees and surviving spouses are not required to experience a qualifying event if they wish to dis-enroll themselves or their dependents from the Plan; they may dis-enroll at any time.

Adding or Removing a Dependent

If you want to add or remove a *dependent* due to a qualifying life event, contact your *HBR*. Failure to timely notify your *HBR* of the need to remove a *dependent* could result in loss of eligibility for continuation of coverage.

To add a *dependent*, you must notify the *HBR* or add your *dependent* through your online enrollment system. For coverage to be effective on the date the *dependent* becomes eligible due to a qualifying life event or the first day of the month following the qualifying life event, the completion of the enrollment must occur within 30 days after the *dependent* becomes eligible.

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 owed (you are already paying for family coverage or *employee-children* coverage), 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.

In order for a newborn child to be covered from the date of birth, the coverage *effective date* must be the first day of the month in which the child is born. For more information, see "Newborn Care" in "*Covered Services*."

For *members* with *employee-only* or *employee-spouse* coverage, a newborn child, a child legally placed for adoption or a *foster child* may be covered on their *effective date* - as long as the child is enrolled within 30 days of their *effective date* **and the subscriber changes to employee/child(ren) or employee-family coverage and pays any additional premiums required for the selected coverage type retroactive to the first of the month in which the child is born or to the first of the month in which the date of placement occurred for adoptive and *foster children*.**

If you are an active member you may remove *dependents* from your coverage by contacting your *HBR* or through your online enrollment system when there is a qualifying life event. You must dis-enroll your *Dependent* within 30 days of the qualifying event. *Dependents* **must** be removed from coverage when they are no longer eligible, such as when a child is no longer eligible due to age, or when the *spouse* is no longer eligible due to divorce or death.

When Coverage Begins and Ends

If you are a retired member or surviving spouse you may remove *dependents* from your coverage without a qualifying life event. To add dependents you must experience a qualifying life event or add them during Annual Enrollment.

Qualified Medical Child Support Order

A qualified medical child support order (QMCSO) is any judgment, decree or order that is issued by an appropriate court or through an administrative process under state law that: (1) provides for coverage of the child of a *member* under the *State Health Plan*; and (2) is either issued according to state law or a law relating to medical child support described in Section 1908 of the Social Security Act. A QMCSO must be specific as to the plan, the participant whose child(ren) is (are) to be covered, the type of coverage, the child(ren) to be covered and the length of coverage.

Effective Dates of Coverage

The *effective date* for new *employees* is determined based on the following:

The *effective date* of coverage is the first day of the month following the date of employment or the first day of the second month. For example, if the date of employment is October 12, coverage may begin November 1 or December 1. Eligible *dependents* must be enrolled with the same *effective date* as the *employee*, unless there is a qualifying event.

Types of Coverage

Your health benefit plan offers the following types of coverage:

- *Employee* only coverage - The health benefit plan covers the *employee* or retiree
- *Employee spouse* coverage - The health benefit plan covers the *employee* or the *retiree* and his/her *spouse*.
- *Employee* child(ren) coverage - The health benefit plan covers the *employee* and his/her *dependent child* or children; or the *retiree* and his/her *dependent child* or children
- Family coverage - The health benefit plan covers the *employee*, his/her *spouse* and his/her *dependent child* or children; or the *retiree*, his/her *spouse* and his/her *dependent child* or children;

Reporting Changes

Have you moved, added or changed other health coverage, changed your name or phone number? If so, contact your *HBR* or follow the online process for updating your information through your enrollment system. It will help us give you better service if the *State Health Plan* or its representative is kept informed of these changes.

When Coverage Ends

Coverage for you or your *dependents* ends the last day of the month in which an ineligibility event occurs. Some examples of ineligibility events are divorce, *dependent child* becomes eligible for their own health coverage, and termination of employment. For additional ineligibility events, contact Customer Service at the number in “Whom Do I Call?” You must notify your *HBR* when there is a change of eligibility or make the change request through your online enrollment system. If notification is not made within the 30 days following the *dependent's* ineligibility event, the *dependent* will be retroactively removed the end of the month of the *dependent's* ineligibility event, and the coverage type change will be the first of the month following written notification, except in the case of death, in which case the coverage type change will be made retroactively to the first of the month following death.

Coverage for you or your *dependents* may also end on the date through which premiums have been paid.

Coverage ends when your coverage is fully contributory and your premium is not received within 60 days after your premium due date. After 30 days, claims for you and any *dependents* will be placed on hold or will be denied during the period for which a premium has not been paid.

You or your *dependents* may be eligible for continuation coverage under COBRA or to convert to a non-employer sponsored plan the first day of the month following an eligibility event.

When Coverage Begins and Ends

Coverage may end on the last day of the month in which you or your covered *dependent* is found to have knowingly and willfully made or caused to be made a false statement or false representation of a material fact in a claim for reimbursement under the Plan. Persons that commit fraud against the *State Health Plan* are ineligible for coverage for minimum of five years and there is no guarantee that coverage will ever be reinstated.

Please notify your health care *providers* and pharmacy if you are no longer eligible for coverage. In the event claims are paid on behalf of a former *member* who is no longer eligible or whose coverage has terminated, the Plan reserves the right to recover those amounts directly from the *subscriber* or former *member*.

