State Health Plan for Teachers and State Employees

TRADITIONAL 70/30 PPO PLAN
BENEFITS BOOKLET

January 1 – December 31, 2017
TRADITIONAL 70/30 PLAN (PPO) BENEFITS BOOKLET

Welcome to the State Health Plan's Traditional 70/30 PPO Plan, also referred to in this benefits booklet simply as your health benefit plan, or the PPO Plan. Your health benefit plan is offered under a Blue Options Plan administered by Blue Cross and Blue Shield of North Carolina (BCBSNC).

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

You also have the freedom to choose health care providers who do not participate in the Blue Options network. You may receive, upon request, information about your health benefit plan, its services and doctors, including this benefits booklet with a benefit summary, and a directory of in-network providers.

If any information in this booklet conflicts with North Carolina state law, North Carolina law will prevail. The availability of benefits is described in this booklet and member benefit language should be reviewed before applying the terms of any medical policy. 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.

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.

As you read this benefits booklet, keep in mind that any word you see in italics is a defined term and will appear in the “Definitions” section at the end of this benefits booklet.

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 Atencion al Cliente para recibir ayuda.

Notice for Members Not Conversant In English: This benefits booklet contains a summary in English of your rights and benefits under your health benefit plan. If you have difficulty understanding any part of this booklet, contact Customer Service to obtain assistance.
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 Center is just a phone call away at 888-234-2416.
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<th>For questions regarding your benefits, claim inquiries and new ID card requests.</th>
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<td>888-234-2416</td>
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<tr>
<td>TTY and TDD: 800-442-7028</td>
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<tr>
<td>8 a.m.-6 p.m., Monday-Friday, except holidays</td>
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<tr>
<td><strong>Medical Certification or Prior Authorization</strong></td>
<td>To request prior authorization (certification) for certain out-of-network or out-of-state services.</td>
</tr>
<tr>
<td>800-672-7897</td>
<td></td>
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<tr>
<td><strong>Medical Claims Filing</strong></td>
<td>Mail completed medical claims to:</td>
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<td></td>
<td>State Health Plan</td>
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<td></td>
<td>c/o BCBSNC</td>
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<td></td>
<td>PO Box 30087</td>
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<td></td>
<td>Durham, NC 27702</td>
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<tr>
<td><strong>State Health Plan Eligibility and Enrollment Center</strong></td>
<td>For questions regarding member eligibility and enrollment.</td>
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<tr>
<td>855-859-0966</td>
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<tr>
<td>8 a.m.-5 p.m., Monday-Friday, except holidays</td>
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<td><strong>COBRA Administration and Individual Billing Services Customer Service</strong></td>
<td>For questions relating to premium payments for Retirees/COBRA/Surviving Spouses</td>
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<tr>
<td>877-679-6272</td>
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<tr>
<td>8 a.m.-5 p.m., Monday-Friday, except holidays</td>
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<tr>
<td><strong>CVS/Caremark Customer Service</strong></td>
<td>For questions regarding your pharmacy benefits, to obtain a preferred drug list, information on prior authorizations, refills, and more.</td>
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<tr>
<td>888-321-3124</td>
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<td>24 hours a day, 7 days per week</td>
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<tr>
<td><strong>CVS Caremark Specialty Pharmacy</strong></td>
<td>For information regarding the specialty pharmacy services offered or to obtain specialty medications.</td>
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<tr>
<td>800-238-7828</td>
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<tr>
<td><strong>CVS Caremark - Prior Authorization Number</strong></td>
<td>To initiate a prior authorization request for a prescription medication.</td>
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<tr>
<td>800-294-5979</td>
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<tr>
<td><strong>Prescription Drug Claims Filing</strong></td>
<td>Mail completed prescription drug claim forms to:</td>
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<td>CVS/Caremark</td>
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<tr>
<td></td>
<td>P.O. Box 52136</td>
</tr>
<tr>
<td></td>
<td>Phoenix, Arizona 85072-2136</td>
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<tr>
<td><strong>Medical and Pharmacy Appeals</strong></td>
<td>See &quot;Appeals Correspondence&quot; in &quot;What If You Disagree With A Decision?&quot;</td>
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<tr>
<td>888-234-2416</td>
<td></td>
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<tr>
<td><strong>Mental Health Case Manager:</strong></td>
<td>For mental health and chemical dependency prior authorization and certification available 24 hours a day, 7 days per week.</td>
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<tr>
<td>800-367-6143</td>
<td>Services for the speech and hearing impaired are available.</td>
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<tr>
<td><strong>Mental Health TTY (Teletypewriter)</strong></td>
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<tr>
<td>866-835-2755</td>
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<tr>
<td><strong>Mental Health Appeals</strong></td>
<td>See &quot;Appeals Correspondence&quot; in &quot;What If You Disagree With A Decision?&quot;</td>
</tr>
<tr>
<td>800-367-6143</td>
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<tr>
<td><strong>NC HealthSmart</strong></td>
<td>Quick answers to medical concerns.</td>
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<tr>
<td>24hr Nurseline</td>
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<td>Available 7 days a week</td>
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<tr>
<td>800-817-7044</td>
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<tr>
<td><strong>NC HealthSmart Kidney Disease</strong></td>
<td>Specialty Case Managers are available to assist members with Chronic Kidney Disease (CKD) and End Stage Renal Disease (ESRD).</td>
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<tr>
<td>Care Management</td>
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<tr>
<td>800-817-7044</td>
<td></td>
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<tr>
<td><strong>NC Tobacco Use Quitline (QuitlineNC)</strong> 800-QUIT-NOW (800-784-8669) 24 hours a day, 7 days per week</td>
<td>For tobacco cessation assistance including obtaining nicotine replacement therapy.</td>
</tr>
<tr>
<td><strong>BlueCard® PPO Program</strong> 800-810-2583 (Inside USA) 804-673-1177 (Call collect outside USA)</td>
<td>To find a participating provider outside of North Carolina and worldwide.</td>
</tr>
<tr>
<td><strong>TruHearing℠</strong> 1-877-343-0745 1-800-975-2674 (TTY toll-free)</td>
<td>For information about discounts on hearing aids, call or visit mybcbsnc.com.</td>
</tr>
<tr>
<td><strong>Blue365℠</strong> 1-855-511-2583 8 a.m. - 6 p.m. Monday-Friday, except holidays</td>
<td>Health and wellness information support and services, and special Member savings available 365 days a year.</td>
</tr>
<tr>
<td><strong>Davis Vision®</strong> 1-888-897-9350 8 a.m. - 11 p.m. Monday-Friday 9 a.m. - 4 p.m. Saturday 12 p.m. - 4 p.m. Sunday</td>
<td>For information about discounts on corrective laser eye surgery, call or visit mybcbsnc.com.</td>
</tr>
<tr>
<td><strong>N.C. Department of State Treasurer Retirement Systems Division</strong> 325 North Salisbury Street Raleigh, NC 27603-1385 919-733-4191 or 877-733-4191 toll-free <a href="http://www.mynceretirement.com">www.mynceretirement.com</a></td>
<td>If you are a benefit recipient (Retirees, Beneficiaries, Disability recipients) and you have questions about your retirement benefits.</td>
</tr>
<tr>
<td><strong>Blue Connect®</strong> <a href="http://www.shpnc.org">www.shpnc.org</a></td>
<td>To enroll in a safe, secure customer service website in order to: Check claim status, verify benefits and eligibility, change your address or request a new Identification Card (ID card). (Note: Blue Connect formerly known as My Member Services.)</td>
</tr>
<tr>
<td><strong>State Health Plan Website</strong> <a href="http://www.shpnc.org">www.shpnc.org</a></td>
<td>To obtain information on Pharmacy benefits, search for a provider, obtain claim forms, obtain &quot;proof of coverage&quot; portability certificates, NC HealthSmart and more.</td>
</tr>
<tr>
<td><strong>State Health Plan Office</strong> 919-814-4400</td>
<td>Enrollment exceptions for Non-Active Members (Retirees, Disabled Members, RIF Members, COBRA Members, former Members of the General Assembly and other 100% contributory Members). Active members must contact their HBR.</td>
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UNDERSTANDING YOUR STATE HEALTH PLAN COVERAGE

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:

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<th>Term</th>
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<td>Copayment</td>
<td>The fixed-dollar amount that is due and payable by the member at the time a covered service is provided.</td>
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<td>Deductible</td>
<td>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 copayments, coinsurance, charges in excess of the allowed amount, amounts exceeding any maximum and expenses for non-covered services.</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>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.</td>
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<td>Out-of-Pocket Limit</td>
<td>This is the most you pay for covered services (medical and pharmacy) in a calendar year. It includes deductibles and coinsurance, but excludes premiums. It also excludes copays on the medical benefit.</td>
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If you are trying to determine whether coverage will be provided for a specific service, you may want to review all of the following:

- “Summary of Benefits” to get an overview of your specific benefits, such as deductible, coinsurance, copayments and maximum amounts
- “Covered Services” to get more detailed information on what is covered and what is excluded from coverage
- “What Is Not Covered?” to see general exclusions from coverage.
- “Utilization Management” for important information on when prior authorization and certification are required
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 inpatient 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 medications
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 copayment. When there is more than one brand name drug available for your medical condition, it is suggested that you ask your provider 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 copayments 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 with 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.-9 p.m., Saturday 9 a.m.-2 p.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 including a Personal Health Assessment
• 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, Chronic Kidney Disease (CKD), or End Stage Renal Disease (ESRD), multiple hospitalizations or a sudden catastrophic event

*Members eligible for NC HealthSmart Services are members whose primary health coverage is through the State Health Plan. Federal and state 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 employer or other unauthorized third party unless allowed or required by law.
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
- 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
TRADITIONAL 70/30 PLAN (PPO) SUMMARY OF BENEFITS

The following is a summary of your Traditional 70/30 Plan (PPO) benefits. A more complete description of your benefits is found in "Covered Services." General exclusions may also apply. Please see "What Is Not Covered?"

- The copayment amounts are fixed dollar amounts the member must pay for some covered services depending on the provider network selection made at the time of service.
- Multiple office visits or emergency room visits on the same day may result in multiple copayments.
- 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.
- 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 “Who to Contact.”
- 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.
- This plan offers a Wellness Premium Credit to encourage decisions that are good for your health.
- To receive the Wellness Premium Credit, you must choose to participate in the Wellness Activity (Tobacco Attestation and Enrollment in the QuitlineNC –if you are a tobacco user-) during Open Enrollment, Annual Enrollment or within 30 days of becoming first eligible.

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 network before receiving care. A Provider locator (locator) is available through our website at www.shpnc.org or by calling State Health Plan Customer Service at the number given in “Who to Contact.”
Traditional 70/30 Plan Summary of Benefits

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

<table>
<thead>
<tr>
<th></th>
<th>In-Network</th>
<th>Out-of-Network*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lifetime Maximum, Deductible, and Out-of-Pocket Limit</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The following deductibles and maximums apply to the services listed above in the “Summary of Benefits” unless otherwise noted.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Lifetime Maximum</strong></td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td>Unlimited for all covered services except where otherwise specifically indicated or excluded.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Deductible</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual, per benefit period</td>
<td>$1,080</td>
<td>$2,160</td>
</tr>
<tr>
<td>Family, per benefit period</td>
<td>$3,240</td>
<td>$6,480</td>
</tr>
<tr>
<td>Charges for the following do not apply to the benefit period deductible:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Office visit copayments, emergency room copayments, urgent care copayments, and inpatient admission copayments.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Inpatient newborn care for well baby</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Prescription medications</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Medical Coinsurance Limit</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual, per benefit period</td>
<td>$4,388</td>
<td>$8,776</td>
</tr>
<tr>
<td>Family, per benefit period</td>
<td>$13,164</td>
<td>$26,328</td>
</tr>
<tr>
<td>Charges for prescription medications do not apply to the medical coinsurance limit.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Pharmacy Out-of-Pocket Limit</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual, per benefit period</td>
<td>$3,360</td>
<td>$3,360</td>
</tr>
<tr>
<td>Family, per benefit period</td>
<td>$10,080</td>
<td>$10,080</td>
</tr>
</tbody>
</table>

Provider Office Service

See Outpatient Service for outpatient clinic or hospital-based services. Office visits for the evaluation and treatment of obesity are limited to a combined in- and out-of-network maximum of four visits per benefit period.

