North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
A Division of the Department of State Treasurer

State Health Plan for Teachers and State Employees

TRADITIONAL 70/30 PPO PLAN BENEFITS BOOKLET

January 1 – December 31, 2017

BlueCross BlueShield of North Carolina

Revised: November 14, 2016

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

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 *(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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WHO TO CONTACT

***State Health Plan* Customer Service** 888-234-2416 8 a.m-6 p.m., Monday-Friday, except holidays	For questions regarding your benefits, claim inquiries and new *ID card* requests.
Medical Certification or Prior Authorization 800-672-7897	To request *prior authorization* (*certification*) for certain *out-of-network* or out-of-state services.
Medical Claims Filing	Mail completed medical claims to: *State Health Plan* c/o *BCBSNC* PO Box 30087 Durham, NC 27702
***State Health Plan* Eligibility and Enrollment Center** 855-859-0966 8 a.m.-5 p.m., Monday-Friday, except holidays	For questions regarding *member* eligibility and enrollment.
COBRA Administration and Individual Billing Services Customer Service 877-679-6272 8 a.m.-5 p.m., Monday-Friday, except holidays	For questions relating to premium payments for *Retirees*/COBRA/Surviving *Spouses*
CVS/Caremark Customer Service 888-321-3124 24 hours a day, 7 days per week	For questions regarding your *pharmacy benefits*, to obtain a preferred drug list, information on *prior authorizations*, refills, and more.
CVS Caremark Specialty Pharmacy 800-238-7828	For information regarding the specialty pharmacy services offered or to obtain *specialty medications*.
CVS Caremark - *Prior Authorization* Number 800-294-5979	To initiate a *prior authorization* request for a *prescription medication*.
***Prescription Drug* Claims Filing**	Mail completed *prescription drug* claim forms to: CVS/Caremark P.O. Box 52136 Phoenix, Arizona 85072-2136
Medical and Pharmacy *Appeals* 888-234-2416	See "*Appeals* Correspondence" in "What If You Disagree With A Decision?"
Mental Health Case Manager: 800-367-6143 **Mental Health TTY (Teletypewriter)** 866-835-2755	For mental health and *chemical dependency prior authorization* and *certification* available 24 hours a day, 7 days per week. Services for the speech and hearing impaired are available.
Mental Health *Appeals* 800-367-6143	See "*Appeals* Correspondence" in "What If You Disagree With A Decision?"
NC Health*Smart* 24hr Nurseline Available 7 days a week 800-817-7044	Quick answers to medical concerns.
NC Health*Smart* Kidney Disease Care Management 800-817-7044	Specialty Case Managers are available to assist *members* with Chronic Kidney Disease (CKD) and End Stage Renal Disease (ESRD).

NC Tobacco Use Quitline (QuitlineNC) 800-QUIT-NOW (800-784-8669) 8 a.m.-3 a.m., 7 days per week	For tobacco cessation assistance including obtaining nicotine replacement therapy.
BlueCard® PPO Program 800-810-2583 (Inside USA) 804-673-1177 (Call collect outside USA)	To find a participating *provider* outside of North Carolina and worldwide.
TruHearing℠ 1-877-343-0745 1-800-975-2674 (TTY toll-free)	For information about discounts on hearing aids, call or visit **mybcbsnc.com**.
Blue365™ 1-855-511-2583 8 a.m. - 6 p.m. Monday-Friday, except holidays	Health and wellness information support and services, and special *Member* savings available 365 days a year.
Davis Vision® 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	For information about discounts on corrective laser eye *surgery*, call or visit **mybcbsnc.com**.
N.C. Department of State Treasurer **Retirement Systems Division** 325 North Salisbury Street Raleigh, NC 27603-1385 919-733-4191 or 877-733-4191 toll-free **www.myncretirement.com**	If you are a benefit recipient (*Retirees*, Beneficiaries, Disability recipients) and you have questions about your retirement benefits.
Blue Connect® **www.shpnc.org**	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.)
***State Health Plan* Website** **www.shpnc.org**	To obtain information on Pharmacy benefits, search for a *provider*, obtain claim forms, obtain "proof of coverage" portability certificates, NC Health*Smart* and more.
State Health Plan Office ***919-814-4400***	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.

