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

STATE TREASURER OF NORTH CAROLINA
DALE R. FOLWELL, CPA

State Health Plan for Teachers and State Employees

80/20 PPO Plan

Benefits Booklet

January 1, 2018-December 31, 2018

BlueCross BlueShield of North Carolina

Revised: March 14, 2018

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80/20 PLAN (PPO) BENEFITS BOOKLET

Welcome to the *State Health Plan*'s 80/20 *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 availability of benefits is described in this booklet and *member* benefit language should be reviewed before applying the terms of any medical policy.

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.

The information contained in this booklet is supported by medical policies which are used as guides to make coverage determinations. For specific detailed information, or medical policies, please call Customer Service at 888-234-2416, or visit the *State Health Plan* website at **www.shpnc.org**. To obtain a copy of the General Statutes visit the North Carolina General Assembly at **www.ncga.state.nc.us** and search for Article 3B in Chapter 135.

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 TTY and TDD: 800-442-7028 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 *PBM* Customer Service 888-321-3124 24 hours a day, 7 days per week	For questions regarding your *pharmacy* benefits, to obtain a preferred medication list, information on *prior authorizations*, refills, and more.
CVS Caremark *PBM* Specialty Pharmacy 800-238-7828	For information regarding the specialty pharmacy services offered or to obtain *specialty medications*.
CVS Caremark *PBM - Prior Authorization* Number 800-294-5979	To initiate a *prior authorization* request for a *prescription medication*.
Prescription Medication **Claims Filing**	Mail completed *prescription medication* 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 *substance abuse* *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 Tobacco Use Quitline (QuitlineNC) 800-QUIT-NOW (800-784-8669) 24 hours a day, 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.
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.
N.C. Department of State Treasurer **Retirement Systems Division** 3200 Atlantic Avenue Raleigh, NC 267604 919-814-4000 or 1-877-NCSECURE (1-877-627-3287) **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 *Member*s (*Retiree*s, Disabled *Member*s, RIF *Members*, COBRA *Members*, former *Members* of the General Assembly and other 100% contributory *Members*). Active *members* must contact their *HBR*.

MEMBER RIGHTS AND RESPONSIBILITIES

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

- Receive, upon request, information about your health benefit plan including its services and *doctors*, a benefits booklet, benefit summary and directory of *in-network provider*s
- 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 the reasons why *BCBSNC* denied a request for treatment or health care service, and the rules used to reach those results.
- Receive (upon request) information on the procedure and medical criteria used to determine whether a procedure, treatment, facility, equipment, medication 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 *provider*s
- 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 *provider*s, their staff and *State Health Plan* representatives
- 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
- 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
- Play an active part in your healthcare

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. *Copayment*s are not credited to the *deductible*; however, they are credited to the *out-of-pocket limit.* See "Summary of Benefits" for your specific *copayment* amount.
Deductible	The dollar amount you must incur for *covered services* in a *benefit period* before benefits are payable under the *Plan*. The *deductible* does not include *coinsurance*, charges in excess of the allowed amount, amounts exceeding any maximum, or expenses for non-covered expenses. This plan has an embedded *deductible* which means you have an individual *deductible* and if *dependent*s are covered, you also have a combined family *deductible*. You must meet your individual *deductible* before benefits are payable under the *Plan*. Once the family *deductible* is met, it is met for all covered family members. Amounts applied to your *out-of-network deductible* are credited to your *in-network deductible*. Amounts applied to your *in-network deductible* are not credited to your *out-of-network deductible*. *Copayment*s are not credited to the *benefit period deductible*. See "Summary of Benefits" for your specific *deductible* amounts.
Coinsurance	Your share of the cost of a *covered service*, after you have met your *benefit period deductible*. This is stated as a percentage of the *allowed amount*. 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 you pay for *covered services* in a *benefit period* before the *Plan* pays 100%. Your *out-of-pocket limit* is determined by your type of coverage. The individual *out-of-pocket limit* applies to each individual covered by the *Plan*. If one or more *dependents* are covered under the *Plan*, all covered family members contribute to the same family *out-of-pocket limit*. When either the family *in-network* or *out-of-network out-of-pocket limit* is met, the family *out-of-pocket limit* is met for all covered family members. *Coinsurance, copayments* and *deductibles*, are included in the *out-of-pocket limit*. Non-*covered services* and amounts over allowed amounts or UCR (usual, customary and reasonable amounts) are not included in the *out-of-pocket limit*. Charges for *prescription medications* do not apply to the *medical out-of-pocket limit* but apply to the *benefit period* ***total*** *out-of-pocket limit.* Amounts applied to your *out-of-network coinsurance* are credited to your *in-network coinsurance;* however, amounts applied to your *in-network coinsurance* are not credited to your *out-of-network coinsurance.* 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.