Office Services

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary Care Provider</strong></td>
<td>$40 copayment</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Specialist</td>
<td>$94 copayment</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Includes office surgery, X-rays and lab tests. For MRIs, MRAs, CT scans and PET scans, see Outpatient Diagnostic Services.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CT Scans, MRIs, MRAs, and PET Scans</strong></td>
<td>30% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td><strong>Preventive Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care Provider</td>
<td>$40 copayment</td>
<td>Benefits not available¹</td>
</tr>
<tr>
<td>Specialist</td>
<td>$94 copayment</td>
<td>Benefits not available¹</td>
</tr>
<tr>
<td>Includes routine physical exams, well baby, well child care, and immunizations.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

¹The following preventive care benefits are available both in- and out-of-network: gynecological exams, cervical cancer screening, ovarian cancer screening, screening mammograms, colorectal screening, and prostate specific antigen tests. See Covered Services.

Nutrition Counseling

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes (first 6 visits)</td>
<td>100%</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>After 6th visit</td>
<td>30% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>All other conditions limited to a combined in- and out-of-network maximum of four visits per benefit period.</td>
<td>$40 copayment</td>
<td>50% after deductible</td>
</tr>
</tbody>
</table>
### Short-Term Rehabilitative Therapies
Limited to rehabilitative speech, physical, and occupational therapy.

<table>
<thead>
<tr>
<th>Service</th>
<th>Copayment</th>
<th>Percentage After Deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluation and Management</td>
<td>$72 copayment</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Therapy Services</td>
<td>$72 copayment</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Short-Term Rehabilitative Therapies</td>
<td>$72 copayment</td>
<td>50% after deductible</td>
</tr>
</tbody>
</table>

Short-Term Rehabilitative Therapies include chiropractic care, occupational therapy, and physical therapy. Combined in-and out-of-network benefit maximums apply to chiropractic services only. There is a 30-visit limit for Chiropractic care. Any visits in excess of this benefit period maximum are not covered services.

### Other Therapies
Includes chemotherapy, dialysis and cardiac rehabilitation provided in the office. See Outpatient Services for other therapies provided in an outpatient setting.

<table>
<thead>
<tr>
<th>Service</th>
<th>Percentage</th>
<th>Percentage After Deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>100%</td>
<td>50% after deductible</td>
</tr>
</tbody>
</table>

### Infertility and Sexual Dysfunction Services

<table>
<thead>
<tr>
<th>Provider</th>
<th>Copayment</th>
<th>Percentage After Deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Provider</td>
<td>$40 copayment</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Specialist</td>
<td>$94 copayment</td>
<td>50% after deductible</td>
</tr>
</tbody>
</table>

Combined in- and out-of-network lifetime limit of 3 ovulation induction cycles and associated services. Any services in excess of this lifetime limit are not covered services.

### Routine Hearing Evaluation Tests

<table>
<thead>
<tr>
<th>Provider</th>
<th>Copayment</th>
<th>Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Provider</td>
<td>$40 copayment</td>
<td>Benefits not available</td>
</tr>
<tr>
<td>Specialist</td>
<td>$94 copayment</td>
<td>Benefits not available</td>
</tr>
</tbody>
</table>

### Urgent Care Centers and Emergency Room

<table>
<thead>
<tr>
<th>Service</th>
<th>Copayment</th>
<th>Percentage After Deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent Care Centers</td>
<td>$100 copayment</td>
<td>$100 copayment</td>
</tr>
<tr>
<td>Emergency Room Visit</td>
<td>$337 copayment, then 30% after deductible</td>
<td>$337 copayment, then 30% after deductible</td>
</tr>
</tbody>
</table>

If admitted to the hospital from the emergency room, inpatient hospital benefits apply to all covered services provided, and the emergency room copayment is waived. If held for observation, outpatient benefits apply to all covered services provided. If you are sent to the emergency room from an Urgent Care Center, you may be responsible for both the emergency room copayment and the urgent care copayment.

### Ambulatory Surgical Center

<table>
<thead>
<tr>
<th>Service</th>
<th>Percentage</th>
<th>Percentage After Deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulatory Surgical Center</td>
<td>30% after deductible</td>
<td>50% after deductible</td>
</tr>
</tbody>
</table>
## Outpatient Services

<table>
<thead>
<tr>
<th>Nutritional Counseling</th>
<th>30% after deductible</th>
<th>50% after deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>(See Provider Office Services for visit maximums)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Provider Services</strong></td>
<td>30% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td><strong>Hospital and Hospital Based Services</strong></td>
<td>30% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td><strong>Outpatient Clinical Services</strong></td>
<td>30% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td><strong>Outpatient Diagnostic Services:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient lab tests and screening mammography</td>
<td>Covered at 100%</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Outpatient X-rays, ultrasounds, and other diagnostic tests, such as EEGs, EKGs and pulmonary function tests</td>
<td>30% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>CT scans, MRIs, MRAs and PET scans received in any location, including in a provider office</td>
<td>30% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td><strong>Therapy Services</strong></td>
<td>30% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Includes short-term rehabilitative therapies and other therapies.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Inpatient Hospital Services

| **Provider Services**         | 30% after deductible | 50% after deductible |
| **Hospital and Hospital Based Services** | $337 copayment, then 30% after deductible | $337 copayment, then 50% after deductible |

Includes maternity delivery, prenatal and post-delivery care. For inpatient mental health and chemical dependency services, refer to the “Mental Health and Chemical Dependency Services” section later in this summary.

## Skilled Nursing Facility

| **In-Network** | 30% after deductible | 50% after deductible |
| **Out-of-Network** |                      |                      |

Combined in- and out-of-network maximum of 100 days per benefit period. Services applied to the deductible count towards the day maximum.

## Other Services

| **Ambulance Services** | 30% after deductible | 30% after deductible |
| **Private Duty Nursing** | 30% after deductible | 50% after deductible |

Includes durable medical equipment, hospice services, medical supplies, orthotic devices – orthotic devices for correction of positional plagiocephaly limited to one covered per lifetime – prosthetic appliances, private duty nursing for ventilated patients.

## Failure to Obtain Certification

Certain services require prior authorization and certification by the State Health Plan in order to receive benefits. For in-network services provided in North Carolina, your provider will request prior authorization when necessary. If you go to an out-of-network provider in North Carolina or any provider outside of North Carolina, you are responsible for requesting or ensuring that your provider requests prior authorization by the State Health Plan. Failure to request prior authorization and receive certification will result in full denial of benefits. Certification is not a guarantee of payment. See “Covered Services” and “Prospective Review/Prior authorization in Utilization Management.”

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 authorization and certification. You are responsible...
Traditional 70/30 Plan Summary of Benefits

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.

<table>
<thead>
<tr>
<th>Mental Health / Chemical Dependency Services</th>
<th>In-Network</th>
<th>Out-of-Network*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health / Chemical Dependency Office Visit</td>
<td>$40 copayment</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Mental Health / Chemical Dependency Outpatient Services</td>
<td>30% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Mental Health / Chemical Dependency Inpatient Services**</td>
<td>$337 copayment, then 30% after deductible</td>
<td>$337 copayment, then 50% after deductible</td>
</tr>
<tr>
<td>Residential Treatment Centers*** Covered up to age 18.</td>
<td>$337 copayment, then 30% after deductible</td>
<td>$337 copayment, then 50% after deductible</td>
</tr>
</tbody>
</table>

No age limit for Substance Abuse.
**Requires certification within two business days of admission.
***Requires certification and prior authorization in advance by the Mental Health Case Manager; and must be an approved residential treatment center.
Failure to request prior authorization and receive certification will result in full denial of benefits. Certification is not a guarantee of payment. See “Covered Services” and “Prospective Review/Prior Authorization” in “Utilization Management.”
### Prescription Medications

Prescription medication benefits are administered by CVS Caremark. See “Prescription Medication Copayment and Benefits” in “Covered Services” for more information.

<table>
<thead>
<tr>
<th>Tier</th>
<th>0-30 Day Supply</th>
<th>31-60 Day Supply</th>
<th>61-90 Day Supply</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1</td>
<td>$16</td>
<td>$32</td>
<td>$48</td>
</tr>
<tr>
<td>Tier 2</td>
<td>$47</td>
<td>$94</td>
<td>$141</td>
</tr>
<tr>
<td>Tier 3</td>
<td>$74</td>
<td>$148</td>
<td>$222</td>
</tr>
<tr>
<td>Tier 4</td>
<td>10% up to $100</td>
<td>(10%) up to $200</td>
<td>(10%) up to $300</td>
</tr>
<tr>
<td>Tier 5</td>
<td>25% up to $103</td>
<td>25% up to $206</td>
<td>25% up to $309</td>
</tr>
<tr>
<td>Tier 6</td>
<td>25% up to $133</td>
<td>25% up to $266</td>
<td>25% up to $399</td>
</tr>
</tbody>
</table>

All specialty medications covered under the pharmacy benefit, excluding cancer medications, must be obtained through CVS/Caremark Specialty Pharmacy.

### Diabetic Testing Supplies

Diabetic testing supplies are covered under your medical and pharmacy benefit. Under your pharmacy benefit, for a single copayment, insulin dependent members may receive up to 204 test strips (depending on manufacturer’s packaging) and non-insulin dependent members may receive 102 test strips (depending on manufacturer’s packaging) per 30-day supply. Additional test strips are covered under your medical supply benefit and are subject to deductible and coinsurance.

<table>
<thead>
<tr>
<th></th>
<th>0-30 Day Supply</th>
<th>31-60 Day Supply</th>
<th>61-90 Day Supply</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preferred Brand Testing Supplies</td>
<td>$10</td>
<td>$20</td>
<td>$30</td>
</tr>
<tr>
<td>Non-Preferred Brand Testing Supplies</td>
<td>$74</td>
<td>$148</td>
<td>$222</td>
</tr>
</tbody>
</table>

Prescription medication copayments are limited to $3,360 per person per benefit period. After the $3,360 maximum is reached, the health benefit plan pays 100% of allowed prescription medication charges. For certification of certain prescription medications, your provider may call CVS Caremark at 800-294-5979 to initiate a certification request.

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 authorization 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.
Traditional 70/30 Plan Summary of Benefits

*Certification Requirements*
In-network providers outside of North Carolina, except for Veterans Affairs (VA) and military providers, are responsible for requesting prior authorization 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 authorization by the State Health Plan even if you see an in-network provider.

Certification Requirements
In-network providers outside of North Carolina, except for Veterans Affairs (VA) and military providers, are responsible for requesting prior authorization 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 authorization by the State Health Plan even if you see an in-network provider.

Certification Requirements
In-network providers outside of North Carolina, except for Veterans Affairs (VA) and military providers, are responsible for requesting prior authorization 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 authorization by the State Health Plan even if you see an in-network provider.

Certain services, regardless of the location, require prior authorization and certification in order to receive benefits. If you go to an in-network provider in North Carolina, your provider will request prior authorization 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 authorization. Failure to request prior authorization and receive certification will result in full denial of benefits. See "Covered Services" and "Prior authorization (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 authorization 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 "Who to Contact" for certification for certain prescription medications, your physician may call CVS Caremark at 800-294-5979 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.
HOW THE TRADITIONAL PPO PLAN WORKS

The Traditional PPO Plan gives you the freedom to choose any provider — the main difference will be the cost to you, depending on whether or not you choose to see an in-network or out-of-network provider. This plan also offers members the option to participate in a Wellness Activity to receive Wellness Premium Credits.

Wellness Activity
During Open Enrollment, Annual Enrollment, or when enrolling within 30 days of being first eligible, you have the option to complete a wellness activity. Wellness premium credits lower your monthly employee-only premium. The wellness activity is:

Tobacco Attestation
During Open Enrollment, Annual Enrollment or when enrolling within 30 days of being first eligible, active employees will need to attest to being a non-tobacco user or commit to a tobacco 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 eEnroll, the Plan’s enrollment system, to complete the attestation. Completing this attestation during enrollment will save active employees $40 per month off of the employee-only premium. Note: This does not apply to retirees.

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. You may participate actively in all decisions related to your health care and discuss all treatment options with your health care provider regardless of cost or benefit coverage. PCPs are trained to deal with a broad range of health care issues and can help you to determine when you need a specialist.

Providers from the following medical specialties may participate as a Blue Options PCP:

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

Please note, however, that not every provider in these specialties is available to be a PCP in the Blue Options plan. Please visit the State Health Plan website at www.sshpnc.org or call State Health Plan Customer Service to be sure the provider you choose is available to be a Blue Options PCP. You may want to confirm that the provider is in the network before receiving care.

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 “Who to Contact” for additional information.