Value-Added Programs



An initiative of the State Health Plan

Go to www.shpnc.org and click **NCHealthSmart** or call 800-817-7044

TTY line: 800-817-6044

Your Resource for Better Health

NC HealthSmart is the *State Health Plan's* healthy living initiative. NC HealthSmart is designed to help *members* stay safe and healthy and empower *members* with chronic disease to better manage their health.

Health Coach

Health Coaches are specially trained health care professionals (nurses, and dietitians) who are available by phone Monday – Friday 8:30 a.m. – 11 p.m., Saturday 9 a.m. – 2 p.m. to help eligible *members* understand health issues and to provide support. Contact a Health Coach at 800-817-7044. At no additional charge to *members*, Health Coaches provide one-on-one:

- Stress Management counseling
- Nutritional and weight management information
- Support for managing illness
- Goal setting, monitoring and support to help you increase your physical activity

Case Management

Case management services are offered to eligible *members* with complex medical needs. The program focuses on early identification of a *member's* need for assistance with multiple hospitalizations, a high risk pregnancy or a sudden catastrophic event. If you or a family *member* needs intensive case management support, please contact a NC HealthSmart Nurse Case Manager at 800-817-7044.

Specialty Case Managers are available to assist *members* with Chronic Kidney Disease (CKD) and End Stage Renal Disease (ESRD). To contact a CKD/ESRD case manager, call 800-817-7044.

NC HealthSmart Website and HA

NC HealthSmart *members* can access interactive tools and lifestyle programs (including tobacco cessation and weight management) and retrieve information on treatment tips, prevention tips, lifestyles changes, and healthy living. The *Health Assessment (HA)* is an easy- to- complete survey that provides you with a health risk status and an action plan that will tell you changes you can make that will have the greatest impact on your health. The HA is available on the *State Health Plan* website at www.shpnc.org by clicking Personal Health Portal or by calling 800-817-7044.

Health Education Programs and Tools

NC HealthSmart offers a host of free resources to assist in managing your health needs by promoting healthy living. Many of these resources are available online at www.shpnc.org and include:

- Free Internet-based programs designed to provide assistance and support to help you stop smoking, eat smarter and live healthier.
- Printed materials mailed to your home
- Health videos provided at no charge, as approved by your Health Coach
- Health related online library

Value-Added Programs

Worksite Wellness Programs

The *State Health Plan* has worked with agencies, universities, community colleges and public schools to establish and train worksite wellness committees and has sponsored the development of the NC HealthSmart Worksite Wellness Toolkit as a resource to guide wellness committee efforts. The Toolkit and other worksite wellness resources, including five turnkey programs, may be found at www.shpnc.org. Contact your *Health Benefits Representative* or Wellness Leader for more information about *wellness activities* at your worksite.

Members eligible for NC HealthSmart services are members whose primary health coverage is through the State Health Plan. The NC HealthSmart program is voluntary and eligible members can utilize the program at no charge. Federal law prohibits the State Health Plan or its representative from using your personal information to discriminate against you in any way or from giving this information to your employing agency/school or other unauthorized third party, unless required by law.

Value-Added Programs

Blue Cross and Blue Shield of North Carolina offers Value-Added Programs to help you take charge of your care and save you money. These innovative programs complement your health plan and are available at no additional cost. Value-Added Benefits include discounts, information and more on a variety of health related products, services and topics. Now that's value-added. That's your plan for better health. For more information, visit Blue Connect at www.shpnc.org.

TruHearing

Hearing aid discount program

AudioBlueSM offers a 25% discount on manufacturers' suggested retail prices or \$250 off usual and customary fees, whichever provides greater savings. With AudioBlueSM, when you purchase a hearing aid you'll also get:

- Free hearing aid fittings
- Free hearing aid cleanings and checks for one year
- Free follow-up visits for one year
- Free one-year warranties for service, loss or damage
- Free one-year supply of batteries

Schedule a hearing consultation at a participating AudioBlueSM *provider* and present your *ID card*.



Taking charge of your health is the best investment you can make in your future. But with so much wellness information to sort through these days, decision-making can be difficult. Count on Blue365SM_{1,2} to bring you access to trusted wellness resources, and valuable offers.

- Discounts and savings on fitness/health clubs, weight-loss programs, healthy travel experiences, and more
- Information on alternative/preventive care, elective procedures, family care services health-focused financial services, and more

Value-Added Programs

- Educational seminars on estimating health-related expenses as a part of your financial planning

For more information on these programs, see the number in the Quick Reference Value-Added Programs section in the front of this booklet.

- ¹ *The State Health Plan or BCBSNC reserves the right to discontinue or change these programs at any time.*
- ² *These programs are not covered benefits under your health benefit plan contract. The State Health Plan does not accept claims or reimburse for these services and members are responsible for paying all bills.*

Davis VisionSM

Discounts on vision and corrective laser eye surgery

OpticBlueSM offers exceptional vision discounts to help you maintain your vision health. Just present your *ID card* at a participating *provider* location in order to receive the following discounts:

- Save 30% on *prescription* eyewear, including lenses, frames and nondisposable contact lenses, with *BCBSNC* network optometrists. Plus, save 15% on disposable contact lenses.
- Get discounts on lenses, frames, contacts, nonprescription sunglasses and more from a nationwide network of vision *providers* through Davis Vision.
- Save up to 25% off standard costs (or 5% off advertised specials) for corrective laser eye *surgery* services.