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

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
- The *out-of-pocket limit* includes your *deductible* and *coinsurance*. It does not include charges over the *allowed amount*; including any charges over the allowable cost difference for *out-of-network* services and charges for non-*covered services*

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 medication 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* medication available for your medical condition, it is suggested that you ask your physician to prescribe a medication in a lower brand Tier.

Pick a Primary Care Provider (PCP)

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

- 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. Staying healthy at home and at work
- Case and Disease Management Services - Get assistance with chronic conditions such as diabetes, with Chronic Kidney Disease (CKD) or End Stage Renal Disease (ESRD), multiple hospitalizations or a sudden catastrophic event

**Members eligible for NC HealthSmart Services are members whose primary health coverage is through the State Health Plan. Federal and state law prohibits the State Health Plan from using your personal information to discriminate against you in any way, or from giving this information to your employer or other unauthorized third party unless required by law.*

HOW THE 80/20 PPO PLAN WORKS

The 80/20 *PPO* Plan gives you the freedom to choose any *provider* — the main difference will be the cost to you, depending on whether you see an *in-network* or *out-of-network provider*. This plan also offers *members* the option to participate in *Wellness Activities* to receive *Premium Credits* and additional *Wellness Incentives* for seeking care from certain *providers*.

Wellness Activities

During Open Enrollment, Annual Enrollment, or when enrolling within 30 days of being first eligible, you have the option to complete one *wellness activity, the tobacco attestation*. A *wellness premium credit can* lower your monthly *employee*-only premium. See *Wellness Premium Credit* below.

Wellness Premium Credit*:* Tobacco Attestation

During Open Enrollment, Annual Enrollment or when enrolling within 30 days of being first eligible, you will need to attest that you do not use tobacco or will commit to a smoking cessation program by the start of the benefit year or, if enrolling during the benefit year, within 45 days of enrollment. You will need to log into your enrollment system to complete the attestation. Completing this attestation during enrollment will save you $60 per month off of your *employee*-only premium.

Wellness Incentives

In addition to the *Wellness Premium Credit*, you can also take advantage of additional *Wellness Incentives* that lower your out-of-pocket costs and encourage you to save money for various health care services you receive throughout the year.

Visit the *PCP* listed on your *ID card*	Your *copay* is reduced to $10 each visit
Visit a *Blue Options Designated specialist*	Your *copay* is reduced to $45 each visit
Receive *inpatient* care in a *Blue Options Designated hospital*	Your $450 *copay* is waived

Notice Regarding Wellness Activities

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

Blue Options Designated Providers

This network of *providers*, includes various *providers* and *hospitals*, has been "designated" because they provide both quality and cost-effective care according to criteria set forth by Blue Cross and Blue Shield of North Carolina. To find a *Blue Options Designated provider*, visit the *Plan's* website at **www.shpnc.org** and click on Find a *Doctor* or call 888-234-2416. *Blue Options Designated Provider*s are noted as "Designated for Cost and Quality." If your *hospital* is not on the *Blue Options Designated Hospital* list, you can still select an *in-network hospital*, however, your *inpatient copay* would apply. If you select a *hospital* that is neither on the Blue Options Designated list or is *in-network*, you will be subject to *out-of-network hospital* charges. *Blue Options Designated Provider*s include the following *specialist* areas: General *Surgery*, OB-GYN, Gastroenterology, Orthopedics, Cardiology, Neurology and Endocrinology.

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 should 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. If you selected a *PCP* during enrollment, you may change your *PCP* at

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

A *Primary Care Provider* can practice:

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

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:

- *Doctor*s — classified as *primary care providers* (described above) or *specialists*
- *Other Providers* — health care professionals, such as physical therapists, occupational therapists, 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 *substance abuse* 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 subject to *out-of-network* benefits and/or reimbursements 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*." See "*Out-of-Network* Benefits Exceptions" and "*Emergency* and *Urgent Care* Services." Also see "Mental Health and *Substance Abuse* Services" for additional information on *prior authorization* and *certification* requirements for these services.