In-Network Benefits
By receiving care from an in-network provider, you receive a higher level of benefit coverage. In-network providers will file claims for you and request prior authorization when necessary. You may want to check with your in-network provider to make sure that prior authorization has been requested. Your in-network provider is required to use the Blue Options network hospital where they practice, unless that hospital cannot provide the services you need. BCBSNC contracts with a broad network of North Carolina providers to deliver covered services to Blue Options members. Please note that dentists and orthodontists do not participate in the
Understanding Your Share of the Cost

Blue Options provider network but there are a limited number of oral maxillofacial surgeons available in-network. However, if the condition is an emergency or if an in-network provider is not reasonably available or that provider type does not participate in the network, benefits will be paid at the in-network level. For more information on BCBSNC’s access to care standards, see the State Health Plan website at [www.shpnc.org](http://www.shpnc.org) or call Customer Service at the number given in “Who to Contact.” In-network providers include:

- **Doctors** — classified as primary care providers (described above) or specialists
- **Other Providers** — health care professionals, such as physical therapists, occupational therapists, audiologists, speech pathologists, clinical social workers and nurse practitioners
- **Hospitals** — both general and specialty hospitals
- **Non-hospital facilities** — such as skilled nursing facilities, ambulatory surgical centers and chemical dependency treatment facilities.

You do not need a referral to see a Blue Options provider. To see which providers are available in-network, please refer to a Blue Options provider directory, “Find a Doctor,” on our website at [www.shpnc.org](http://www.shpnc.org) or call State Health Plan Customer Service at the number given in “Who to Contact.” The list of in-network providers may change from time to time, so please verify that the provider is still in the Blue Options network before receiving care, even if referred by an in-network provider.

If you see a Blue Options provider outside of North Carolina, see “Receiving Care When You Are Outside Of North Carolina” for information about requesting prior authorization.

Please refer to "Summary of Benefits" to see when deductibles or coinsurance apply to any of your in-network-benefits. Also see "Understanding Your Share of the Cost" for an explanation of deductibles, copayments, coinsurance and out-of-pocket limits.

**Out-of-Network Benefits**

With the PPO Plan, you may choose to receive covered services from an out-of-network provider and benefits will be paid at the lower out-of-network level. However, if the condition is an emergency, or if in-network providers are not reasonably available to the member as determined by BCBSNC’s access to care standards, benefits will be paid at the in-network benefit level. For more information on BCBSNC’s access to care standards, see the State Health Plan website at [www.shpnc.org](http://www.shpnc.org) or call Customer Service at the number given in “Who to Contact” 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 State Health Plan Customer Service before receiving care from an out-of-network provider. See the number for "Prior authorization (Certification)" in “Who to Contact.”

When you see an out-of-network provider, you may be responsible for more of the cost. Out-of-network benefits are generally lower than in-network benefits. In addition, you may be required to pay the difference between the provider’s actual charge and the allowed amount. You eliminate this additional cost by receiving care from in-network providers. The State Health Plan encourages you to discuss the cost of services with out-of-network providers before receiving care so you will be aware of your total financial responsibility. Out-of-network providers may or may not bill the State Health Plan directly for services. If the provider does not bill the State Health Plan, you will need to submit a claim form to the State Health Plan.

Out-of-network providers, unlike in-network providers, are not obligated by contract to request prior authorization by the State Health Plan. If you go to an out-of-network provider or receive care outside of North Carolina, it is your responsibility to request or ensure that your provider requests prior authorization by the State Health Plan or its representative. Failure to request prior authorization and obtain certification will result in a full denial of benefits. Before receiving the service, you may want to verify with the State Health Plan or its representative, that certification has been obtained. See “Prospective Review/Prior Authorization” in “Utilization Management” for additional information.

Note: Some services may not be covered out-of-network. See "Summary of Benefits" and "Covered Services." For out-of-network benefits, you may be required to pay for charges over the allowed amount, in addition to
Understanding Your Share of the Cost

any copayment or coinsurance amount. For emergencies or if in-network providers are not reasonably available as determined by BCBSNC’s access to care standards, you may receive in-network benefits for care from an out-of-network provider. See "Out-of-Network Benefits" and "Emergency and Urgent Care Services." Access to care standards is available on our website at www.shpnc.org or by calling State Health Plan Customer Service at the number given in “Who to Contact.” Also see "Mental Health and Chemical Dependency Services" for additional information on prior authorization and certification requirements for these services.

How to File a Claim
If you visit in-network providers, they will file claims for you. If you visit out-of-network providers, you may be responsible for paying for care at the time of service and filing claims for reimbursement. Whenever you need to file a claim, you should mail the completed claim form to:

For your medical, mental health and chemical dependency services:
State Health Plan
c/o BCBSNC
PO Box 30087
Durham, NC 27702

For your prescription medications:
CVS Caremark
P.O. Box 52136
Phoenix, Arizona 85072-2136

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 paid. You may obtain a claim form, including international claim forms, by visiting the State Health Plan website at www.shpnc.org or calling State Health Plan Customer Service at the number listed in “Who to Contact” For help filing a claim, call State Health Plan Customer Service at the number given in “Who to Contact.”

Identification Card
Your ID card identifies you as a PPO member and serves as your health and pharmacy ID card. If any information on your ID card is incorrect, or if you need additional cards, please visit our website at www.shpnc.org or call State Health Plan Customer Service at the number listed in “Who to Contact” or on the back of your ID card. Be sure to carry your ID card with you at all times and present it each time you seek health care. The Plan will seek reimbursement for claims incurred with a State Health Plan ID card before coverage is effective or after coverage has ended. Only subscribers and their enrolled eligible dependents may seek services with this 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.

Making an Appointment
Call the provider's office and identify yourself as a Blue Options member. Please ask the receptionist whether the provider's office is hospital-owned or operated or provides hospital-based services. This may subject your in-network medical services to the Outpatient Services benefit. Your provider directory will also help you make this determination. Provider locators are available online at our website or by calling State Health Plan Customer Service at the number given in “Who to Contact.” If you need nonemergency services after your provider's office has closed, please call your provider's office for their recorded instructions. If you cannot keep an appointment, call the provider's office as soon as possible. Charges for missed appointments, which providers may require as part of their routine practice, are not covered.
UNDERSTANDING YOUR SHARE OF THE COST

This section explains how you and the State Health Plan share the cost of your State Health Plan benefits. If you receive covered services from an in-network provider, you are not responsible for any charge over the allowed amount. If you receive covered services from an out-of-network provider you are responsible for the portion of the charge over the allowed amount.

**Copayments**

A copayment (copay) is a fixed dollar amount you must pay for some covered services. The provider usually collects this amount at the time the service is received. One copayment covers most services at a provider's office as long as it is billed with an office visit, second surgical opinion, surgery, consultation or short term rehabilitative therapies, except for CT Scans, PET Scans, MRIs and MRAs. Refer to "Summary of Benefits" for your specific copayment amounts.

Copayments also apply to urgent care, inpatient admissions, and emergency room services. When you seek these services from an out-of-network provider, you may be required to pay the entire bill at the time of service, and file a claim with the State Health Plan.

**Deductibles**

A deductible is the dollar amount you must incur for certain covered services in a benefit period before benefits are payable by the State Health Plan. If one or more dependents are covered under the State Health Plan, you and each of your dependents have an individual deductible and a combined family deductible. Refer to "Summary of Benefits" for your specific deductible amounts.

The following special rules apply:

- Copayments are not credited to the benefit period deductible
- These services do not apply to the benefit period deductible:
  - Out-of-network office visits for Mental Health and Chemical Dependency
  - Inpatient newborn care
  - Prescription medications.
- 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.

**Coinsurance**

Coinsurance applies after you have satisfied your benefit period deductible. The coinsurance percentage shown in "Summary of Benefits" is the portion the member pays.

**Out-of-Pocket Limit**

The out-of-pocket limit is the dollar amount of coinsurance you pay for covered services in a benefit period before the State Health Plan pays 100% of covered services, after any applicable copayments.

The following special rules apply:

- Charges for prescription medications do not apply to the benefit period out-of-pocket limit.
- Copayments, deductibles, amounts over allowed amounts or UCR (usual, customary and reasonable) amounts and non-covered services are not included in the out-of-pocket limit.
- Amounts applied to your out-of-network coinsurance are credited to your in-network out-of-pocket limit; however
- Amounts applied to your in-network coinsurance are not credited to your out-of-network out-of-pocket limit.
- For out-of-network services, members are responsible for the difference between the allowed amount and the total billed amount even after the out-of-pocket limit has been met, except for emergency room services.
COVERED SERVICES

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 “Who to Contact.”

Also keep in mind as you read this section:

- Certain services require prior authorization and certification in order for you to avoid a denial of your services. While general categories or services are noted in the sections below as requiring prior authorization, please see “Prospective Review/Prior Authorization” in “Utilization Management” for information about the review process, and visit our website at www.shpnc.org or call State Health Plan Customer Service to ask whether a specific service requires prior authorization 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?”

- Certain services are covered pursuant to BCBSNC medical policies, which are updated throughout the plan year. These policies lay out the procedure and criteria to determine whether a procedure, treatment, facility, equipment, drug or device is medically necessary and eligible for coverage, investigational or experimental, cosmetic, a convenience item, or requires prior authorization and certification by BCBSNC. The most up-to-date medical policies are available at www.shpnc.org, or call State Health Plan Customer Service at the number listed in “Who to Contact.”

Office Services

Care you receive from a doctor, physician’s assistant, nurse practitioner or nurse midwife as part of an office visit or house call is covered with a copayment, except as otherwise noted in this benefits booklet. Some providers may receive items such as supplies or drugs from third parties. In these cases, you may be billed directly by the supplier. Benefit payments for these services will be based on the type of supplier and how the services are billed.

Some doctors or other providers may practice in outpatient clinics or provide hospital-based services in their offices. In these cases, the services received may be billed as Outpatient Services and may be subject to your benefit period deductible and coinsurance. See Outpatient Clinic Services in the "Summary of Benefits." These providers are identified in the provider directory, which is available on our website at www.shpnc.org or by calling State Health Plan Customer Service at the number in “Who to Contact.”

Covered office services include care such as consultations, second surgical opinions, office surgery, diagnostic tests, medical supplies, rehabilitative therapy, and allergy injections. Certain diagnostic imaging procedures, such as CT scans and MRIs, are subject to coinsurance and any applicable deductible, and may require prior authorization and certification or services will not be covered.

A copayment will not apply if you only receive services such as allergy shots or other injections and are not charged for an office visit.
Covered Services

Office Services Exclusions
Services not covered when billed as an office service include:

- Services in free-standing surgical facilities, independent laboratories, therapy facilities or outpatient hospital departments
- 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 or call State Health Plan Customer Service for a list of these drugs excluded in the office. Also see “Pharmacy Benefits” for information about purchasing prescription medications at the pharmacy.

Diagnostic Services
Diagnostic procedures help your provider find the cause and extent of your condition in order to plan for your care. Benefits may differ depending on where the service is performed and if the service is associated with a surgical procedure. For member responsibility see Provider Office Services or Outpatient Diagnostic Services in "Summary of Benefits," depending on where services are received.

Separate benefits for interpretation of diagnostic services by the attending doctor are not provided in addition to benefits for that doctor's medical or surgical services, except as otherwise determined by 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.

Laboratory, Radiology and Other Diagnostic Testing
Laboratory studies are services such as diagnostic blood or urine tests or examination of biopsied tissue (that is, tissue removed from your body by a surgical procedure). Radiology services are diagnostic imaging procedures such as X-rays, ultrasounds, computed tomographic (CT) scans and magnetic resonance imaging (MRI) scans. Other diagnostic testing includes electroencephalograms (EEGs), electrocardiograms (ECGs), Doppler scans and pulmonary function tests (PFTs). Certain diagnostic imaging procedures, such as CT scans and MRIs, may require prior authorization and certification or services will not be covered.

Bone Mass Measurement Services
Your health benefit plan covers one scientifically proven and approved bone mass measurement for the diagnosis and evaluation of osteoporosis or low bone mass during any 23 month period for certain qualified individuals only. Additional follow-up bone mass measurement tests will be covered if medically necessary.

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

See Outpatient Services in the "Summary of Benefits."
Covered Services

Emergency and Urgent Care Services

Emergency Care
In the case of an emergency, your health benefit 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

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 authorization is not required for emergency services. Your visit to the emergency room will be covered if your condition meets the definition of an emergency.