Chiropractic Services

Discounts on chiropractic services^{1, 3}

Chiropractic care is one of the most popular forms of medicine. It's another way to help you take care of your body. Present your *member ID card* at a participating *provider* location and receive up to 25% off services.

Definitions

AFFORDABLE CARE ACT (ACA) – The law enacted on March 23, 2010 also known as the Patient Protection and *Affordable Care Act*, that requires health plans and health plan *providers* to offer certain provisions and consumer protections.

AFFORDABLE CARE ACT (ACA) PREVENTIVE CARE PRESCRIPTION DRUGS – prescription drugs identified by the *Affordable Care Act* covered at 100%.

ALLOWED AMOUNT — the maximum amount that BCBSNC determines is reasonable for covered services provided to a member. The allowed amount includes any BCBSNC payment to the provider, plus any deductible, coinsurance or copayment. For providers that have entered into an agreement with BCBSNC, the allowed amount is the negotiated amount that the provider has agreed to accept as payment in full. Except as otherwise specified in “Emergency Care,” for providers that have not entered into an agreement with BCBSNC, the allowed amount will be the lesser of the provider’s billed charge or an amount based on an out-of-network fee schedule established by BCBSNC that is applied to comparable providers for similar services under a similar health benefit plan. Where BCBSNC has not established an out-of-network fee schedule amount for the billed service, the allowed amount will be the lesser of the provider’s billed charge or a charge established by BCBSNC using a methodology that is applied to comparable providers who may have entered into an agreement with BCBSNC for similar services under a similar health benefit plan. Calculation of the allowed amount is based on several factors including BCBSNC's medical, payment and administrative guidelines. Under the guidelines, some procedures charged separately by the provider may be combined into one procedure for reimbursement purposes.

ALTERNATIVE MEDICINE — medicine services, which are unproven preventive or treatment modalities, generally also described as alternative, holistic, integrative, or complementary medicine, whether performed by a physician or any other provider.

AMBULANCE — transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured, includes ground and aircraft.

AMBULATORY SURGICAL CENTER — a *nonhospital facility* with an organized staff of *doctors*, which is licensed or certified in the state where located, and which:

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

APPEAL — a written request for a review of a denial of a *noncertification* and/or a denial based on *medical necessity*. See also the definitions for "*Noncertification*" and "*Medical Necessity*."

BCBSNC — Blue Cross and Blue Shield of North Carolina.

BENEFIT PERIOD — the period beginning January 1, 2015, and ending on December 31, 2015, which charges for *covered services*, if applicable, are applied to the annual *deductible* and *coinsurance maximum* and during which annual benefit maximums accumulate.

BENEFIT PERIOD MAXIMUM — the maximum amount of allowed charges for *covered services* in a *benefit period* that will be reimbursed on behalf of a *member* while covered under the health benefit plan.

Definitions

BLUE OPTIONS DESIGNATED PROVIDER – A specific network of *providers* that can be used to lower a *member's* out-of-pocket costs. These *providers* have been “designated” because they provide both quality and cost-effective care.

BRAND NAME — the proprietary name of the *prescription drug* that the manufacturer owning the patent places upon a drug product or on its container, label or wrapping at the time of packaging. The *State Health Plan* makes the final determination of the classification of *brand name* drug products based on information provided by the manufacturer and other external classification sources.

CDHP PREVENTIVE MEDICATIONS – A list of preventive medications used to help prevent and manage certain health conditions. The *prescription* medication on this list will be covered as if the *deductible* is already met and will be subject only to *coinsurance*. This list is subject to change. The most up-to-date list of *CDHP Preventive Medications* can be found at www.shpnc.org under Pharmacy Benefits.

CERTIFICATION — the determination by the *State Health Plan* or its representative that an admission, availability of care, continued stay, or other services, supplies or drugs have been reviewed and, based on the information provided, satisfy the requirements for *medically necessary* services and supplies, appropriateness, health care setting, level of care and effectiveness.

CHEMICAL DEPENDENCY — the pathological use or abuse of alcohol or other drugs in a manner or to a degree that produces impairment in personal, social, or occupational functioning and which may, but need not, include a pattern of tolerance and withdrawal.

COINSURANCE — the sharing of charges by the *State Health Plan* and the *member* for *covered services* received by a *member*, usually stated as a percentage of the *allowed amount*.

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

COMPOUND DRUG – is prepared by a pharmacist when mixing or altering ingredients to create a unique *prescription* medication that is specific for an individual patient.

CONGENITAL — existing at, and usually before, birth referring to conditions that are present 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 their health benefit plan.