How to File A Claim

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

For your medical, mental health and *substance abuse* 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."

Making an Appointment

Call the *provider's* office and identify yourself as a *State Health Plan 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 non-*emergency 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.

Identification (ID) Card

Your *ID card* identifies you as a Blue Options 80/20 (*PPO*) *member* and serves as your health and pharmacy *ID card*. **Be sure to carry your *ID card* with you at all times and present it each time you seek health care.** Each *dependent* will receive their own *ID card*.

If you select a *PCP* for each family *member* upon enrollment, each family member's *ID card* will have the selected *PCP* printed on the front of the *ID card*.

Only *subscriber*s and their enrolled eligible *dependents* may seek services with their card. The *State Health Plan* may consider unauthorized use of this card to be fraud. To find out how to report fraud go to "Report Suspected Abuse and Fraud" in the Contact Us section of the *State Health Plan's* website at **www.shpnc.org**. The *Plan* will seek reimbursement for claims *incurred* with a *State Health Plan ID card* before coverage is effective or after coverage has ended.

If any information on your ID is incorrect or for *ID card* requests, please visit "Blue Connect" on the *Plan's* website at **www.shpnc.org** or call Customer Service at the number listed in "Who to Contact" or on the back of your *ID card*.

UNDERSTANDING YOUR SHARE OF THE COST

As a *member* of the *Plan*, you enjoy quality health care from a network of health care *providers* and easy access to *specialists*. You also have the freedom to choose health care *providers* who do not participate in the Blue Options network – the main difference will be the cost to you.

Benefits are available for service from an *in- or out-of-network provider* that is recognized as eligible. For a list of eligible *provider*s, please visit the *Plan's* website at **www.shpnc.org** or call Customer Service at the number listed in "Who to Contact."

	In-Network	***Out-of-Network***
Type of *Provider*	*In-network providers* are health care professional and facilities that have contracted with *BCBSNC*, or a *provider* participating in the BlueCard program. *Ancillary providers* outside of North Carolina are considered *in-network* only if they contract directly with *BCBSNC*, even if they participate in the *BlueCard program*. *In-network providers* agree to limit charges for *covered services* to the *allowed amount*. 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*. The list of *in-network providers* may change from time to time. *In-network providers* are listed on the *Plan's* website at **www.shpnc.org** or call Customer Service at the number listed in "Who to Contact."	*Out-of-network providers* are not designated as Blue Options *provider*s by *BCBSNC*. Also see "*Out-of-Network* Benefit Exceptions."
Allowed Amount vs. Billed Amount	If the billed amount for a *covered service* is greater than the *allowed amount*, you are not responsible for the difference. You only pay any applicable copays, *deductible*, *coinsurance*, and non-covered expenses.	You may be responsible for paying any charges over the *allowed amount* in addition to any applicable *deductible*, *coinsurance*, non-covered expenses and *certification* amounts, if any, except for emergency services in the case of an *emergency*.
Referrals	The *Plan* does not require you to obtain any referrals.	The *Plan* does not require you to obtain any referrals.
After-hours Care	If you need non-*emergency services* after your *provider*'s office has closed, please call your *provider*'s office for their recorded instructions.	
Care Outside of North Carolina	Your *ID card* gives you access to participating *provider*s outside the state of North Carolina through the BlueCard program, and benefits are provided at the *in-network* benefit level.	If you are in an area that has participating *provider*s and you choose a *provider* outside the network, you will receive the lower *out-of-network* benefit.

		Also see "*Out-of-Network* Benefit Exceptions."
Prior authorization	*In-network providers* in North Carolina will request *prior authorization* when necessary. If you receive services outside of North Carolina (even if you see an *in-network provider*), you are responsible for ensuring that you or your provider requests *prior authorization*. For *inpatient* or certain *outpatient* mental health and *substance abuse* services, either in or outside of North Carolina, contact the *Mental Health Case Manager* to request *prior authorization* and receive *certification*. *Prior authorization* is not required for an *emergency* or for an *inpatient hospital* stay for 48 hours after a vaginal delivery or 96 hours after a cesarean section.	You are responsible for ensuring that you or your *out-of-network provider* requests *prior authorization*. Failure to request *prior authorization* and obtain *certification* will result in full denial of benefits. *Prior authorization* is not required for an *emergency* or for an *inpatient hospital* stay for 48 hours after a vaginal delivery or 96 hours after a cesarean section.
Filing Claims	*In-network providers* in North Carolina are responsible for filing claims directly with *BCBSNC*.	You may have to pay the *out-of-network provider* in full and submit your own claim to *BCBSNC*. Mail claims in time to be received within 18 months of the date the service was provided. Claims not received within 18 months from the service date will not be covered, except in the absences of legal capacity of the *member*.