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:

Copayment	The fixed-dollar amount that is due and payable by the *member* at the time a *covered service* is provided.
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*.
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*.
Out-of-Pocket Limit	This is the most you pay for *covered services* (medical and pharmacy) in a calendar year. It includes *deductibles* and *coinsurance*, but excludes *premiums*.

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 Health*Smart** 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 Health*Smart* 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 Health*Smart* 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 *doctor*s, 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?"

- 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.

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* locater *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.

	In-Network	*Out-of-Network**
Lifetime Maximum, Deductible, and Out-of-Pocket Limit		
The following *deductibles* and maximums apply to the services listed above in the "Summary of Benefits" unless otherwise noted.		
Lifetime Maximum	Unlimited	Unlimited
Unlimited for all covered services except where otherwise specifically indicated or excluded.		
Deductible		
Individual, per *benefit period*	$1,080	$2,160
Family, per *benefit period*	$3,240	$6,480
Charges for the following do not apply to the *benefit period deductible*: • *Office visit copayments*, *emergency* room *copayments*, *urgent care copayments*, and *inpatient* admission *copayments*. • *Inpatient* newborn care for well baby • *Prescription medications*		
Medical Coinsurance Limit		
Individual, per *benefit period*	$4,388	$8,776
Family, per *benefit period*	$13,164	$26,328
Charges for prescription medications do not apply to the medical *coinsurance limit*.		
Pharmacy Out-of-Pocket Limit		
Per *benefit period*	$3,360	$3,360
***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		
Primary Care Provider	$40 *copayment*	**50% after *deductible***
Specialist	$94 *copayment*	**50% after *deductible***
Includes office *surgery,* X-rays and lab tests. For MRIs, MRAs, CT scans and PET scans, see *Outpatient Diagnostic Services.*		
CT Scans, MRIs, MRAs, and PET Scans	**30% after *deductible***	**50% after *deductible***
Preventive Care		
Primary Care Provider	$40 *copayment*	Benefits not available[1]
Specialist	$94 *copayment*	Benefits not available[1]
Includes routine physical exams, well baby, well child care, and immunizations.		
[1]The 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		
Diabetes (first 6 visits)	100%	50% after *deductible*
After 6th visit	30% after *deductible*	50% after *deductible*
All other conditions limited to a combined in- and *out-of-network* maximum of four visits per *benefit period.*	$40 *copayment*	50% after *deductible*

Short-Term Rehabilitative Therapies Limited to rehabilitative speech, physical, and *occupational* therapy.		
Evaluation and Management	$72 *copayment*	50% after *deductible*
Therapy Services	$72 *copayment*	50% after *deductible*
Short-Term Rehabilitative Therapies	$72 *copayment*	50% after *deductible*
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	100%	50% after *deductible*
Includes chemotherapy, dialysis and cardiac rehabilitation provided in the office. See *Outpatient Services* for *other therapies* provided in an *outpatient* setting.		
***Infertility* and *Sexual Dysfunction* Services**		
Primary Care Provider	$40 *copayment*	50% after *deductible*
Specialist	$94 *copayment*	50% after *deductible*
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		
Primary Care Provider	$40 *copayment*	**Benefits not available**
Specialist	$94 *copayment*	**Benefits not available**
Urgent Care Centers* and *Emergency Room		
Urgent Care Centers	$100 *copayment*	$100 *copayment*
***Emergency Room* Visit**	$337 *copayment,* then 30% after *deductible*	$337 *copayment,* then 30% after *deductible*
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	30% after *deductible*	50% after *deductible*

Outpatient Services

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

*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.

	In-Network	***Out-of-Network****
## *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.

*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.

	In-Network	*Out-of-Network**
Skilled Nursing Facility	30% after *deductible*	50% after *deductible*
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	30% after *deductible*	50% after *deductible*
Includes *ambulance*, *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.		
Private Duty Nursing	30% after *deductible*	50% after *deductible*

There is a 4 hour per day limit on private duty nursing care for non-ventilated patients and 12 hours per day limit on 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 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.