Definitions

CREDITABLE COVERAGE — accepted health insurance coverage carried prior to the *State Health Plan*. Coverage can be group health insurance, self-funded plans, individual health insurance, public health plan, Children's Health Insurance Program (CHIP), Medicare, Medicaid, and any other coverage defined as *creditable coverage* under state or federal law. *Creditable coverage* does not include coverage consisting solely of excepted benefits.

CUSTODIAL CARE — care comprised of services and supplies, including room and board and other *facility services*, which are provided to the patient, whether disabled or not, primarily to assist him or her in the activities of daily living. *Custodial care* includes, but is not limited to, help in walking, bathing, dressing, feeding, preparation of special diets and supervision over self-administration of medications. Such services and supplies are custodial as determined by the *State Health Plan* or its representative without regard to the place of service or the *provider* prescribing or providing the services.

DEDUCTIBLE — the specified dollar amount for certain *covered services* that the *member* must incur each *benefit period* before benefits are payable for the remaining *covered services*. The *deductible* does not include *premiums*, charges in excess of the *allowed amount*, amounts exceeding any maximum and expenses for non-*covered services*.

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* up to the maximum *dependent age*, as specified in "When Coverage Begins And Ends."

DEVELOPMENTAL DYSFUNCTION — difficulty in acquiring the activities of daily living including, but not limited to, walking, talking, feeding or dressing oneself or learning in school. Developmental therapies are those to facilitate or promote the development of skills, which the *member* has not yet attained. Examples include, but are not limited to: *speech therapy* to teach a *member* to talk, follow directions or learn in school; *physical therapy* to treat a *member* with low muscle tone or to teach a *member* to roll over, sit, walk or use other large muscle skills; occupational therapy to teach a *member* the activities of daily living, to use small muscle skills or balance or to assist with behavior or achievement in the learning setting.

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

DURABLE MEDICAL EQUIPMENT — items designated by the *State Health Plan* or its representative which can withstand repeated use, are used primarily to serve a medical purpose, are not useful to a person in the absence of illness, injury or disease, and are appropriate for use in the patient's home.

EFFECTIVE DATE — the date on which coverage for a *member* begins, according to "When Coverage Begins and Ends."

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

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

EMPLOYEE — the person who is eligible for coverage under the *State Health Plan* due to employment with the State of North Carolina, including, but not limited to teachers, state *employees*, *retirees*; certain *members* of boards and commissions; certain counties and municipalities; firemen and rescue workers; National Guard; and anyone else eligible pursuant to North Carolina General Statutes.

EXPERIMENTAL — see *Investigational*.

FACILITY SERVICES — *covered services* provided and billed by a *hospital* or *non-hospital facility*. All services performed must be within the scope of license or *certification* to be eligible for reimbursement.

FAMILY PLANNING — reproductive health services, including care for maternity, *complications of pregnancy*, *infertility* and *sexual dysfunction* and contraception.

FOSTER CHILD(REN) — children under age 18 i) for whom a guardian has been aCDHPinted 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 aCDHPinted 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.

GENERIC — a drug name not protected by a trademark which has the same active ingredient, strength and dosage form, and which is determined by the Food and Drug Administration (FDA) to be therapeutically equivalent to the *prescription brand name* drug.

GRIEVANCE — *grievances* include dissatisfaction with a claims denial or any decisions (including an *appeal* of a *noncertification* decision), policies or actions related to the availability, delivery or quality of health care services.

HBR — see *Health Benefits Representative*.

HEALTH ASSESSMENT - A confidential questionnaire that identifies potential health risks and suggests steps you can take to lessen those risks. The questions on this assessment deal with your overall health and lifestyle, your health history, work and daily life routines and barriers that may be preventing you from turning unhealthy behaviors into healthy ones.

HEALTH BENEFITS REPRESENTATIVE — an *employee* designated by the employing unit who is responsible for administering the *State Health Plan*. Duties include enrolling new *employees*, reporting changes, explaining benefits, reconciling group statements and remitting group fees. The State Retirement System is the *HBR* for retired *members*.

HOMEBOUND — a *member* who cannot leave their home or temporary residence due to a medical condition which requires both the assistance of another person and the aid of supportive devices or the use of special transportation. A *member* is not considered *homebound* solely because the assistance of another person is required to leave the home.

HOME HEALTH/HOME CARE AGENCY — a *nonhospital facility* which is primarily engaged in providing *home health care* services, and which:

- a) Provides skilled nursing and other services on a visiting basis in the *member's* home,
- b) Is responsible for supervising the delivery of such services under a plan prescribed by a *doctor*,
- c) Is accredited and licensed or certified in the state where located,
- d) Is certified for participation in the Medicare program, and

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e) Is acceptable to *BCBSNC*.

HOSPICE — a *nonhospital facility* that provides medically related services to persons who are terminally ill, and which:

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

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

IDENTIFICATION CARD (ID card) — the card issued to *subscribers* upon enrollment which provides your *member* identification numbers, names of the *members*, applicable *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.

INFERTILITY — the inability of a heterosexual couple to conceive a child after 12 months of unprotected male/female intercourse.

IN-NETWORK —designated as participating in the Blue Options network. The *State Health Plan's* payment for *in-network covered services* is described in this benefit booklet as *in-network* benefits or *in-network* benefit levels.