Out-Of-Network Benefit Exceptions

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

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

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80/20 PLAN (PPO) SUMMARY OF BENEFITS

The following is a summary of your 80/20 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?" As you review the Summary of Benefits chart, keep in mind:

- The *copayment* amounts are fixed dollar amounts the *member* must pay for some *covered services* depending on the *provider* network selection made at the time of service.
- Multiple *office visits* or *emergency* room visits on the same day may result in multiple *copayments*.
- *Coinsurance* percentages shown in this section are the portion of the *allowed amount* that you pay.
- *Deductible* and *coinsurance* are based on the *allowed amount.*
- Services applied to the *deductible* also count toward any visit or day maximums.
- If your benefit level for services includes *deductibles* and *coinsurance*, your *provider* may collect an estimated amount of these at the time you receive services.
- To receive *in-network* benefits, you must receive care from a Blue Options *in-network provider.* **However, in an *emergency*, or when *in-network providers* are not reasonably available as determined by *BCBSNC's* access to care standards, you may also receive *in-network* benefits for care from an *out-of-network provider*.** Please see "*Out-of-Network* Benefits" and "*Emergency* and *Urgent Care* Services" for additional information on *emergency* care. Access to care standards are available on our website at **www.shpnc.org** or by calling the *State Health Plan* Customer Service number given in "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 deductible coinsurance* level. 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.
- For some services that are not covered benefits, discounts may be available as "value-added benefits." Please see the section called "Value-Added Programs" in the back of this booklet.
- This plan offers *Wellness Premium Credits* and *Wellness Incentives* to encourage decisions that are good for your health.
- To receive *Wellness Premium Credits*, you must choose which *Wellness Activities* you would like to participate in during Open Enrollment, Annual Enrollment or within 30 days of becoming first eligible.
- To receive *Wellness Incentive* discounts, you must use the *Primary Care Provider (PCP)* on your *member* identification (ID) card, or you must receive care from a *Blue Options Designated provider* and/or Blue Options Designated Facility.
- *Preventive Care* as described under the *Affordable Care Act (ACA)* is covered at 100% so long as any applicable medical management requirements are met.
- *Preventive medications* listed under the *Affordable Care Act (ACA)* with a *prescription* written by a *provider* and filled at a participating pharmacy, are covered at 100%.
- In the *formulary*, *prescription medications* are divided into six categories or tiers: (Tier 1), the most cost-effective non-*specialty medication*s, which would include mostly *generic* medications; (Tier 2), preferred brand non-*specialty medication*s, including some high-cost *generic* medications; (Tier 3), non-preferred brand non-*specialty medication*s and compounds ; (Tier 4), the most cost-effective *specialty medications*, including *generics* and some *biosimilars*; (Tier 5), preferred brand *specialty medications*, and (Tier 6) non-preferred brand *specialty medication*s. Refer to the *State Health Plan* website for a list of *specialty medications*.
- The *Plan* may use reasonable medical management procedures to determine any coverage limitations or restrictions that may apply

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

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

Lifetime Maximum, Deductible, and Out-of-Pocket Limit

	In-Network	*Out-of-Network**
Lifetime Maximum	Unlimited	Unlimited
Unlimited for all *covered services* except where otherwise specifically indicated or excluded. If you exceed any *lifetime maximum,* additional services of that type are not covered. In this case, you may be responsible for the entire amount of the *Provider*'s billed charge.		
Deductible		
Individual, per *benefit period*	$1,250	$2,500
Family, per *benefit period*	$3,750	$7,500
Charges for the following do not apply to the *benefit period deductible*: • *Preventive Care* as defined by the *Affordable Care Act* • *Copayments* • *In-Network* services do not apply to the *Out-of-Network deductible*. • *Inpatient* newborn care for well-baby		
Medical Out-of-Pocket Limit		
Individual, per *benefit period*	$4,350	$8,700
Family, per *benefit period*	$10,300	$26,100
Charges for *prescription medications* do not apply to the medical *out-of-pocket limit.* Charges over *allowed amounts* and charges for non-*covered services* do not apply to the *out-of-pocket limit*. The *out-of-pocket limit*, which is the *deductible* plus the *coinsurance* you pay, is the total amount you will pay for *covered services* Other charges for medical *covered services* do not apply to the pharmacy *out of pocket limit*.		
Pharmacy Out-of-Pocket Limit		
Individual, per *benefit period*	$2,500	$2,500
Family, per *benefit period*	$4,000	$4,000