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

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.

	0-30 Day Supply	31-60 Day Supply	61-90 Day Supply
Tier 1	$16	$32	$48
Tier 2	$47	$94	$141
Tier 3	$74	$148	$222
Tier 4	10% up to $100	25% up to $200	25% up to $300
Tier 5	25% up to $103	25% up to $206	25% up to $309
Tier 6	25% up to $133	25% up to $266	25% up to $399

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*.

	0-30 Day Supply	31-60 Day Supply	61-90 Day Supply
Preferred Brand Testing Supplies	$10	$20	$30
Non-Preferred Brand Testing Supplies	$74	$148	$222

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.

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*.

Wellness Activity

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.shpnc.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 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** 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** 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** 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 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 and 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 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.

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."

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

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*
- 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.

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)

- *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 *phmaracy* 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.shpnc.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. Please see "Other Services" in the "Summary of Benefits."

Orthotic Devices Exclusions

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

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

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
- 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.*
- Simultaneous pancreas and kidney
- Liver
- Small bowel
- Simultaneous small bowel and liver
- Simultaneous liver and kidney

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

Outpatient Services

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

- Each service listed in the section under *office visit* services
- Partial-day/night hospitalization services (minimum of four hours per day and 20 hours per week)
- Intensive *Outpatient* Program Services (less than four hours per day and minimum of nine hours per week)
- Certain *in-network* and out-of-network outpatient services, such as partial hospitalization and intensive therapy, require prior 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 is requested.

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

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

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

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

Coverage of ABA services is limited to:

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

Or

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

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

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[SM] 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[SM] 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*.

Timeframe Requirements for Prior Authorization and Treatment Certification of Covered Services

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

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

*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.
- C*hemical 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 assessment and psychotherapy treatment in conjunction with proposed gender transformation
- Psychological testing for those persons with a *chemical dependency* diagnosis until 30 consecutive days of abstinence are obtained
- Therapeutic boarding schools as a psychiatric residential treatment center (RTC) unless the program is licensed for psychiatric RTC in the state in which services are provided, has *registered nurses* who are present on-site 24-hours per day, and holds current national accreditation by a national health care accrediting body approved by the *Mental Health Case Manager*
- Therapeutic boarding schools as a *chemical dependency* or substance abuse residential treatment center (RTC) unless the program is licensed as a *chemical dependency* RTC in the state in which services are provided and has licensed supervision of all residents 24 hours per day, seven days per week
- 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-along outdoor treatment programs are not covered as *chemical dependency* or substance abuse RTC programs
- Academic education during residential treatment when charged separately
- Administrative psychiatric services (e.g., expert testimony, report writing, medical records review and maintenance, case management or case coordination, chart review, etc.)
- Consultation with a mental health professional for adjudication of marital, child support, and custody cases
- Evaluations, consultations, testing or therapy for educational, professional training, or for investigation purposes relating to employment, insurance, judicial or administrative proceedings
- Training analysis
- Treatment for personal or professional growth, development, training or professional *certification*
- Aversive Treatment
- Treatment programs based solely on the 12-step Model
- Erhard Seminar Training (EST) or similar motivational services

- Bioenergetic, carbon dioxide, confrontational, hyperbaric or normobaric oxygen, marathon, megavitamin, orthomolecular, primal, rebirthing, or sleep therapies
- Expressive therapies (art, poetry, movement, psychodrama), guided imagery, or stress and relaxation therapy when billed separately
- Telephonic crisis management as a separate charge
- Sedative action, electro stimulation therapy
- Z therapy, also known as "holding therapy"
- Narcotherapy with LSD
- Environmental ecology treatments
- Hemodialysis for schizophrenia
- Rolfing
- Sensitivity training
- Room and Board costs for patients admitted to a partial hospital or intensive outpatient program are not covered.
- Intensive in-home services less than two hours per day
- Private duty nursing
- Therapeutic family, foster or home care
- L-tryptophan and vitamins, except thiamine injections on admission for alcoholism when there is a diagnosed nutritional deficiency
- Travel time necessary for service delivery
- Behavioral health; long term care residential (non-acute care in a residential treatment program where stay is typically longer than 30 days), with room and board, per diem
- Community or work integration training, work hardening or conditioning
- Family psychotherapy without patient present

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* and it must be filled at a participating pharmacy. 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 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** 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 cos-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* 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.