IN-NETWORK PROVIDER — a *hospital, doctor, other medical practitioner or provider of medical services* and supplies that has been designated as a Blue Options *provider* by *BCBSNC* or a *provider* participating in the BlueCard[®] program.

INPATIENT — pertaining to services received when a *member* is admitted to a *hospital or nonhospital facility* as a registered bed patient for whom a room and board 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 the *State Health Plan* or its representative does not recognize as standard *medical care* of the condition, disease, illness, or injury being treated. The following criteria are the basis for 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 the *State Health Plan* or its representative's evaluation of the therapeutic value of the service or supply
- c) There is inconclusive evidence that the service or supply has a beneficial effect on health outcomes
- d) The service or supply under consideration is not as beneficial as any established alternatives
- e) There is insufficient information or inconclusive scientific evidence that, when utilized in a non-*investigational* setting, the service or supply has a beneficial effect on health outcomes and is as beneficial as any established alternatives.

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

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

LICENSED PRACTICAL NURSE (LPN) — a nurse who has graduated from a formal practical nursing education program and is licensed by the appropriate state authority.

LIFETIME MAXIMUM — the maximum amount of allowed *covered services* that will be reimbursed on behalf of a *member* while covered under this health benefit plan.

MEDICAL CARE/SERVICES — professional services provided by a *doctor* or *other provider* for the treatment of an illness or injury.

MEDICAL SUPPLIES — health care materials that include ostomy supplies, catheters, oxygen and diabetic supplies.

MEDICALLY NECESSARY (or MEDICAL NECESSITY) — those *covered services* or supplies that are:

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

For *medically necessary* services, the *State Health Plan* or its representative may compare the cost effectiveness of alternative services, settings or supplies when determining which of the services or supplies will be covered and in what setting *medically necessary* services are eligible for coverage.

MEMBER — a *subscriber* or a *dependent*, who is currently enrolled in the health benefit plan and for whom a premium is paid.

MENTAL HEALTH CASE MANAGER — the company that is contracted to manage the mental health and *chemical dependency* benefits.

MENTAL ILLNESS — mental disorders, psychiatric illnesses, mental conditions and psychiatric conditions (whether organic or nonorganic, whether of biological, nonbiological, chemical or nonchemical origin and irrespective of cause, basis or inducement). This includes, but is not limited to, psychoses, neurotic disorders, schizophrenic disorders, affective disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems. (This is intended to include disorders, conditions and illnesses classified on Axes I and II in the current edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, Washington, DC.)

NONCERTIFICATION — a determination by the *State Health Plan* or its representative that a service covered under your health benefit plan has been reviewed and does not meet requirements for *medical necessity*, appropriateness, health care setting, level of care or effectiveness or the prudent layperson standard for coverage of *emergency services* and, as a result, the requested service is denied, reduced or terminated. The determination that a requested service is *experimental*, *investigational* or *cosmetic* is considered a *noncertification*. A *noncertification* is not a decision based solely on the fact that the requested service is specifically excluded under your benefits.

NONHOSPITAL FACILITY — an institution or entity other than a *hospital* that is accredited and licensed or certified in the state where located to provide *covered services* and is acceptable to *BCBSNC*. All services performed must be within the scope of license or *certification* to be eligible for reimbursement.

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OFFICE VISIT — *medical care, surgery, diagnostic services, short term rehabilitative therapy services and medical supplies provided in a provider's office. See also the definition for "Outpatient Clinic."*

OTHER PROFESSIONAL PROVIDER — a person or entity other than a *doctor* who is accredited and licensed or certified in the state where located to provide *covered services* and which is acceptable to *BCBSNC*. All services performed must be within the scope of license or *certification* to be eligible for reimbursement.

OTHER PROVIDER — an institution or entity other than a *doctor* or *hospital*, which is accredited and licensed or certified in the state where located to provide *covered services* and which is acceptable to *BCBSNC*. All services performed must be within the scope of license or *certification* to be eligible for reimbursement.

OTHER THERAPY(IES) — the following services and supplies, both *inpatient* and *outpatient*, ordered by a *doctor* or *other provider* to promote recovery from an illness, disease or injury when provided by a *doctor, other provider* or professional employed by a *provider* licensed in the state of practice.

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

OUT-OF-NETWORK — not designated as participating in the Blue Options or BlueCard[®] networks and not certified in advance by *BCBSNC* to be considered as *in-network*. Payment for *out-of-network covered services* is described in this benefit booklet as *out-of-network* benefits or *out-of-network* benefit levels.

OUT-OF-NETWORK PROVIDER — a *provider* that has not been designated as participating in the Blue Options or BlueCard[®] network.

OUT-OF-POCKET MAXIMUM — This is the most you pay for covered expenses (medical and pharmacy) in a calendar year. It includes *deductibles* and *coinsurance*, but excludes *premiums*.

OUTPATIENT — pertaining to services received from a *hospital* or *nonhospital facility* by a *member* while not an *inpatient*.

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

PHARMACY BENEFIT MANAGER (PBM) — the company with which the State of North Carolina contracts to manage the *prescription drug* benefit.