Preventive Care

	In-Network	*Out-of-Network**
Primary Care Provider	No Charge	Benefits not available[1]
Specialist	No Charge	Benefits not available[1]
Nutrition Counseling	No Charge	**40% after *deductible***
All other conditions limited to a combined in- and *out-of-network* maximum of four visits per *benefit period.*	$25 *copayment*	40% after *deductible*

Available in an office-based, *outpatient*, or ambulatory surgical setting, or *urgent care* center. Services include among others: routine physical exams and screenings, well-baby care, well-child care, well-woman care, immunizations, nutritional counseling, gynecological exams, cervical cancer screening, ovarian cancer screening, screening mammograms, colorectal screening, bone mass measurement, prostate-specific antigen tests, and newborn hearing screening.
This benefit is only for services that indicate a primary diagnosis of preventive or wellness. Please visit the *Plan's* website at **www.shpnc.org** for the most up-to-date information on *preventive care* covered under federal law.

[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, bone mass measurement, newborn hearing screenings and prostate specific antigen tests. See *Covered Services*.

Provider's Office

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*. Any visits in excess of these *benefit period maximum* are not *covered services*.

***Office Visit* Services**	***In-Network***	***Out-of-Network****
Primary Care Provider	$25 **or $10 copay** when using *PCP* listed on *ID card*	**40% after *deductible***
Specialist	$85 **or $45 copay** when a *Blue Options Designated provider* is utilized	**40% 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	20% after *deductible*	40% after *deductible*

Short-Term Therapy Services (Includes Evaluation and Management)

Limited to rehabilitative speech, physical, and *occupational* therapy.

	In-Network	***Out-of-Network****
Short-Term Rehabilitative Therapies	$52 *copayment*	40% 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	No Charge	40% 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	$25 **or $10 *copay*** when using *PCP* listed on *ID card*	40% after *deductible*
Specialist	$85 **or $45 *copay*** when a *Blue Options Designated provider* is utilized	40% after *deductible*
Combined in- and out-of-network lifetime limit of 3 ovulation induction cycles and associated services without insemination. Any services in excess of this lifetime limit are not *covered services*.		
Routine Hearing Evaluation Tests		
Primary Care Provider	$25 **or $10 *copay*** when using *PCP* listed on *ID card*	**Benefits not available**
Specialist	$85 **or $45 *copay*** when a *Blue Options Designated provider* is utilized	**Benefits not available**

Urgent Care Centers, Emergency Room and Ambulance

	In-Network	*Out-of-Network**
Urgent Care Centers	$70 *copayment*	$70 *copayment*
***Emergency Room* Visit**	$300 *copayment,* then 20% after *deductible*	$300 *copayment,* then 20% after *deductible*
Emergency Room Copayment is waived if admitted or held for observation at the *hospital*. If admitted to the *hospital* from the *emergency room*, *inpatient hospital* benefits apply to all *covered services* provided. 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*.		
***Ambulance* Services**	20% after *deductible*	20% after *deductible*

Ambulatory Surgical Center

	In-Network	*Out-of-Network**
Ambulatory Surgical Services	20% after *deductible*	40% after *deductible*