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. However, when you receive services from an out-of-network provider you may be required to pay the entire bill at the time of service, and file a claim with the State Health Plan. In these situations, you will be reimbursed the billed amount minus the applicable copayment and/or coinsurance. If you are admitted to the hospital from the emergency room, inpatient hospital benefits apply to all covered services provided. Non-emergency services provided in an emergency room will be covered as an outpatient service instead of an emergency room service.

If you are admitted as a hospital inpatient immediately following emergency services, your benefits will be paid like any other inpatient hospital or provider charges. See “Inpatient Hospital Services.” Prior authorization and certification by the State Health Plan are required for inpatient hospitalization and other selected services following emergency services (including screening and stabilization) in order to avoid a denial of services. You may need to transfer to an in-network hospital once your condition has been stabilized in order to continue receiving in-network benefits.

Care Following Emergency Services
In order to receive in-network benefits for follow-up care related to the emergency (such as office visits or therapy once you leave the emergency room or were discharged from the hospital), you must use in-network providers. Follow-up care related to the emergency condition is not considered an emergency and will be treated the same as a normal health care benefit.

Urgent Care
Your health benefit plan also provides benefits for urgent care services. Urgent care includes services provided for a condition that occurs suddenly and unexpectedly, and requires prompt diagnosis or treatment, such that in the absence of immediate care, the member could reasonably expect to suffer chronic illness, prolonged impairment or the need for more serious treatment. Fever over 101 degrees Fahrenheit, ear infection, sprains, some lacerations and dizziness are examples of conditions that would be considered urgent.

What to do When You Need Urgent Care
When you need urgent care, you may call your PCP, a specialist or go to an urgent care provider.
**Family Planning**

**Maternity Care**
Maternity care benefits are available to all subscribers and enrolled spouses of subscribers. Maternity benefits are not available to dependent children. Maternity care includes prenatal care, labor and delivery, and post-delivery care. Prenatal care is all care related to the pregnancy before the baby's birth. Labor and delivery services for mother and newborn received during an inpatient hospital stay are covered. Post-delivery care is all care for the mother after the baby's birth that is related to the pregnancy. A copayment may apply for the office visit to diagnose pregnancy, otherwise deductible and coinsurance apply for the remainder of your maternity care benefits. If a member changes providers during pregnancy, terminates coverage during pregnancy, or the pregnancy does not result in delivery, one or more copayments may be charged for prenatal services depending upon how the services are billed by the provider.

**Delivery**
Your health benefit plan covers an inpatient hospital stay for you and your newborn for 48 hours for a vaginal delivery or 96 hours for a cesarean section, without prior authorization by the State Health Plan. However, the State Health Plan may pay for a shorter stay if the attending provider (e.g., your doctor or nurse midwife), after consultation with the mother, discharges the mother or newborn earlier. If the mother chooses a shorter stay, coverage is available for a home health visit for post-delivery follow-up care if received within 72 hours of discharge. In order to avoid a denial of services, prior authorization and certification are required for inpatient stays extending beyond 48 hours following vaginal delivery or 96 hours following cesarean section.

**Statement of Rights Under The Newborns' And Mothers' Health Protection Act**
Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your doctor, nurse midwife or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

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

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

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

**Complications of Abortion**
Benefits for complications of abortion are available to all members.
Newborn Care

*Inpatient* newborn care is covered under the mother's maternity benefits described above only during the first 48 hours after a vaginal delivery or 96 hours after delivery by cesarean section. This *inpatient* newborn care requires only one admission *copayment* and *benefit period deductible* for both mother and baby. Benefits also include circumcision and newborn hearing screening ordered by a *doctor* to determine the presence of permanent hearing loss.

For additional coverage of the newborn after the first 48/96 hours, whether *inpatient* or *outpatient*, the newborn must be enrolled for coverage as a *dependent child*, according to the rules in "When Coverage Begins and Ends." At this time, the baby must meet its individual *benefit period deductible* if applicable and *prior authorization* and *certification* are required to avoid a denial of services.

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 “Pharmacy 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 medications* related to *sexual dysfunction* are not covered. See Prescription Medication Exclusions.

Sterilization

This benefit is covered for all *members*. Sterilization includes tubal ligation and vasectomy.

Contraceptive Medications and Devices

This benefit is available for all *members*. Coverage includes the insertion or removal of and any *medically necessary* examination associated with the use of a covered contraceptive device. Covered contraceptives include oral medications, intrauterine devices, diaphragms, injectable contraceptives and implanted hormonal contraceptives.

**Family Planning Exclusions**

- Artificial means of conception, including, but not limited to, artificial insemination, invitro fertilization (IVF), ovum or embryo placement, intracytoplasmic sperm insemination (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*
  - *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 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 medications associated with artificial reproductive technology.
- Ovulation tests
- Blood typing for paternity testing
- Biopsy, oocyte polar body or embryo blastomere, microtechnique
Facility Services

Outpatient Services
Benefits are provided for outpatient services received in a hospital, a hospital based facility or an outpatient clinic.

The following are covered services:

- Medical care provided by a doctor or other professional provider
- Observation
- General nursing care
- Drugs administered by the facility
- Diagnostic services
- Medical supplies
- Use of appliances and equipment ordinarily provided by the facility for the care and treatment of outpatients
- Operating room, recovery room and related services (outpatient surgery)
- Short-term rehabilitative therapies and other therapies.
- Chiropractic services: 30 visits per benefit period.

Certification in advance must be obtained for certain outpatient services. See “Prior authorization or Certification” for more information on certifications.

Inpatient Hospital Services
Your health benefit plan provides coverage when you are admitted to a hospital as an inpatient. If you are admitted before the effective date, benefits will not be available for services received prior to the effective date. If you are in the 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. You should work with your doctor to make sure prior authorization has been requested. Certification must be obtained in advance from the State Health Plan or its representative to avoid a denial of services.

The following are covered services:

- Medical care provided by a doctor or other professional provider
- A semi-private room; or a private room if medically necessary or the hospital has only private rooms
- Use of the operating room, delivery room, recovery room, nursery and related services
- General nursing care
- Intensive care
- Critical care
- Drugs administered by the hospital
- Diagnostic services and medical supplies
- Use of appliances and equipment ordinarily provided by the hospital
- Short-term rehabilitative therapies and other therapies.

Ambulatory Surgical Centers
Benefits are provided for surgical services received in an ambulatory surgical center.

The following are covered services:

- Medical care provided by a doctor or other professional provider
- General nursing care
- Drugs administered by the facility
- Diagnostic services
- Medical supplies
Covered Services

- Use of appliances and equipment ordinarily provided by the facility for the care and treatment of surgical procedures
- Operating, recovery room and related services.

Skilled Nursing Facilities
Your health benefit plan provides benefits for covered services received in a skilled nursing facility. You should work with your doctor to make sure prior authorization has been requested. Prior authorization is not required for members with Medicare as their primary health coverage. If Medicare denies the covered services, they will be reviewed for medical necessity. Certification must be obtained in advance from the State Health Plan or its representative to avoid a denial of services. Skilled nursing facility services are limited to a combined in-network and out-of-network day maximum per benefit period. Refer to "Summary of Benefits." Services determined to be custodial care are not a covered benefit.

Other Services

Ambulance Services
Your health benefit plan covers ambulance transportation services when 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.
- Air ambulance traveling from the site of an emergency to a hospital, or when ground transportation is not medically appropriate due to the severity of the illness, or the pick-up point is inaccessible by land

Transport to and from a dialysis center:
- Transportation to and from a dialysis center will be covered when the member is certified as having end-stage renal disease, and Medicare is the member’s primary insurance.
- Transportation to or from a dialysis center for members other than those noted above will not be covered unless it is determined to be medically necessary

Medical documentation from a provider may be required to substantiate medical necessity of transport by ambulance and that other means of transportation would be contraindicated for your condition.

Ambulance transportation services will be reviewed for medical necessity in the case of:
- Ambulance services from a hospital or skilled nursing facility to a member’s home
- Non-emergency air ambulance services

If non-emergency ground ambulance service is not medically necessary, you may be responsible for charges.

Ambulance Service Exclusion
- No benefits are provided primarily for the convenience of travel.
Bariatric Surgery
Your health benefit 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
Your health benefit 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
Your health benefit plan provides benefits for participation in clinical trials phases I, II, III, and IV. Coverage is provided only for medically necessary costs of health care services associated with the trials, and only to the extent such costs have not been or are not funded by other resources. The member must meet all protocol requirements and provide informed consent in order to participate. The trial must involve the treatment of 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, 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 medications and devices and services that are not for the direct clinical management of the patient.

Dental Treatment Covered Under Your Medical Benefit
Your health benefit plan provides limited benefits for diagnostic, therapeutic or surgical procedures, including oral surgery involving bones or joints of the jaw, when the procedure is related to one of the following conditions:
• Accidental injury of the natural teeth, jaw, cheeks, lips, tongue, roof and floor of the mouth
• Congenital deformity, including cleft lip and cleft palate
• Removal of oral tumors, oral cysts which are not related to teeth or associated dental procedures, and exostosis for reasons other than preparation of 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 the condition requires surgical correction, the medical necessity review of the surgery will 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. Reconstructive dental services following accidental injury are only covered when the accident occurred while the member is covered by the State Health Plan and the services are provided within two years of the accident.

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. Unless treatment is for an emergency, prior authorization and certification are required or services will not be covered. Other dental services, including the charge for surgery, are not covered.

Dental Treatment Exclusions:
- 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:
- Orthodontic braces
- Removal of teeth and intrabony cysts
- Procedures performed for the preparation of the mouth for dentures
- Crowns, bridges, dentures or in-mouth appliances.

Diabetes Related Services
All medically necessary diabetes-related services. The following are covered:
- Meters
- Supplies including needles, test strips and lancets
- Medications
- Laboratory testing
- Self-management training
- Orthotics
- Insulin
- Educational services
- Eye exams for diabetic retinopathy

Diabetic testing supplies are covered under your pharmacy benefit. For a single copayment, insulin dependent members may receive up to 204 test strips (depending on manufacturer’s packaging) and non-insulin dependent members may receive up to 102 test strips (depending on manufacturer’s packaging) per 30-day supply. Additional test strips are covered under your medical supply benefit and are subject to deductible and coinsurance.

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 authorization and certification or services will not be covered.

The following are examples of covered durable medical equipment:
- Wheel chairs
- Traction equipment
- Hospital beds
- Respiratory (inhalation) or suction machines

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, except as required for operation of medically necessary equipment prescribed by a provider
- 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
Coverage includes all medically necessary hearing aids, including implantable bone-anchored hearing aides (BAHA) and services ordered by a provider or an audiologist. The following are covered:
- Initial hearing aids and replacement hearing aids
- New hearing aids with alterations to the existing hearing aid that does not adequately meet the member’s need
- Services, including the initial hearing aid evaluation, fitting, and adjustments and supplies including ear molds

Coverage is limited to one hearing aid per hearing-impaired ear every 36 months for members under the age of 22. 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 allowed amount.
Covered Services

Home Health Care

Home health care services are covered by the State Health Plan when the member is homebound due to illness or injury. Prior authorization is required for home health care services, except for physical therapy. Benefits for the following may be provided to a homebound member:

- Professional services of a registered nurse (RN) or licensed practical nurse (LPN) for visits totaling eight hours or less per day
- Short-term rehabilitative therapies
- Medical supplies
- Oxygen and its administration
- Medical social service consultations
- Home health aide services, provided by someone other than a professional nurse, which are medical or therapeutic in nature and furnished to a member who is receiving covered nursing or therapy services. For example, the presence of the home health aide is necessary to assist or work in conjunction with the licensed personnel, such as assisting with wound care that requires more than one staff member to complete.

Home Health Care Exclusions

- Personal comfort or convenience items
- Dietitian services or meals
- Homemaker services, such as cooking and housekeeping
- Maintenance therapy/custodial care
- 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 medications 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 authorization and certification or services will not be covered.

The following are covered services:

- Professional services of an RN or LPN
- Specimen collection, laboratory testing and analysis
- Patient and family education
- Management of emergencies arising from home infusion therapy
- Prescribed medications related to infusion services, and delivery of drugs and supplies.

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. Hospice services are covered only as part of a licensed health care program that provides an integrated set of services and supplies designed to give comfort, pain relief and support to terminally ill patients and their families. A hospice care program is centrally coordinated through an interdisciplinary team directed by a doctor.