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

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PRE-EXISTING CONDITION or PRE-EXISTING HEALTH CONDITION — a condition, disease, illness or injury for which medical advice, diagnosis, care or treatment was received or recommended within the 6-month period prior to your *effective date*. Pregnancy and genetic information are not considered *pre-existing conditions*.

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

PRESCRIPTION DRUG — a drug that has been approved by the Food and Drug Administration (FDA) and is required, prior to being dispensed or delivered, to be labeled "Caution: Federal law prohibits dispensing without *prescription*," or labeled in a similar manner (also known as a federal legend drug), and is appropriate to be administered without the presence of a medical supervisor.

PREVENTIVE CARE — *medical services* provided by or upon the direction of a *doctor* or *other provider* related to the prevention of disease. Certain services are identified by the *Affordable Care Act* as being "*Preventive Care*" and are covered at 100%.

PRIMARY CARE PROVIDER (PCP) — a *provider* who has been designated by *BCBSNC* as a *PCP*.

PRIOR REVIEW — the consideration of benefits for an admission of care, continued stay, or other services, supplies or drugs, based on the information provided and requirements for a determination of *medical necessity* of services and supplies, appropriateness, health care setting, or level of care and effectiveness. *Prior review* results in *certification* or *noncertification* of benefits.

PROSTHETIC APPLIANCES — fixed or removable artificial limbs or other body parts, which replace absent natural ones.

PROVIDER — a *hospital*, *nonhospital facility*, *doctor*, *other provider*, or *other professional providers* accredited, licensed or certified where required in the state of practice, performing within the scope of license or *certification*. All services performed must be within the scope of license or *certification* to be eligible for reimbursement.

REGISTERED NURSE (RN) — a nurse who has graduated from a formal program of nursing education (diploma school, associate degree or baccalaureate program), and is licensed by the appropriate state authority in the state of practice.

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

RETIREE — an enrolled retired *employee* who receives monthly retirement benefits from any retirement system supported in whole or in part by contributions of the State of North Carolina and who is eligible for benefits pursuant to North Carolina General Statutes.

ROUTINE FOOT CARE — hygiene and preventive maintenance such as trimming of corns, calluses or nails that do not usually require the skills of a qualified *provider* of foot care services.

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

SHORT-TERM REHABILITATIVE THERAPY — services and supplies both *inpatient* and *outpatient*, ordered by a *doctor* or *other provider* to promote the recovery of the *member* from an illness, disease or injury when provided by a *doctor*, *other provider* or professional employed by a *provider* licensed by the appropriate state authority in the state of practice and subject to any licensure or regulatory limitation as to location, manner or scope of practice.

Definitions

- a) Occupational therapy — treatment by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those required by the person's particular occupational role after such ability has been impaired by disease, injury or loss of a body part
- b) Physical therapy — treatment by physical means, hydrotherapy, heat or similar modalities, physical agents, biomechanical and neurophysiological principles and devices to relieve pain, restore maximum function and prevent disability following disease, injury or loss of body part
- c) Speech therapy — treatment for the restoration of speech impaired by disease, *surgery*, or injury; or certain significant physical *congenital* conditions such as cleft lip and palate; or swallowing disorders related to a specific illness or injury.

SKILLED NURSING FACILITY — a *nonhospital facility* licensed under state law that provides skilled nursing, rehabilitative and related care where professional *medical services* are administered by a registered or *licensed practical nurse*. All services performed must be within the scope of license or *certification* to be eligible for reimbursement.

SPECIALIST — a *doctor* who is recognized by *BCBSNC* as specializing in an area of medical practice.

SPECIALTY MEDICATION — Specialty and biosimilar medications are designated and classified by the Plan as medications that meet the following criteria and are listed on the Specialty Drug List, which is located on the Plan's [website](#): treats complex medical condition(s), requires frequent clinical monitoring, e.g. dosing adjustments, requires special patient education, training and/or coordination of care and generally prescribed by a specialist provider.

SPOUSE — the husband or wife of an *employee* or *retiree* who enters into a marriage that is legally recognized by the State of North Carolina.

STABILIZE — to provide *medical care* that is appropriate to prevent a material deterioration of the *member's* condition, within reasonable medical certainty.

STATE HEALTH PLAN — the state organization authorized pursuant to North Carolina General Statutes to make available the *State Health Plan* for Teachers and State *Employees* and optional *hospital* and medical benefits and programs to *employees* and *dependents*.

SUBSCRIBER — the *employee* who is eligible for coverage under the *Plan* and who is enrolled for coverage.

SURGERY — the performance of generally accepted operative and cutting procedures including specialized instrumentations, endoscopic examinations and other invasive procedures, such as:

- a) The correction of fractures and dislocations
- b) Usual and related preoperative and postoperative care
- c) Other procedures as reasonable and approved by the *State Health Plan*.

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

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

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USUAL, CUSTOMARY AND REASONABLE (UCR) — the amount the *provider* charges based on the most typical charge for medical service that does not exceed the customary fee in that geographic area, and is reasonable based on the circumstance.