Outpatient Services

	In-Network	*Out-of-Network**
***Provider* Services**	20% after *deductible*	40% after *deductible*
***Hospital* and *Hospital Based* Services**	20% after *deductible*	40% after *deductible*
***Outpatient Clinical* Services**	20% after *deductible*	40% after *deductible*
***Outpatient* Diagnostic Services**		
***Outpatient* lab tests, when performed alone (physician and *hospital*-based services)**	No Charge	40% after *deductible*
***Outpatient* lab tests, when performed with another service**		
Physician Services	No Charge	40% after *deductible*
Hospital and *Hospital*-based Services	20% after *deductible*	40% after *deductible*
***Outpatient* x-rays, ultrasounds, and other diagnostic test, such as EEGs, EKGs and pulmonary function tests**	20% after *deductible*	40% after *deductible*
CT scans, MRIs, MRAs, and PET scans	20% after *deductible*	40% after *deductible*
***Outpatient* diagnostic mammography (physician and *hospital*-based services)**	No Charge	40% after *deductible*
See "Preventative Care" for coverage of screening mammograms		
Therapy Services Includes *short-term rehabilitative therapies* and *other therapies*.	20% after *deductible*	40% after *deductible*

Inpatient Hospital Services

	In-Network	*Out-of-Network**
***Provider* Services**	20% after *deductible*	40% after *deductible*
***Hospital* and *Hospital Based* Services**	$450 *copayment,* then 20% after *deductible* or $0, then 20% after *deductible* when a *Blue Options Designated hospital* is utilized	$450 *copayment,* then 40% after *deductible*

Includes maternity delivery, prenatal and post-delivery care. For *inpatient* mental health and *substance abuse* services, refer to the "Mental Health and *Substance Abuse Services*" section later in this summary. If you are in a *hospital* as an *inpatient* at the time you begin a new *benefit period,* you may have to meet a new *deductible* for *covered services* from *doctors* or *other professional providers.*

Nursing

	In-Network	*Out-of-Network**
Skilled Nursing Facility	20% after *deductible*	40% 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. Any services in excess of this *benefit period maximum* are not *covered services*.

Private Duty Nursing	20% after *deductible*	40% 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.		
Other Services	20% after *deductible*	40% after *deductible*

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

Mental Health / *Substance Abuse Services*

	In-Network	*Out-of-Network**
Mental Health / *Substance Abuse Office Services*	$25 *copayment*	40%
Mental Health / *Substance Abuse Outpatient* Services	20% after *deductible*	40% after *deductible*
Mental Health / *Substance Abuse Inpatient* Services**	$450 *copayment,* then 20% after *deductible*	$450 *copayment,* then 40% after *deductible*
Residential Treatment Centers*** Covered up to age 18.	$450 *copayment,* then 20% after *deductible*	$450 *copayment,* then 40% 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 (the Pharmacy Benefits Manager – *PBM*). 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	$5	$10	$15
Tier 2	$30	$60	$90
Tier 3	20% *coinsurance* after *deductible*	20% *coinsurance* after *deductible*	20% *coinsurance* after *deductible*
Tier 4	$100	$200	$300
Tier 5	$250	$500	$750
Tier 6	20% *coinsurance* after *deductible*	20% *coinsurance* after *deductible*	20% *coinsurance* after *deductible*
Affordable Care Act Preventive Medications	Covered at 100%		

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

NOTE: All *specialty medication* 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	$5	$10	$15
Non-Preferred Brand Testing Supplies	20% *coinsurance* after *deductible*	20% *coinsurance* after *deductible*	20% *coinsurance* after *deductible*

Prescription medication copayments are limited to $2,500 per person per *benefit period.* After the $2,500 maximum is reached, the health benefit plan pays 100% of allowed *prescription medication* charges. For *certification* for certain *prescription medications*, your physician may call CVS Caremark at 800-294-5979 to initiate a *certification* request.

Certification Requirements

*In-network provider*s outside of North Carolina, except for Veterans Affairs (VA) and military *provider*s, 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.

Obesity Treatment/ Weight Management

	In-Network	***Out-of-Network***
Primary Care Provider	$25 **or $10 *copay*** when using *PCP* listed on *ID card*	40% after *deductible*
Specialist	$85 **or $45 *copay*** when a *Blue Options Designated provider* is utilized	40% after *deductible*
***Outpatient* Physician Services**	20% after *deductible*	40% after *deductible*
***Outpatient Hospital* and *Hospital*-based Services**	20% after *deductible*	40% after *deductible*
***Inpatient* Physician Services**	20% after *deductible*	40% after *deductible*
***Inpatient Hospital* and *Hospital*-based Services**	20% after *deductible*	40% after *deductible*

Offices visits for the evaluation and treatment of obesity are limited to a combined *in*-and *out-of-network* maximum for four visits per *benefit period.* Any visits in excess of these *benefit period maximums* are not *covered 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, medication 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 get *ancillary services*, such as laboratory services, medical equipment, supplies or *specialty medication*s from third parties. In these cases, you may be billed directly by the *ancillary provider*. Benefit payments for these services will be based on the type of *ancillary provider*, its network status, and how the services are billed. If you select a *PCP* during enrollment, and you use the *PCP* printed on the front of your *ID card*, you will pay the lower *copay* amount each time you see that *PCP*.