The following are covered services:

- Professional services of an RN or LPN
- Medical services, equipment and supplies
- Prescribed drugs
- In-home laboratory services
- Medical social service consultations
- Inpatient hospice room, board and general nursing services (requires prior authorization and certification to avoid a denial of services)
Covered Services

- **Inpatient** respite care, which is short-term care provided to the *member* only when necessary to relieve the family *member* or other persons caring for the individual
- Family counseling related to the *member's* terminal condition
- Dietitian services
- Pastoral services
- Bereavement services
- Educational services
- *Home health* aide services, provided by someone other than a professional nurse, which are medical or therapeutic in nature and furnished to a *member* who is receiving covered nursing or therapy services.

**Hospice Services Exclusions**
- Homemaker services, such as cooking, housekeeping, food or meals
- *Medical services* provided by a *doctor* other than as part of your *hospice* care program.

**Medical Supplies**
Coverage is provided for *medical supplies* such as ostomy supplies, catheters, oxygen, and diabetic supplies (glucose monitoring strips, lancets, syringes and needles). Select diabetic supplies are covered under your *pharmacy* benefit. Your benefit payments are based on where supplies are received, either as part of your *medical supplies* benefit or your *pharmacy* benefit. See “Summary of Benefits” and “Pharmacy Benefits.” To obtain *medical supplies/equipment*, please find a *provider* on our website at [www.sbpnc.org](http://www.sbpnc.org) or call State Health Plan 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
- Pocket nebulizers
- Replacement bulbs or lamps for therapeutic light

**Nutritional Services**
Nutritional visits with a licensed, registered dietitian are covered. Up to six *in-network* office-based nutrition visits are covered at 100% per *benefit period* for *members* with a diagnosis of diabetes. Additional nutrition visits are covered for *members* with diabetes at *deductible* and *coinsurance*. For all other conditions, *members* can receive up to four nutritional visits per *benefit period*. Please see “Nutritional Counseling” in the “Summary of Benefits.”

**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, one per lifetime. Please see “Other Services” in the "Summary of Benefits."
Private Duty Nursing

Your health benefit plan provides benefits for private duty services of an RN or LPN. Coverage is limited to 4 hours per day for non-vented members and 12 hours per day for vented members. These services must be ordered by your doctor and be medically necessary. You should work with your doctor to make sure prior authorization has been requested. Certification must be obtained in advance from the State Health Plan or its representative or services will not be covered. These services are always subject to the deductible and coinsurance.

PDN services are intended to be intermittent and temporary services for members with an unstable condition. The goal is for the member/family to be as independent as possible and to work toward a plan to eventually terminate PDN services. See the BCBSNC Private Duty Nursing Services Medical Policy here.

Private Duty Nursing Exclusion
- Private duty nursing services provided by a close relative or a member of your household.

Prosthetic Appliances

Your health coverage provides benefits for the purchase, fitting, adjustments, repairs, and replacement of prosthetic appliances following permanent loss of a body part. The prosthetic appliances must replace all or part of a body part or its function in order to be covered. The type of prosthetic appliance will be based on the functional level of the member. Benefits include a one-time replacement of eyeglass or contact lenses because of a prescription change after cataract surgery. Therapeutic contact lenses may be covered when used as a corneal bandage for a medical condition. Certain prosthetic appliances require prior authorization 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 your health benefit 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 or its representative before receiving surgical treatment for TMJ.

Prior authorization 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.


**Preventive Care**

*The following benefits are only available in-network:*

Preventive care can help you stay safe and healthy. Your health benefit plan covers preventive care services and includes:

**Routine Physical Examinations**
One routine physical examination and related diagnostic services per *benefit period* will be covered for each *member* age two and older.

**Well-Baby and Well-Child Care**
These services are covered for each *member* up to 24 months of age including periodic assessments and immunizations. Benefits are limited to six well-baby visits for *members* through 12 months old and three well-child visits for *members* 13 months up to 24 months old.

**Immunizations**
The full series of standard immunizations recommended by the Centers for Disease Control and Prevention (CDC) and the American Academy of Family Physicians (AAFP) is covered.

Covered immunizations include the following:

- Diphtheria-Pertussis-Tetanus Toxoid (DPT)
- Polio
- Measles-Mumps-Rubella (MMR)
- Influenza
- Pneumococcal vaccine
- Human papilloma virus (HPV)
- HiB
- Hepatitis A and B
- Meningococcal vaccine
- Chicken pox
- Rotavirus
- Shingles (covered in accordance with the Food and Drug Administration guidelines)

**Immunizations Exclusions**
- Immunizations required for occupational hazard
- Immunizations required for international travel.

*The following benefits are available in-network and out-of-network:*

**Gynecological Exam, Including Cervical Cancer Screening**
The cervical cancer screening benefit includes the examination and laboratory tests for early detection and screening of cervical cancer, and *doctor's* interpretation of the lab results. Coverage for cervical cancer screening includes Pap smear screening, liquid-based cytology, and human papilloma virus detection, and shall follow the American Cancer Society guidelines or guidelines adopted by the North Carolina Advisory Committee on Cancer Coordination and Control. See *Provider Office Services* or *Outpatient Services* in the “Summary of Benefits,” depending on where services are received.

**Ovarian Cancer Screening**
For *members* age 25 and older at risk for ovarian cancer, an annual screening, including a transvaginal ultrasound and a rectovaginal pelvic examination, is covered. A *member* is considered "at risk" if the member:

- 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.

See *Provider Office Services* or *Outpatient Services* in the “Summary of Benefits,” depending on where services are received.
**Screening Mammograms**
Beginning at age 35, coverage is provided for one screening mammogram per 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 member is considered at risk for breast cancer.

A member is "at risk" if the member:
- 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.

See Physician Office Services or Outpatient Diagnostic Services in “Summary of Benefits.”

**Colorectal Screening**
Colorectal cancer examinations and laboratory tests for cancer are covered for any symptomatic or nonsymptomatic 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. See Provider Office Services, Ambulatory Surgical Center or Outpatient Services in the “Summary of Benefits,” depending on where services are received. However, lab work for the removal of polyps during the screening exam is considered preventive care.

**Prostate Screening**
One Prostate Specific Antigen (PSA) test or an equivalent serological test will be covered per member per benefit period. Additional PSA tests will be covered if recommended by a doctor. Benefits may vary depending on where services are received. See Provider Office Services or Outpatient Services in the “Summary of Benefits.”

**Surgical Benefits**
Surgical benefits by a professional or facility provider on an inpatient or outpatient basis are covered. These benefits include the services of the surgeon or medical specialist, assistant, and anesthetist or anesthesiologist, together with pre-operative and post-operative care. Surgical benefits include diagnostic surgery, such as biopsies, sigmoidoscopies and colonoscopies. Certain surgical procedures, including those that are potentially cosmetic, require prior authorization and certification or services will not be covered.

Such services include pre-operative physical examinations and any services related to the surgical procedure, including care of complications. This includes reconstructive surgery performed to correct congenital defects that result in functional impairment of newborn, adoptive, and foster children.

Multiple surgical situations, procedures performed on the same date of service and/or during the same patient encounter, may not be eligible for separate reimbursement. If you go to an out-of-network provider, you may be required to pay for charges over the allowed amount in addition to any coinsurance amount. For information about coverage of multiple surgical procedures, please refer to the Blue Options PPO medical policies, which are on our website at www.shpnc.org, or call State Health Plan Customer Service at the number listed in “Who to Contact.”

**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. Your coverage does not provide additional benefits for local anesthetics. The following services are included as part of the anesthesia charge:
administration of an anesthetic, drugs, materials, diagnostic laboratory services and monitoring. Separate benefits are not available for related services.

**Mastectomy Benefits**
Under the Women’s Health and Cancer Rights Act of 1998, your health benefit plan provides for the following services related to mastectomy surgery:

- Reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the nondiseased breast to produce a symmetrical appearance without regard to the lapse of time between the mastectomy and the reconstructive surgery
- Prostheses and physical complications of all stages of the mastectomy, including lymphedemas. See Physician Office Services, or for external prostheses, see prosthetic appliances in Other Services in the “Summary of Benefits.”

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

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

**Therapies**
Your health benefit plan provides coverage for the following therapy services to promote the recovery of a member from an illness, disease or injury. A doctor or other professional provider must order these services.

**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
- Rehabilitative speech therapy.

**Chiropractic Therapy**
Benefits are limited to a combined *in-network* and *out-of-network* benefit period maximum for chiropractic services. This visit limit applies in all places of service (e.g., outpatient, office and home therapies). There is a 30-visit limit for Chiropractic care. Any visits in excess of this benefit period maximum are not covered services. *In-network* chiropractic providers file claims through Health Network Solutions (HNS). Your *in-network* provider is responsible for filing your claim. If you or your *provider* has a question, please call Customer Service at the number listed in “Who to Contact.” Refer to "Summary of Benefits" for additional information.

**Other Therapies**
Your health benefit plan covers:

- Cardiac rehabilitation therapy
- Dialysis treatment
- Chemotherapy, including intravenous chemotherapy. (This does not include high dose chemotherapy with bone marrow or peripheral blood stem cell *transplants*. Refer to "Transplants.")
- Pulmonary and respiratory therapy
- Radiation therapy

**Therapy Exclusions**

- 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
Covered Services

- Peripheral arterial disease rehabilitation
- Community or work integration training, work hardening or conditioning.

**Transplants**
Your health benefit plan provides benefits for transplants, including hospital and professional services for only those transplant procedures listed below. Your health benefit 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. Call State Health Plan Customer Service at the number listed in “Who to Contact” to speak with a transplant coordinator and to request prior authorization. Certification must be obtained in advance for all transplant-related services in order to assure coverage of these services.

- Heart
- Lung, single and bilateral
- Combined heart and lung
- Pancreas
- Kidney
- Allogenic bone marrow transplants
- High dose chemotherapy with bone marrow or peripheral blood stem cell rescue, including autologous (self-donor) and allogeneic (other donor) bone marrow transplant.

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. However, other costs related to evaluation and procurement are covered up to the recipient member coverage limit.
- 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, drugs and supplies for or related to transplants, except those transplants specifically listed as covered services
- Services for or related to the transplantation of animal or artificial organs or tissues.

**Mental Health and Chemical Dependency Benefits**
Your health benefit plan provides benefits for the treatment of mental illness and chemical dependency by a hospital, doctor or other provider. See “Summary of Benefits,” and information below.

**Office Visit Services**
Prior authorization by your Mental Health Case Manager is not required for mental health and chemical dependency office visit services. The following professional services are covered when provided in an office setting:
- Evaluation and diagnosis
- Preventive office visits
- Medication checks
Covered Services

- **Medically necessary** biofeedback and neuropsychological testing
- Individual and family counseling
- Group therapy
- Medically necessary services for the treatment of gender dysphoria.

**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 authorization and *certification* or services will not be covered. The timeframe for receiving prior authorization and treatment certification are set forth in the table below. The list of services that require prior authorization 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*.

**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 (Applied Behavior Analysis) 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](http://www.cdc.gov/ncbddd/autism/screening.html).

ABA medical necessity criteria are available on the Mental Health Case Manager’s web site at [https://www.beaconhealthoptions.com/providers/beacon/handbook/clinical-criteria/](https://www.beaconhealthoptions.com/providers/beacon/handbook/clinical-criteria/).

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 (ABA)* 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.

Substance abuse 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 “Who to Contact” 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 the 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 the 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 Options℠ 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 Options℠ network hospital where they practice, 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.

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 authorization 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 “Who to Contact” for certification.
**Covered Services**

**Timeframe Requirements for Prior Authorization and Treatment Certification of Covered Services**

<table>
<thead>
<tr>
<th>Covered Service</th>
<th>Within Two (2) Business Days of Admission</th>
<th>Prior to Admission to the Program</th>
<th>Continuing Treatment Certifications*</th>
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<tbody>
<tr>
<td>Crisis Evaluation &amp; Stabilization</td>
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<tr>
<td>Psychiatric Inpatient Hospital</td>
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<td>Chemical Dependency Inpatient Hospital</td>
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<td>Inpatient Medical Detoxification</td>
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<td>Psychiatric Residential Treatment Center</td>
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<td>Psychiatric Partial Hospitalization Program</td>
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<td>Psychiatric Intensive Outpatient Program</td>
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*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.*

*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 authorization 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 and Limitations**

- 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 psychiatric residential treatment facilities when age 18 or older.
- Chemical dependency residential treatment facilities are covered for all ages.
- 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 currently 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 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
• 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
Covered Services

- 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
- 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

Pharmacy Benefits

Prescription Medication Copayment and Benefits

A Pharmacy Benefit Manager (PBM) manages administration of the pharmacy benefit.