UTILIZATION MANAGEMENT (UM) — a set of formal processes that are used to evaluate the *medical necessity*, quality of care, cost-effectiveness and appropriateness of many health care services, including procedures, treatments, medical devices, *providers* and facilities.

WAITING PERIOD — the amount of time that must pass before a *member* is eligible to be covered for benefits under the terms of the health benefit plan.

WELLNESS ACTIVITY(IES) – One of the 3 activities that can be completed during enrollment to qualify for *Wellness Premium Credits*.

WELLNESS INCENTIVES – Opportunities for *members* to save on out-of-pocket costs each time they seek care.

WELLNESS PREMIUM CREDITS – The amount you save on your premium by completing *Wellness Activities* during enrollment. *Employees* can complete one, two, or all three *Wellness Activities*.

Notice of Privacy Practices

Notice of Privacy Practices

Original Effective Date: April 14th, 2003

Revised Effective Date: September 23rd, 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED BY THE PLAN AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Introduction

A federal law, the Health Insurance Portability and Accountability Act (HIPAA), requires that health Plan and health care providers protect the privacy of certain medical information. This notice covers the medical information practices of the State Health Plan for Teachers and State *Employees*. This notice is intended to inform you of your rights under the privacy provisions of HIPAA and the HIPAA obligations imposed on the Plan. The Plan is required to maintain the privacy of PHI in accordance with HIPAA (as summarized herein), provide this Notice to covered individuals, and notify affected individuals following a “breach” of unsecured PHI (as defined by HIPAA). The privacy laws of a particular state or other federal laws might impose a stricter privacy standard than HIPAA. If these stricter laws apply, the Plan will comply with the stricter law to the extent such laws are not otherwise preempted. It is necessary that certain *employees* of the plan sponsor be permitted to access, use, and/or disclose the minimum amount of your PHI to perform certain plan administration functions. In accordance with HIPAA, we restrict access to your health plan information only to certain *employees* who need to know that information to perform plan administration and we maintain physical, electronic, and procedural safeguards that comply with federal regulations to guard your health plan information. If you have general questions about your medical claims information maintained by the Plan, call or write to the privacy contact identified at the end of this notice.

What information is protected?

Only identifiable health information that is created or received by or on behalf of the Plan is protected by HIPAA. This health information is called “protected health information” (PHI).

How the Plan May Use and Disclose your PHI

This section describes how the Plan can use and disclose PHI. Please note that this notice does not list every use or disclosure; instead it gives examples of the most common uses and disclosures.

It is necessary for certain third parties to assist the Plan in administering your health benefits under the Plan. These entities keep and use most of the PHI maintained by or on behalf of the Plan such as information about your health condition, the health care services you receive, and the payments for such services. They use and disclose your PHI to process your benefit claims and to provide other services necessary to plan administration. They are legally obligated to use the same privacy protections as the Plan.

Primary Uses and Disclosures of PHI

- The Plan may disclose your PHI so that your *doctors*, dentists, pharmacies, *hospitals* and other health care *providers* may provide you with medical treatment.
- The Plan also may send your PHI to *doctors* for patient safety or other treatment-related reasons.
- The Plan may use and disclose your PHI to facilitate payment of benefits under the Plan; including

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determining eligibility for benefits, calculating your benefits under the Plan, paying your health care *providers* for treating you, calculating your co-pays and *coinsurance* amounts, deciding claims *appeals* and inquiries, and/or coordinating coverage. For example, the Plan may disclose information about your medical history to a physician to determine whether a particular treatment is *experimental*, *investigational*, or *medically necessary* or to decide if the Plan will cover the treatment.

- The Plan may use and disclose your PHI for additional related health care operations necessary to operate the Plan, including but not limited to: underwriting and soliciting bids from potential insurance carriers; merger and acquisition activities; setting premiums; deciding *employee* premium contributions; submitting claims to the Plan's stop-loss (or excess loss) carrier; conducting or arranging for medical review; legal services; audit services; and fraud and abuse detection programs. NOTE: The Plan will not use or disclose "genetic information" (as defined in 45 C.F.R. 160.103) for purposes of underwriting.
- The Plan may use your PHI to contact you or give you information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Other Uses and Disclosures of PHI

- The Plan is required to disclose your PHI to the Secretary of the U.S. Department of Health and Human Services if the Secretary is investigating or determining compliance with HIPAA.
- The Plan will disclose PHI about you when required to do so by federal, state or local law.
- The Plan may release your PHI for Workers' Compensation or similar programs.
- The Plan may use and disclose PHI about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
- If you are an organ donor, the Plan may release your PHI to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.
- If you are a *member* of the armed forces, the Plan may release your PHI as required by military command authorities.
- The Plan may disclose your PHI for certain public health activities including but not limited to:
 - Disclosure to a public health authority that is authorized by law to collect or receive information for the purpose of preventing or controlling disease and conducting public health surveillance and public health investigations;
 - Disclosure to a person who has responsibility to the FDA regarding the quality, safety, or effectiveness of an FDA-regulated product or activity; and
 - Disclosure to a person who may have been exposed to a communicable disease or who may be otherwise at risk of contracting or spreading a disease or condition, if the covered entity is authorized by law to notify such person.
- If the Plan reasonably believe that you or a child has been the victim, of domestic or child abuse or neglect, the Plan may disclose PHI to certain entities authorized by law to receive such information provided certain conditions are satisfied (in most cases your agreement is necessary unless you are incapacitated or the Plan reasonably believe that disclosure is necessary to prevent harm or threat to life).
- The Plan may disclose your PHI to a health oversight agency for activities authorized by law (for example, audits, investigations, inspections, and licensure).
- If you are involved in a lawsuit or a dispute, the Plan may disclose your PHI in response to a court or administrative order.
- The Plan may also disclose your PHI in response to a subpoena, discovery request, or other lawful process provided that, if the Plan is not a party to the litigation, good faith attempts have been made to tell you about the request or to obtain an order protecting the information requested.
- The Plan may release your PHI if asked to do so by a law enforcement official in certain instances.
- The Plan may disclose PHI to a coroner or medical examiner for purposes of identifying a deceased person,