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 "Special Programs."

Specialty Pharmacy

Specially 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. 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 *creditable coverage* from the *State Health Plan*. "*Creditable Coverage*" means that your *prescription drug* coverage is at least as good as Part D coverage.

If your current *prescription drug* coverage qualifies as "*creditable 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

- *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
- Treatment or studies leading to or in connection with sex changes or modifications and related care
- 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
- 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 drugs furnished by a *hospital* or *non-hospital facility*
- Clomiphene (e.g.,Clomid), menotropins (e.g.,Repronex) 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
- 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*.” You**

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.

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:

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

Steps To Follow In the Grievance Process

First Level *Grievance* Review

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

Any request for review should include:

- *Member's* ID number
- *Member's* name
- Patient's name
- The nature of the *grievance*
- 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
- 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

- 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	**In person**	**Web**
NC Department of Insurance Health Insurance Smart NC 1201 Mail Service Center Raleigh, NC 27699-1201	NC Department of Insurance Dobbs Building 430 N. Salisbury Street, 1st Floor, Suite 101 Raleigh, NC 27603 Tel: 919-807-6860 Tel: (toll free in NC) (855) 408-1212	**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.

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 will, at its option, make payment to either the *provider* of the services or to the custodial parent or legal guardian for services provided to the *member*. If the *State Health Plan* or its representative chooses to make the payment to the *subscriber* or custodial parent or legal guardian, it is his or her responsibility to pay the *provider*.

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

Any amounts paid by the *State Health Plan* for services not covered or that are in excess of the benefit provided under your health benefit plan coverage may be recovered by the *State Health Plan*. The *State Health Plan* or its representative may recover the amounts by deducting from a *member's* future claims payments or by collecting directly from *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.

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.

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 *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.

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 *member*ship 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"

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

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:

- 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 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 Market place) 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

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, *dependent child* becomes eligible for their own health coverage, 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 the last day of the effective month. Members who do not pay their premiums in full by the last day of the effective month 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 effective month (end 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 family 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.

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

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

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

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

VALUE-ADDED PROGRAMS

NCHealth*Smart* - Your Resource for Better Health

NC Health*Smart*, 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 Health*Smart* can help.

Members eligible for NC Health*Smart* 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 Health*Smart* for the most current program information.

NC Health*Smart* 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 Health*Smart* include the following:

Tobacco Cessation Support	*Members* are encouraged to call a QuitlineNC **Quit Coach®**and/or their *provider* or behavioral health care *provider* about quitting tobacco use. **Free Hotlines** **QuitlineNC…800-QUIT-NOW** (800-784-8669). Available 24 hours a day, 7 days a week, English/Spanish-speaking. QuitlineNC telephonic support program is tailored to help all *member*s 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. **Nicotine Replacement Therapy Medications** 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. ***Prescription* Medications** 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