Your pharmacy benefit offers a custom, closed formulary, which means that certain medications are not covered. For more information on covered medications, see the information listed under the Preferred Drug List section below.

Some prescription medications 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 medications 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 medications will be covered. If you need quantities in excess of the limit for a medication 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 medications that require prior approval to be covered or require approval for additional quantities, you may call Pharmacy Customer Service at the number listed in “Who to Contact” or visit the State Health Plan website. The State Health Plan or its representative may change the list of these prescription medications from time to time.

Keep in mind that your provider must write a prescription. Additionally, there may be some prescription medications that are administered by a provider in a medical office that may be limited to coverage under your medical benefit.

For certification of your prescription medications, your physician may call the PBM’s Prior Authorization number listed in “Who to Contact” to initiate a certification request.

Prescription medication synchronization as follows:

If you have multiple prescriptions and need to align your refill dates, you may need a prescription for less than a 30-day supply. If your doctor or pharmacy agrees to give you a prescription for less than a
Covered Services

30-day supply for this purpose, you will only pay a prorated daily cost-sharing amount (any dispensing fee will not be prorated). This benefit is only available for medications covered under your prescription medication benefit, received at an in-network pharmacy, and when prior authorization requirements have been met.

In addition, the medications must:

- be used for treatment and management of chronic conditions and are subject to refills
- NOT be a Schedule II or Schedule III controlled substance containing hydrocodone
- be able to be split over short-fill periods, and
- not have quantity limits or dose optimization criteria that would be affected by aligning refill dates.

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 “Who to Contact”

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 copayment.**

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 copayment 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 “Who to Contact.” To learn how to register for the PBM’s online pharmacy services, visit the State Health Plan's website at [www.shpnc.org](http://www.shpnc.org) and click Pharmacy Benefits under your plan.

You may use a credit card for copayments for telephone or online refills.

Preferred Drug List

The State Health Plan, with guidance from the Pharmacy and Therapeutics Committee (P & T Committee), compiles the Preferred Drug List. The Preferred Drug List can be obtained from the State Health Plan's website or by calling the PBM at the number listed in “Who to Contact” The Preferred Drug List is subject to change without notification.

- Generic drugs are often an effective alternative to brand drugs. Ask your physician to consider Tier 1 generic drugs whenever possible. Some higher cost generics may be in Tier 2. If a generic drug is not available, you will be responsible for paying the higher copayment based on the tier placement for the brand name drug.
- When there is more than one brand name drug available for your medical condition, it is suggested that you ask your provider to prescribe a drug on the preferred list. This will reduce your copayment.

Your pharmacy benefit offers a custom, closed formulary (or a list of covered prescription medications). In the formulary, prescription medications are divided into six categories or tiers: (Tier 1), the most cost-effective non-specialty medications, which would include mostly generic drugs; (Tier 2), preferred brand non-specialty medications, including some high-cost generic drugs; (Tier 3), non-preferred brand non-specialty medications and compound; (Tier 4), the most cost-effective specialty medications, including generics and some biosimilars; (Tier 5), preferred brand specialty medications, and (Tier 6) non-preferred brand specialty medications. Refer to the State Health Plan.
Covered Services

website for a list of specialty medications. The placement of drugs in a formulary tier determines what copayment or coinsurance will be charged for a 30-day supply.

If you would like an updated copy of the formulary or you want to check the tier placement of a specific drug, please call the PBM at the number listed in “Who to Contact” or visit the State Health Plan website.

Prescription medication copayments are limited to $3,360 per person per benefit period. After the $3,360 maximum is reached, the health benefit plan pays 100% of allowed prescription medication charges. The family out of pocket maximum is $10,080.00 per benefit year.

Prescription medications are not subject to the benefit period deductible or coinsurance amounts, or applied to their maximums.

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 medications.

Prescription Medication Exclusions
• Any prescription drugs not covered in the formulary
• 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 medications
• Any compound medication that contains an investigational medication
• Any compound medication in which any active ingredient is not a covered prescription medication including bulk chemicals.
• Any compound medication 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.
• Any prescription medication that has a therapeutic equivalent available over-the-counter as determined by the State Health Plan
• Any prescription medical foods

Diabetic Testing Supplies
Diabetic testing supplies are covered under your pharmacy benefit. For a single copayment, insulin dependent members may receive up to 204 test strips (depending on manufacturer’s packaging) and non-insulin dependent members may receive up to 102 test strips (depending on manufacturer’s packaging) per 30-day supply. Additional test strips are covered under your medical supply benefit and are subject to deductible and coinsurance.

Tobacco Cessation Coverage
For information on the tobacco cessation coverage, please see the Tobacco Cessation Support section under “Value Added 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 at [www.shpnc.org](http://www.shpnc.org). Click on Plans for Active Employees, then Traditional 70/30 Health Plan, then Pharmacy Benefits and finally on Specialty Medications.

- 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 *specialty medications* covered under the pharmacy benefit, excluding cancer medications. If you use a pharmacy other than the contracted vendor to purchase any *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 “Who to Contact.”

**How to File a Claim for Prescription Medications**

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 copayment for each 30-day supply. The pharmacist will file the claim.

If you purchased *prescription medications* 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 copayment and charges in excess of the allowed amount. You will need to complete a Prescription Drug Claim Form for reimbursement and submit it to:

CVS/Caremark  
ATTN: Direct Claims  
P.O. Box 52136  
Phoenix, AZ 85072-2136

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 CVS Caremark Customer Service at the number given in “Who to Contact.”
Medicare Part D

**IMPORTANT INFORMATION REGARDING YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE**

Effective January 1, 2006, Medicare began offering *prescription drug* coverage for all persons enrolled in Medicare. The *State Health Plan* will continue to provide *prescription drug coverage* for all members on this plan.

When *members* become eligible for Medicare Part D, they will receive a notice of *credible coverage* from the *State Health Plan*. "Credible Coverage" means that your *prescription drug* coverage is at least as good as Part D coverage.

If your current *prescription drug coverage* qualifies as "credible coverage," you should not need Part D coverage, unless you are Medicaid eligible or eligible for low-income assistance. *Members* of the *State Health Plan* should evaluate their own coverage needs prior to purchasing a Medicare *Prescription Drug Plan*.

Part D: Is provided* by the *State Health Plan* and pays for *prescription drug coverage*.

*High income members may be subject to an income-related monthly adjustment amount by Social Security.*
WHAT IS NOT COVERED?

Exclusions that are specific to a type of service are stated along with the benefit description in "Covered Services." Exclusions that apply to many services are listed in this section. To understand all of the exclusions that apply, read "Covered Services," "Summary of Benefits" and "What Is Not Covered?" In addition, your health benefit plan does not cover services, supplies, drugs or charges that are:

- Not medically necessary
- Anything specifically listed in this benefits booklet as not covered or excluded, regardless of medical necessity.
- 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.
- Any experimental medication or any medication or device not approved by the Food and Drug Administration (FDA) for the applicable diagnosis or treatment. However, this exclusion does not apply to prescription medications used in covered phases I, II, III and IV clinical trials, or drugs approved by the FDA for treatment of cancer, if prescribed for the treatment of any type of cancer for which the medication has been approved as effective and accepted in any one of the following:
  - The National Comprehensive Cancer Network Drugs & Biologics Compendium
  - The Thomson Micromedex DrugDex
  - The Elsevier Gold Standard’s Clinical Pharmacology
  - Any other authoritative compendia as recognized periodically by the United States Secretary of Health and Human Services
- Side effects and complications of non-covered services, except as specifically covered by your health benefit plan or except for emergency services in the case of an emergency
- Not prescribed or performed by or upon the direction of a doctor or other provider
- For any condition, disease, illness or injury that occurs in the course of employment, if the employee, employer or carrier is liable or responsible for the specific medical charge (1) according to a final adjudication of the claim under a state's workers' compensation laws, or (2) by an order of a State Industrial Commission or other applicable regulatory agency approving a settlement agreement
- For basic life or work-related or medical disability examinations
- For a health care professional to administer injectable prescription medications which can be self-administered, unless medical supervision is required
- For inpatient admissions primarily for the purpose of receiving diagnostic services or a physical examination. Inpatient admissions primarily for the purpose of receiving therapy services are excluded except when the admission is a continuation of treatment following care at an inpatient facility for an illness or accident requiring therapy
- For care in a self-care unit, apartment or similar facility operated by or connected with a hospital
- For custodial care, 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
- For respite care of any kind except as specifically covered by your health benefit plan
- For services provided at request of patient in a location other than physician’s office which normally provided in the physician’s office
- For day care services, chore services, attendant care services, homemaker services, companion services, foster care services
- 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
- For telephone consultations or web-based, online or other electronic evaluations, charges for failure to keep a scheduled visit, charges for completion of a claim form, charges for obtaining medical records, and late payment charges
What is not Covered?

- Incurred more than 18 months prior to the member’s submission of a claim
- For cosmetic purposes for any reason, including but not limited to excess skin from the abdomen, arms or thighs, and surgery for psychological or emotional reasons except as specifically covered by this health benefit plan.
- For camisoles, or other clothing, post-mastectomy
- For any services that would not be necessary if a non-covered service had not been received, except for emergency services in the case of an emergency
- For benefits that are provided by any governmental unit except as required by law
- For services that are ordered by a court that are otherwise excluded from benefits under this health benefit plan
- For care that the provider cannot legally provide or legally charge or is outside the scope of license or certification
- Provided and billed by a licensed health care professional who is in training
- For any services provided and billed by a lactation consultant
- For breast pumps
- Available to a member without charge and/or care given to a member by a provider who is in a member’s immediate family
- For any condition suffered as a result of any act of war or while on active or reserve military duty
- In excess of the allowed amount for services usually provided by one doctor, when those services are provided by multiple doctors
- For palliative, cosmetic or routine foot care
- For 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 when a hazardous condition exists at the same time or covered oral surgery services are required at the same time as a result of a bodily injury
- For 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 nutritional visits or surgical treatment of morbid obesity, or as specifically covered by your health benefit plan
- Bariatric surgery, except when provided at a Blue Distinction Center (BDC).
- Wigs, hair pieces and services for hair implants and electrolysis for any reason
- 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
- For prescribed sexual dysfunction medications
- Music therapy, remedial reading, recreational or activity therapy, alternative therapy services, all forms of special education and supplies or equipment used similarly
- Hypnosis except when used for control of acute or chronic pain
- Acupuncture and acupressure
- Travel, whether or not recommended or prescribed by a doctor or other licensed health care professional, except as specifically covered by your health benefit plan
- For heating pads, hot water bottles, ice packs and personal hygiene and convenience items such as, but not limited to, devices and equipment used for environmental control, incontinence products (including briefs, diapers, underwear, underpads), and urinary incontinence devices (including bed wetting devices) and equipment
- For 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
- Communication boards or alternative communication devices
- For safety equipment, devices or accessories, including but not limited to helmets with face guards and soft interfaces and any type of restraints
- Air conditioners, furnaces, humidifiers, dehumidifiers, vacuum cleaners, electronic air filters and similar equipment
What is not Covered?

- Physical fitness equipment, hot tubs, Jacuzzis, heated spas, whirlpools, pool or memberships to health clubs
- Athletic training evaluations or re-evaluations
- 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.
  - Routine eye examination services except as specifically covered by the Plan
  - Eyeglasses or contact lenses, except as specifically covered in “prosthetic appliances”
  - Orthoptics, vision training, and low vision aids
- Hearing aids or examinations for the fitting of hearing aids except as specifically covered by your health benefit plan
- Routine hearing examinations except as specifically covered by your health benefit plan
- Audiometric testing of groups, Bekesy audiometry, ear protector attenuation measurements
- Evaluation and treatment of developmental dysfunction and/or learning differences
- Medical care provided by more than one doctor for treatment of the same condition
- Take home medications furnished by a hospital or non-hospital facility
- Clomiphene (e.g., Clomid), menotropins (e.g., Reprofax) or other medications associated with conception by artificial means
- For maintenance therapy. Maintenance therapy includes therapy services that are provided over a long period of time in order to keep your condition stable
- For massage therapy services, including but not limited to reflexology
- For holistic medicine or alternative services, except as specifically covered by your health benefit plan
- For services primarily for educational purposes including, but not limited to, books, tapes, pamphlets, seminars, classroom, web or computer programs, individual or group instruction and counseling, 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 your health benefit plan
- 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
- For medical testimony
- For genetic testing, except for high risk patients when the therapeutic or diagnostic course would be determined by the outcome of the testing
- For genetic testing for amyotrophic lateral sclerosis (ALS)
- For hair analysis, excluding arsenic
- For low density lipoprotein (LDL) apheresis using heparin-induced extracorporeal LDL precipitation
- For bone density wrist or heel radiological testing
- For thermography or thermograph examination
- For transportation of portable x-ray equipment and personnel to home or nursing home, transportation of portable EKG to facility or other location
- 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 your health benefit plan
- Shoe lifts, shoe accessories, attachments, equipment, inserts, or other modifications, and shoes of any type, including therapeutic shoes, unless part of a brace, except as specifically covered by your plan
- Compression stockings, garter belts, except as specifically covered by your health benefit plan
What is not Covered?