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determining the cause of death, or other duties as authorized by law.

- The Plan may disclose your PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
- If you are an inmate of a correctional institution or under the custody of a law enforcement official, the Plan may release your PHI to the correctional institution or law enforcement official.
- Using its best judgment, the Plan may disclose your PHI to a family *member*, other relative, or close friend. Such a use will be based on how involved the person is in your care or payment that relates to that care.
- The Plan may release claims payment information to *spouses*, parents, or guardians, unless you specifically object in writing to the Privacy Manager identified in the Notice.
- Other uses and disclosures of your PHI that are not described above will be made only with your written authorization. For example, an authorization is required in the following instances: (i) any use or disclosure of psychotherapy notes except as otherwise permitted in 45 C.F.R. 164.508(a)(2); (ii) any use or disclosure for “marketing” except as otherwise permitted in 45 C.F.R. 164.508(a)(3); (iii) any disclosure which constitutes a sale of PHI. If you authorize the Plan to use or disclose your PHI, you may revoke the authorization at any time in writing. However, your revocation will only stop future uses and disclosures that are made after the Plan receive your revocation. It will not have any effect on the prior uses and disclosures of your PHI.

Your Rights Regarding PHI

You have the following rights regarding PHI the Plan has about you:

- You have the right to inspect and copy your PHI that may be used to make decisions about your benefits. To inspect and copy your PHI that may be used to make decisions about you, you must submit your request in writing to the appropriate privacy contact listed on page If you request a copy of this information, the Plan may charge a fee for the costs of copying, mailing or other supplies associated with your request. The Plan may deny your request to inspect and copy your PHI in certain very limited circumstances. HIPAA provides several important exceptions to your right to access your PHI. For example, you will not be permitted to access psychotherapy notes or information compiled in anticipation of, or for use in, a civil, criminal or administrative action or proceeding. The Plan will not allow you to access your PHI if these or any of the exceptions permitted under HIPAA apply. If you are denied access to your PHI, you may request a review of the denial.
- If you feel that PHI the Plan have about you is incorrect or incomplete, you may ask the Plan to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, you must submit your request in writing to the appropriate Privacy Contact listed below. Your request must list the specific PHI you want amended and explain why it is incorrect or incomplete. The Plan may deny your request for an amendment if it is not in writing or does not list why it is incorrect or incomplete. In addition, the Plan may deny your request if you ask the Plan to amend information that is:
 - Not part of the PHI kept by or for the Plan;
 - Not created by the Plan or its third party administrators;
 - Not part of the information which you would be permitted to inspect and copy; or
 - Accurate and complete.

If the Plan denies your request, they must provide you a written explanation for the denial and an explanation of your right to submit a written statement disagreeing with the denial no later than 60 days after receipt of your request.

- When you request, we are required to disclose to you the portion of your PHI that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. You also have the right to request an “accounting” of certain disclosures of your PHI. The accounting will not

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include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures. To request an accounting, you must submit a written request to the Privacy Contact identified in this Notice. Your request must state a time period of no longer than six (6) years.

- You have the right to request that the Plan communicate with you about health plan matters in a certain way or at a certain location. We are only obligated to comply with such a request if the disclosure will endanger you. For example, you can ask that the Plan only contact you at work or by mail. You also have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations or for disclosures to other individuals involved in your care. We are generally not obligated to comply with any request for restrictions or limitations. To request alternative communications or restrictions and/or limitations, you must submit your request in writing to the appropriate privacy contact listed below or you can call **888-234-2416**. Your request must specify how or where you wish to be contacted.

Changes to This Notice

The Plan has the right to change this notice at any time. The Plan also have the right to make the revised or changed notice effective for medical information the Plan already have about you as well as any information received in the future. The Plan will post a copy of the current notice at www.shpnc.org. You may request a copy by calling **888-234-2416**.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the Plan or with the Secretary of the Department of Health and Human Services.

To file a complaint with the Plan, contact the Privacy Contact identified in this Notice. You will not be penalized or retaliated against for filing a complaint.

Privacy Contact

The Privacy Contact is:

State Health Plan
**Attention: HIPAA Privacy Officer,
3200 Atlantic Avenue
Raleigh, NC 27604
919-814-4400**