Some *doctor*s 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."

A *copayment* will not apply if you receive *Preventive Care* services or other 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 medications* that can be self-administered. The list of these excluded medications 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 medications excluded in the office. Also see "*Prescription Medication* Benefits" for information about purchasing *prescription medications* at the pharmacy.

Preventive Services

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

Under federal law, you can receive certain covered *preventive care* services from an *in-network provider* in an office-based, *outpatient*, or ambulatory surgical setting, or *urgent care* center, at no cost to you. Please note, this benefit is only for services that indicate a primary diagnosis of preventive or wellness and which are identified by recent federal legislation as being eligible. Services that do not include a primary diagnosis of preventive or wellness will be subject to your *in-network* benefit level for the location where services are received.

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

Preventive care covered services include the following. A complete list can be located on the *Plan's* website at **www.shpnc.org** .

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

➢ Contraceptive Methods

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

Contraceptive Methods Exclusions

- Male contraception

➢ 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.

➢ *Nutritional Counseling*

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

➢ Routine Physical Examinations and Screenings

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

➢ Well-Baby and Well-Child Care

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

➢ Well-Woman Care

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

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

➢ Bone Mass Measurement Services

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

Qualified individuals include *member*s 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 medication therapies
- History of low-trauma fractures
- Other conditions, or receiving medical therapies known to cause osteoporosis or low bone mass.

➢ Colorectal Screening

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

➢ Gynecological Exam and Cervical Cancer Screening

The cervical cancer screening benefit includes the examination and laboratory tests for early detection and screening of cervical cancer, and a *doctor*'s interpretation of the lab results. Coverage for cervical cancer screening includes Pap smear screening, liquid-based cytology, and human 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.

➢ Newborn Hearing Screening

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

➢ Ovarian Cancer Screening

For *member*s ages 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.

➢ 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*.

➢ Screening Mammograms

The *Plan* provides coverage for one baseline mammogram for any *member* between the ages of 35 and 39. Beginning at age 40, one screening mammogram will be covered 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.

Diagnostic Services

Diagnostic procedures help your physician 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 Physician 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.

Diagnostic Services Exclusion

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

Urgent Care Centers, Emergency Room and Ambulance Services

➢ *Ambulance* Services

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

- From a *member*'s home, scene of an accident, or site of an *emergency* to a *hospital*
- Between *hospitals*
- Between a *hospital* and a *skilled nursing facility* when such a facility is the closest one that can provide *covered services* appropriate to the *member*'s condition
- Benefits may also be provided for *ambulance* services from a *hospital* or *skilled nursing facility* to a *member*'s home when *medically necessary*.

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 physician 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

The *Plan* covers services in an air *ambulance* traveling from the site of an *emergency* to a *hospital* when such a facility is the closest one that can provide *covered services* appropriate to the *member*'s condition. Air *ambulance* services are eligible for coverage only when ground transportation is not medically appropriate due to the severity of the illness, or the pick-up point is inaccessible by land.

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

Ambulance Service Exclusion

- No benefits are provided primarily for the convenience of travel or where not *medically necessary*.
- Transportation for the purpose of receiving services that are not considered *covered services,* even if the destination is an appropriate facility.

➢ *Emergency* Care

The *Plan* provides benefits for *emergency services*.

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

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

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*.

Benefits for services in the *emergency* room

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

➢ *Urgent Care*

The *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.

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

- Breastfeeding counseling covered at 100% through *in-network providers*.
- Certain breast pumps for pregnant and post-partum women

- One manual or electric breast pump purchase per delivery is covered
- Benefit available during third trimester or after member has delivered the baby
- Breast pumps come with certain supplies, such as tubing, shields and bottles
- Additional **replacement** supplies are not covered with the initial breast pump purchase. Replacement supplies are only covered after the breast pump has been purchased.
- Breast pumps must be purchased from participating Durable Medical Equipment (DME) vendors
  - Not all participating DME vendors carry all items; please check with your local participating vendor of choice to see if they carry breast pumps. Edgepark carries breast pumps (1-800-321-0591) or go to the Find A Doctor or Facility page to find a vendor close to you; if you need help finding a DME vendor that carries breast pumps, call the Customer Service number on the back of your BCBSNC member ID card.