• For any condition, disease, ailment, injury or diagnostic service to the extent that benefits are provided or persons are eligible for coverage under Title XVIII of the Social Security Act of 1965, including amendments, except as otherwise provided by federal law
• For conditions that federal, state or local law requires to be treated in a public facility
• For over-the-counter and non-federal legend vitamins
• For food supplements or replacements, nutritional or dietary supplements, formulas, special foods or medical foods of any kind
• For standing frames
• For Applied Behavioral Analysis except as specifically covered by your health benefit plan
• Not specifically listed in this benefits booklet as a covered benefit, drug, service or supply
• Blood pressure machines, cuffs or other blood pressure monitoring devices
• For hypothermia therapy
• For necropsies
• For telehealth services originating site facility fees
• For extracorporeal shockwave lithotripsy (ESWL) of gallbladder and other sites
• For emergency response systems
• For postural drainage boards and similar equipment
• For pacemaker monitors and external defibrillators with integrated electrocardiogram analysis
• Skin tag excisions, cryotherapy or chemical exfoliation for active acne and acne scarring
• Superficial dermabrasion
• Injection of dermal fillers
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 shall 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 “Who to Contact.”
- 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.

Prospective Review/ Prior Authorization
The State Health Plan requires that certain health care services receive prior authorization as noted in “Covered Services.” These types of reviews are called prospective reviews. If neither you nor your provider requests prior authorization and receives certification, this will result in a complete denial of benefits. General categories of services with this requirement are noted in “Covered Services.”


may also visit our website at www.shpnc.org or call State Health Plan Customer Service at the number listed in “Who to Contact” for a detailed list of services. The list of services that require prior authorization may change from time to time.

If the requested certification is denied, you have the right to appeal. See "What If You Disagree With A Decision?" for additional information. Certain services may not be covered out-of-network. See “Covered Services.”

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. If the State Health Plan or its representative does not approve benefit coverage of a health care service, the State Health Plan or its representative will notify you and your provider by written or electronic confirmation.

Expedited Certification

You have a right to an urgent review when the regular time frames for a decision: (i) could seriously jeopardize your life, health, or safety or the life, health or safety of others, due to your psychological state, or (ii) in the opinion of a practitioner with knowledge of your medical or behavioral condition, would subject you to adverse health consequences without the care or treatment that is the subject of the request. BCBSNC will let you and your provider know of its decision within 72 hours after receiving the request. Your provider will be notified of the decision, and if the decision results in an adverse benefit determination, written notification will be given to you and your provider.

If the Plan needs more information to process your urgent review, the Plan will let you and your provider know 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. The Plan will make a decision on your request within a reasonable time but no later than 48 hours after receipt of requested information or within 48 hours after the time period given to the provider to submit necessary clinical information, whichever comes first.

An urgent review may be requested by calling Customer Service at the number given in “Who to Contact.”

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. The State Health Plan or its representative will communicate concurrent review decisions to the hospital or other facility within three business days after the State Health Plan or its representative receives all necessary information but no later than 15 days after the request. If the State Health Plan or its representative does not provide certification, the State Health 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, your health benefit plan will remain responsible for covered services you are receiving until you or your representatives have been notified of the denial of benefit coverage.
Utilization Management

Expedited Concurrent Review
You have a right to an expedited 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. If you request an extension of treatment that the State Health Plan or its representative has already approved at least 24 hours before the current approved treatment ends, 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, but no later than 24 hours after receiving the request.

Retrospective Reviews
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. When the decision is to deny benefit coverage, the State Health 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 your health benefit plan. The State Health Plan or its representative may take an extension of up to 15 days if additional information is needed. Before the end of the initial 30-day period, the State Health Plan or its representative will notify you of the extension, the information needed and the date by which the State Health Plan or its representative expects to make a decision. You will then have 90 days to provide the requested information. As soon as the State Health Plan or representative receives the requested information, or at the end of the 90 days, whichever is earlier, the State Health Plan or its representative will make a decision within 15 days. Services that were approved in advance by the State Health 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
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 “Who to Contact” for additional information.

**Further Review of Utilization Management Decisions**

If you receive a noncertification as part of the prior authorization 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**

Your Mental Health Case Manager is responsible for first level grievance review for mental health and chemical dependency inpatient hospitalizations, residential treatment centers, partial day/night program, and intensive outpatient program services. The Case Manager’s decision making is based on the appropriateness of care and service as well as existence of coverage. All other 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 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 copayments, deductibles, coinsurance or out-of-pocket limit, 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.

The North Carolina Department of Insurance is available to assist you with questions about health insurance. For assistance with appeals, please contact Health Insurance Smart NC at:

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

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 “Who to Contact”

Any request for review should include:

- Member’s ID number
- Member’s name
- Any other information that may be helpful for the review.

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:

- Name, address and telephone number of the grievance coordinator
What if You Disagree with a Decision?

- 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 “Who to Contact.” 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.

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
What if You Disagree with a Decision?

• 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:

**Mail**
NC Department of Insurance
Health Insurance Smart NC
1201 Mail Service Center
Raleigh, NC 27699-1201

**In person**
For the physical address, please visit
www.ncdoi.com/Smart
Toll-Free Telephone: 855-408-1212

**Web**
www.ncdoi.com/Smart
for external review
information and request form
The Health Insurance Smart NC Program provides consumer counseling on utilization review and grievance issues. Within ten business days (or, for an expedited review, within two business days after the 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 after receiving the additional information.

The IRO will send you a written notice of its decision within 45 days (or, for an expedited review, within three business days after the date 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 the same after 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.
What if You Disagree with a 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 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 first level grievance review for mental health and chemical dependency inpatient hospitalizations, residential treatment centers, partial day/night program, 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 under this health benefit plan and the right to enforce any claim arising under this health benefit plan cannot be transferred or assigned to any other person or entity, including providers. Under the health benefit plan, the State Health Plan’s Third Party Administrator, BCBSNC may pay a provider directly. For example, BCBSNC pays in-network providers directly under applicable contracts with those providers. However, any provider’s right to be paid directly is through such contract with BCBSNC, and not through the plan. Under the plan, BCBSNC has the right to determine whether payment for services is made to the provider, to the subscriber, or allocated among both. BCBSNC’s decision to pay a provider directly in no way reflects or creates any rights of the provider under the plan, including but not limited to benefits, payments or procedures.

If a member resides with a custodial parent or legal guardian who is not the subscriber, the State Health Plan or its representative may, 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 member. This can result in a reduction or elimination of future claims payments. In addition, under certain circumstances, if the State Health Plan pays the provider amounts that are your responsibility, such as deductible, copayments or coinsurance, the State Health Plan may collect such amounts directly from you. 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 take your privacy seriously and handle 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.

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.
Services Received Outside Of North Carolina

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

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

All claim types are eligible to be processed through Inter-Plan Arrangements, as described above, except for all dental services (unless provided under your medical benefits), Prescription Drug or vision care benefits that may be administered by a third party contracted by BCBSNC to provide the specific service or services.

Under the BlueCard Program, the amount you pay toward such Covered Services, such as deductibles, copayments or coinsurance is usually based on the lesser of:

- The billed charges for your Covered Services, or
- The negotiated price that the “Host Blue” passes on to BCBSNC.

This “negotiated price” can be:

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

The estimated or average price may be adjusted in the future to correct for over- or underestimation of past prices. However, such adjustments will not affect the price that BCBSNC uses for your claim because they will not be applied retroactively to claims already paid.

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

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

If reference-based benefits, which are service-specific benefit dollar limits for specific procedures, based on a Host Blue’s local market rates, are made available to you, you will be responsible for the amount that the healthcare Provider bills above the specific reference benefit limit for the given procedure. For a participating Provider, that amount will be the difference between the negotiated price and the reference benefit limit. For a nonparticipating Provider, that amount will be the difference between the Provider’s billed charge and the reference benefit limit. Where a reference benefit limit is greater than either a negotiated price or a Provider’s billed charge, you will incur no liability, other than any related patient cost sharing under this Plan.

If you receive Covered Services from a nonparticipating Provider outside the state of North Carolina, the amount you pay will generally be based on either the Host Blue’s nonparticipating Provider local payment or the pricing arrangements required by applicable state law. However, in certain situations, the Plan may use other payment bases, such as billed charges, to determine the amount the Plan will pay for Covered Services.
from a nonparticipating Provider. In any of these situations, you may be liable for the difference between the nonparticipating Provider’s billed amount and any payment the Plan would make for the Covered Services.

Value-Based Programs: BlueCard® Program

If you receive Covered Services under a Value-Based Program inside a Host Blue’s service area, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to BCBSNC through average pricing or fee schedule adjustments.

Value Based Programs: Negotiated (non-BlueCard Program) Arrangements

If BCBSNC has entered into a Negotiated National Account Arrangement with a Host Blue to provide Value-Based Programs to your Employer on your behalf, BCBSNC will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted above for the BlueCard Program.

BlueCard Worldwide® Program:

If you are outside the United States (hereinafter “BlueCard service area”), you may be able to take advantage of the BlueCard Worldwide® Program when accessing Covered Services. The BlueCard Worldwide Program is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although the BlueCard Worldwide Program assists you with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when you receive care from providers outside the BlueCard service area, you will typically have to pay the providers and submit the claims yourself to obtain reimbursement for these services.

If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, you should call the BlueCard Worldwide Service Center at 1-800-810-BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

Inpatient Services

In most cases, if you contact the BlueCard Worldwide Service Center for assistance, hospitals will not require you to pay for covered inpatient services, except for any applicable copay, deductible or coinsurance amounts. In such cases, the hospital will submit your claims to the BlueCard Worldwide Service Center to begin claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for Covered Services. You must contact BCBSNC to obtain precertification for non-emergency inpatient services.

Outpatient Services

Physicians, Urgent Care centers and other outpatient providers located outside the BlueCard service area will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for Covered Services.

Submitting a BlueCard Worldwide Claim

When you pay for Covered Services outside the BlueCard service area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a BlueCard Worldwide International claim form and send the claim form with the provider’s itemized bill(s) to the BlueCard Worldwide Service Center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from BCBSNC, the BlueCard Worldwide Service Center or online at www.bluecardworldwide.com. If you need assistance with your claim submission, you should call the BlueCard Worldwide Service Center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week.
Mental Health and Chemical Dependency Services

Although prior authorization 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 “Who to Contact” for assistance in locating a provider. You must request prior authorization and receive certification from the Mental Health Case Manager for mental health and chemical dependency services other than office visits or in emergencies. BlueCard® PPO does not provide prior authorization or certification for mental health and chemical dependency services. The numbers for Mental Health Case Manager are provided in “Who to Contact” and on the back of your ID card. For more information on these services, see “Covered Services.”

North Carolina Provider Reimbursement

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

Some out-of-network providers have other agreements with BCBSNC that affect their reimbursement for covered services provided to Plan 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 between the Plan’s allowed amount and the contracted amount. Out-of-network providers may bill you directly. If you are billed, you will be responsible for paying the bill and filing a claim with BCBSNC.

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, illness or condition, 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, illness, or condition 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.

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, 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 brought to recover benefits until you have exhausted all administrative remedies, which requires completion of the two-level appeals process. No legal action may be taken later than three years from the date services are incurred. 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.
Additional Terms of Your Coverage

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.
  - Benefits under the health benefit plan that covers the child as a dependent of the spouse of the parent with custody are determined primary.
  - Benefits under the health benefit plan that covers the child as a dependent of the parent without custody are secondary.

**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.

When You Reach Age 65
The State Health Plan mails a Medicare eligibility letter prior to your 65th birthday, which asks that you confirm your eligibility for Medicare benefits.

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 of your benefits, you are required to notify the State Health Plan of Medicare eligibility immediately. If Medicare becomes your primary health coverage, you must elect Medicare Part B to maintain your same level of coverage.