	through the Pharmacy program. For a list of covered medications, please visit the Pharmacy section of the *State Health Plan* website at **www.shpnc.org**. **Worksite Wellness Initiatives** The NC Health*Smart* Worksite Wellness Toolkit, available at **www.shpnc.org**, contains "Quit Now," a guide which provides step-by-step instructions on setting up tobacco cessation educational campaigns and support systems. It also makes recommendations for environmental policy changes that may support *members* in quitting. Contact your *Health Benefits Representative* or Wellness Leader for more information.
Weight Management Support	**Tools and Resources** • **Nutrition Visits** 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 **www.shpnc.org** and select "Find a *Doctor*." • **Weight Management Medications** 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 **www.shpnc.org**. • **Web-based Programs** Eligible *members** may access the NC Health*Smart* Personal Health Portal's interactive weight management and nutrition improvement programs at **www.shpnc.org**. • **Support Line** *Members* may contact the NC Health*Smart* Health Coach at 800-817-7044 for one-on-one nutrition and weight management information, as well as motivational support. • **Eat Smart, Move More, Weigh Less** ESMMWL is a 15-week, live, interactive online weight management program proven to work. Members can enroll for $30 and are reimbursed $25 for attending 10 out of the 15 classes. To learn more about the program and enroll, visit **www.esmmweighless.com**. • **Worksite Wellness Initiatives** The NC Health*Smart* Worksite Wellness Toolkit available online at **www.shpnc.org** contains the "Eat Smart" resource book, which provides organizations with instructions on creating nutrition and weight management programs, making environmental and policy changes that support healthy eating at the work place, and accessing ready-made posters, fliers, and other educational resources. Check with your *Health Benefits Representative* or Wellness Leader to see if the Eat Smart, Move More, Weigh Less program will be offered at your work place.
Maternity Coaching	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 participants will receive an inpatient copayment incentive for delivery in a certified medical facility or birthing center when they: • Call the NC Health*Smart* toll-free number to complete an initial assessment with a maternity coach • Continue to engage with a maternity coach during each trimester Visit **www.shpnc.org** and click NCHealth*Smart* 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
	  • Congestive Heart Failure (CHF)
	  • Diabetes
	  • Depression and stress
	  • Acute respiratory conditions
	  • General arthritis
	  • TMJ syndrome
	  • Stroke
	  • Renal failure
	• 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

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 Health*Smart* 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**, by logging into your Personal Health Portal, or by calling a Health Coach at 800-817-7044.
NCHealth*Smart* *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 Health*Smart* 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@nctreasurer.com**.

For more information on these programs or to obtain further information on NC Health*Smart*, 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.

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[SM]offers a 25% discount on manufacturers' suggested retail prices or $250 off usual and customary fees, whichever provides greater savings. With AudioBlue[SM], 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[SM] *provider* and present your *ID card*.

Blue365
Your resource for living healthier.™

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[SM][1, 2] to bring you access to trusted wellness resources, and valuable offers.

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

Discounts on vision and corrective laser eye surgery

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

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

Chiropractic Services

Discounts on chiropractic services

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 hydramnios; eclampsia; ectopic pregnancy; insulin dependent diabetes mellitus; missed abortion; nephrosis; placenta previa; Rh sensitization; severe preeclampsia; trophoblastic disease; toxemia; immediate postpartum hemorrhage due to uterine atony; retained placenta or uterine rupture occurring within 72 hours of delivery; or, the following conditions occurring within ten days of delivery: urinary tract infection, mastitis, thrombophlebitis, and endometritis. *Emergency* cesarean section will be considered eligible for benefit application only when provided in the course of treatment for those conditions listed above as a complication of pregnancy. Common side effects of an otherwise normal pregnancy, conditions not specifically included in this definition, episiotomy repair and birth injuries are not considered *complications of pregnancy*.

COMPOUND 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.

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

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

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 TREAMENT FACLITY — 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. 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.

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* Enhanced 80/20 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 or it conflicts with medical policies adopted under your health benefit plan, North Carolina law will prevail, followed by medical policies. If any of the Blue Cross and Blue Shield of North Carolina medical policies conflict with the *State Health Plan* medical policies, the *State Health Plan* medical policies will be applied.

Notice of Privacy Practices

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

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

PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Introduction

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

What information is protected?

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

How the Plan May Use and Disclose your PHI

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

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

- Accurate and complete.

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

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

Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 919-814-4400.
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 919-814-4400.
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 919-814-4400.
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 919-814-4400.
French	ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 919-814-4400.
Arabic	ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية المجانية تتوافر لك. اتصل برقم 919-814-4400.

Hmong	LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 919-814-4400.
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 919-814-4400.
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 919-814-4400.
Gujarati	સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 919-814-4400.
Mon-Khmer, Cambodian	ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 919-814 4400.
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 919-814-4400.
Hindi	ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 919-814-4400.
Laotian	ໂປດຊາບ: ຖ້າວ່າທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອ ຂດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 919-814-4400.
Japanese	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。 919-814-4400.