State Health Plan Benefit Coordination with Medicare
- If you are employed and eligible for Medicare, the State Health Plan is primary and Medicare is secondary for you and your dependents. The only exceptions are if you are Medicare primary due to End Stage Renal Disease (ESRD) or are receiving Social Security Disability Income benefits.
- 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.
  - 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.
Additional Terms of Your Coverage

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.

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 of 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 Traditional 70/30 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.
- Permanent hourly employees who work at least one-half of the workdays each pay period.
- 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.
- Retirees employed by an employing unit that elects to provide this coverage and the retiree does not qualify for coverage as a permanent employee and are determined to be “full-time” by their employing unit in accordance with section 4980H of the Internal Revenue Code.

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.
- 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.
- *Employees* of the General Assembly, not otherwise covered by this section, as determined by the Legislative Services Commission, except legislative pages and interns.
- Surviving spouses 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.
- Spouses 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 spouses of deceased retirees and surviving spouses of deceased teachers, State employees, and members of the General Assembly if the spouse 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, they may be eligible for continuation coverage.
- The spouses 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 spouse 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 they are 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 “Who to Contact”

No person shall be eligible for coverage as an employee 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 Open Enrollment.

**Dual Enrollment**

No person shall be eligible for coverage as an employee or retired 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 under another health benefit plan, and each of the following conditions is met:
When Coverage Begins and Ends

- 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 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) in order to enroll in coverage for the current plan year. Members who do not enroll when first eligible must wait until the next Open 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 disenroll themselves or their dependents from the Plan; they may disenroll at any time.

Enrollment Exceptions

To make an enrollment exception request, active members must contact their HBR and request that the HBR file an enrollment exception request with the State Health Plan. Non-Active Members (Retirees, Disabled Members, RIF Members, COBRA Members, former Members of the General Assembly and other 100% contributory Members) must contact the State Health Plan office at 919-814-4400 to file an enrollment...
When Coverage Begins and Ends

exception. Enrollment exception requests must be submitted to the Plan within the following timeframe:
Within sixty (60) days of enrollment, termination or change in benefit election or within thirty (30) days of
premium deduction or premium payment due date reflecting enrollment, termination, or change in benefit
election, whichever is later.

Adding or Removing a Dependent
If you want to add or remove a dependent due to a qualifying life event, you will need to do so through
eEnroll, the Plan’s enrollment system. To access eEnroll, visit www.shpnc.org and click “Enroll Now.”
Failure to timely make this change could result in loss of eligibility for continuation of coverage.

To add a dependent, you will need to do so through eEnroll, the Plan’s enrollment system. To access
eEnroll, visit the www.shpnc.org and click “Enroll Now.” 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 or you must wait until the next Open Enrollment to add your dependent.

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 employee 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 disenroll 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.

If you are a retired member or a 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
Open 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 and his/her spouse; 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 and termination of employment. For additional ineligibility events, contact Customer Service at the number in “Who to Contact.” 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.

Premium payments are due by the first day of the effective month. The premium payment grace period ends thirty (30) days after the due date. Members who do not pay their premiums in full by the end of the grace period will have their coverage canceled. If the premium payment is received after the coverage is canceled for nonpayment, but the postmark is on or before the last day of the grace period, the coverage may be reinstated. This applies to members whose premiums are paid on a partially or fully contributory basis.

If the premium amount due is only for dependent coverage, then only the dependent coverage will be terminated; however, if the premium is for both the subscriber and the dependents, all members of the will have their coverage canceled. If you are terminated due to nonpayment, you will not be able to come back on the Plan until the next Open Enrollment period, even if you experience a qualifying life event.

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.

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 a 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.
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:

<table>
<thead>
<tr>
<th>Tobacco Cessation Support</th>
<th>Members are encouraged to call a QuitlineNC Quit Coach® and/or their provider or behavioral health care provider about quitting tobacco use.</th>
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<tbody>
<tr>
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<td><strong>Free Hotlines</strong></td>
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<tr>
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<td>QuitlineNC…800-QUIT-NOW (800-784-8669). Available 24 hours a day, 7 days a week. (English, Spanish and other languages available.) QuitlineNC telephonic support program is tailored to help all members 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.</td>
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<td><strong>Nicotine Replacement Therapy Medications</strong></td>
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<tr>
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<td>Over the counter, generic nicotine replacement therapy (NRT) patches, gum, or lozenges will be available through QuitlineNC at no additional charge to members. Members do not need a prescription to receive the free patches and/or gum from QuitlineNC, but do need to be enrolled in the multi-call program to be eligible.</td>
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<tr>
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<td><strong>Prescription Medications</strong></td>
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<td>Prescription generic extended-release bupropion 12 hour and brand Chantix (varenicline) will be covered at 100% for members ≥ 18 years with a written prescription. Chantix will be limited to a 6 month supply in 12 months. Other covered prescription medications and over the counter medications are available</td>
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Value-Added Programs

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<tr>
<th>Weight Management Support</th>
<th>Tools and Resources</th>
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<tr>
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<td>Worksite Wellness Initiatives</td>
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<td></td>
<td>The NC HealthSmart Worksite Wellness Toolkit, available at <a href="http://www.shpnc.org">www.shpnc.org</a>, 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 members in quitting. Contact your Health Benefits Representative or Wellness Leader for more information.</td>
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<td>Worksite Wellness Initiatives</td>
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<tr>
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<td>The NC HealthSmart Worksite Wellness Toolkit available online at <a href="http://www.shpnc.org">www.shpnc.org</a> 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.</td>
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<thead>
<tr>
<th>Maternity Coaching</th>
<th>Weight Management Tools and Resources</th>
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<tr>
<td>Maternity Coaching</td>
<td>Nutrition Visits</td>
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<td></td>
<td>Please see “Covered Services” for additional information about nutrition counseling benefits for subscribers and covered dependents. For a listing of participating licensed dietitians, visit the State Health Plan website at <a href="http://www.shpnc.org">www.shpnc.org</a> and select “Find a Doctor.”</td>
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<tr>
<td>Maternity Coaching</td>
<td>Weight Management Medications</td>
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<td></td>
<td>Talk to your physician about FDA-approved medications available to members for managing weight. For a list of covered medications, please visit the Pharmacy section of the State Health Plan website at <a href="http://www.shpnc.org">www.shpnc.org</a>.</td>
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<tr>
<td>Maternity Coaching</td>
<td>Web-based Programs</td>
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<td></td>
<td>Eligible members* may access the NC HealthSmart Personal Health Portal’s interactive weight management and nutrition improvement programs at <a href="http://www.shpnc.org">www.shpnc.org</a>.</td>
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<tr>
<td>Maternity Coaching</td>
<td>Support Line</td>
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<td>Members 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.</td>
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<tr>
<td>Maternity Coaching</td>
<td>Worksite Wellness Initiatives</td>
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</table>

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:

- Monday-Friday, 8:30 a.m.-9 p.m.
- Saturday, 9 a.m.-2 p.m.

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
## Value-Added Programs

Participants will receive an inpatient copayment or HRA incentive for delivery in a certified medical facility or birthing center when they:

- 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

The deadline for enrollment into the Stork Rewards Program is March 31, 2017. If a member enrolled into Stork Rewards earlier this year or by March 31, she should continue to work with her maternity coach each trimester to be eligible to receive the incentive.

Visit [www.shpnc.org](http://www.shpnc.org) and click NCHealthSmart for more information.

### Health Coaching

Health Coaches are specially trained and licensed health care professionals (nurses, registered dieticians) who are available by phone; Monday – Friday 8:30 a.m.-9 p.m., Saturday 9 a.m. - 2 p.m. to talk with you to help you manage your health. They can discuss a variety lifestyle issues such as:

- Tobacco cessation
- Nutrition and weight management
- Exercise
- Stress
- Preventative Health

They can also provide:

- 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:
  - Asthma
  - Coronary Artery Disease
  - Back pain
  - Joint pain
  - Obesity / bariatric surgery
  - Hypertension
  - Migraine/other headache
  - Osteoporosis
  - End of life issues
  - Chronic Obstructive Pulmonary Disease (COPD) includes chronic bronchitis and Emphysema
  - Specialized support during your pregnancy
  - Recommend health education programs, tools, and videos
  - Send printed health-related materials to your home
  - Health Education Programs and Tools
  - Health videos provided at no charge, as approved by your Health Coach
  - Printed materials mailed to your home
## Value-Added Programs

| **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 an 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. |
| **Health Assessment (HA)** | 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](http://www.shpnc.org), by logging into your Personal Health Portal, or by calling a Health Coach at 800-817-7044. |
| **NCHealthSmart Personal Health Portal** | - 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** | The State Health Plan 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 members 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. For more information, contact [NC.HealthSmart@nc treasurer.com](mailto:NC.HealthSmart@nc treasurer.com). |

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.

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

Other 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 Programs 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

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

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

Schedule a hearing consultation at a participating AudioBlue℠ provider and present your ID card.

Blue365℠

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 Blue365℠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
- 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 “Who to Contact” 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 Vision℠

Discounts on vision and corrective laser eye surgery

OpticBlue℠ 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.
Value-Added Programs

Chiropractic Services
Discounts on chiropractic services
Chiropractic care is one of the most popular forms of alternative 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.

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.
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.

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 non-hospital 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 Glossary for "Noncertification" and "Medical Necessity."

BCBSNC — Blue Cross and Blue Shield of North Carolina.

BENEFIT PERIOD — the period beginning January 1, 2017, and ending on December 31, 2017, which charges for covered services, if applicable, are applied to the annual deductible and out-of-pocket limit 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.
BRAND NAME — the proprietary name of the prescription medication 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.

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 hydranmios; 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 MEDICATION — 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.

COPAYMENT — the fixed-dollar amount that is due and payable by the member at the time a covered service is provided.

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, medication, 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.

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 composed 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 copayments, coinsurance, 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 emergencies.

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

FORMULARY — the list of outpatient prescription medications and insulin that are available to members.

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

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 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 non-hospital 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

e) Is acceptable to BCBSNC.
HOSPICE — a non-hospital 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 copayments and/or coinsurance, and key phone numbers and addresses.

INCIRED — the date on which a member receives the service, drug, equipment or supply for which a charge is made.

INFERTILITY — the inability after 12 consecutive months of unsuccessful attempts to conceive a child.

IN-NETWORK — designated as participating in the 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 non-hospital 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 U.S. Food and Drug Administration (FDA) or final approval from any other governmental regulatory body for use in treatment of a specified condition. Any approval that is granted as an interim step in the regulatory process is not a substitute for final or unrestricted market approval.

b) There is insufficient or inconclusive scientific evidence in peer-reviewed medical literature to permit 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 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.

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

OFFICE VISIT — medical care, surgery, diagnostic services, 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 LIMIT — 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 non-hospital 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 pharmacy 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.

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

PRESCRIPTION MEDICATION — a medication 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.

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

PRIOR AUTHORIZATION — 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 authorization results in certification or non-certification of benefits.

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

PROVIDER — a hospital, non-hospital 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 sexual arousal disorder, 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.

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

**SPECIALIST** — a doctor who is recognized by 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 at [www.shpnc.org](http://www.shpnc.org). Click on Plans for Active Employees, then Traditional 70/30 Health Plan, then Pharmacy Benefits and finally on Specialty Medications. Treats complex medical conditions(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 any employee or retiree who enters into a marriage that is legally recognized under any state law.

**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.

**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.

**WELLNESS ACTIVITY (IES)** — The activity (ies) that can be completed during enrollment to qualify for Wellness Premium Credits.

**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.
LEGAL 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 Preferred Provider Organization (PPO) plan 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 135.

Benefits Booklet

This benefits booklet describes the State Health Plan for Teachers and State Employees Traditional 70/30 Plan 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, North Carolina law will prevail. The availability of benefits is described in this booklet and member benefit language should be reviewed before applying the terms of any medical policy. 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 of Privacy Practices**

**Original Effective Date:** April 14th, 2003  
**Revised Effective Date:** September 23rd, 2013

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**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.

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**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 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’ 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, 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. 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 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
Nondiscrimination and Accessibility Notice

The State Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The State Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The State Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator identified below (the “Coordinator”):

State Health Plan Compliance Officer  
(919)-814-4400

If you believe that the State Health Plan has failed to provide these services or discriminated against you, you can file a grievance with the Coordinator. You can file a grievance in person or by mail, fax, or email. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights available at:

U.S. Department of Health and Human Services, 200 Independence Avenue SW.  
Room 509F, HHH Building, Washington, DC 20201  
1–800–368–1019, 800–537–7697 (TDD)

File complaint electronically at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html