- **Exclusions:** All other supplies are excluded (i.e., creams, nursing bras, milk storage bags); hospital-grade breast pumps are excluded and not covered

Please visit the *Plan's* website at www.shpnc.org for the most up-to-date information on *preventive care* covered under federal law. Post-delivery care is all care for the mother after the baby's birth that is related to the pregnancy.

	Mom	Newborn	Payment
Prenatal care	Care related to the pregnancy before birth.		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*.
Labor & delivery services	No *prior authorization* required for *inpatient hospital* stay for 48 hours after a vaginal delivery or 96 hours after a cesarean section. Mothers choosing a shorter stay are eligible for a home health visit for post-delivery follow-up care if received within 72 hours of discharge.	No *prior authorization* required for *inpatient* well baby care for 48 hours after a vaginal delivery or 96 hours after a cesarean section. Benefits include newborn hearing screening ordered by a *doctor* to determine the presence of permanent hearing loss. (Please see *preventive care* in "Summary of Benefits.")	*Deductible*, *copayments coinsurance* apply. If adding the baby changes your policy from *employee* to family coverage, the family *benefit period deductible* applies. *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.

Post-delivery services	All care for the mother after baby's birth that is related to the pregnancy. *Prior authorization* and *certification* are required for *inpatient* stays extending beyond 48/96 hours or coverage will be denied.	After the first 48/96 hours, whether *inpatient* (sick baby) or *outpatient* (well baby), the newborn must be enrolled for coverage as a *dependent child*, according to the rules in "When Coverage Begins Ends." For *inpatient* services following the first 48/96 hours, *prior authorization* and *certification* are required or coverage will be denied.	

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 *member*s except *dependent children*. See "Summary of Benefits" for limitations that may apply.

➢ *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 *member*s.

Sexual Dysfunction Exclusion

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

➢ Sterilization

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

➢ 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 injection (ICSI), and gamete intrafallopian tube placement (GIFT) and associated services
- Donor eggs and sperm
- Cryopreservation of donor eggs, sperm or embryos
- 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 *subscriber*s and enrolled *spouse*s of the *subscriber*s 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 services received in a *hospital*, a *hospital* based facility, nonhospital facility or a *hospital*-based or *outpatient* clinic.

The following are *covered services*:

- *Medical care* provided by a *doctor* or *other professional provider*
- Observation
- General nursing care
- Medications 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

Inpatient services received in a *hospital* or nonhospital facility. You are considered an *inpatient* if you are admitted to the *hospital* or nonhospital facility as a registered bed patient for whom a room and board charge is made. Your *in-network provider* is required to use the Blue Options network *hospital* where they practice, unless that *hospital* cannot provide the services you need. If you are admitted before the *effective date*, benefits will not be available for services

received prior to the *effective date*. Take home medications are covered as part of your pharmacy benefit. 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 *doctor*s or *other professional providers*.
The following are examples of *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
- Operating room, delivery room, recovery room, nursery and related services
- General nursing care
- Intensive care
- Critical care
- Medications 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*.
- *Medical supplies*

Prior authorization must be requested and *certification* must be obtained in advance for *inpatient* admissions or coverage will be denied, except for maternity deliveries and *emergencies*. See "Maternity Care," if applicable and "*Emergency* Care."

➢ 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
- Medications 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

Benefits are provided for *covered services* received in a *skilled nursing facility*. *Skilled nursing facility services* are limited to a combined *in-network* and *out-of-network* day maximum per *benefit period.* See "Summary of Benefits."
Prior authorization must be requested and *certification* must be obtained in advance for payment of claims. Service for which *prior authorization* is not obtained will not be covered. See "Summary of Benefits."

Other Services

➢ Blood

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

Blood Exclusion

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

➢ Clinical Trials

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

- Involve determinations by treating physicians, relevant scientific data and opinions of relevant medical *specialists*
- Be approved by centers or groups funded by the National Institutes of Health, the Food and Drug Administration (FDA), the Centers for Disease Control and Prevention, the Agency for Health Care Research and Quality, 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*

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

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

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

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

When any of the conditions listed above require surgical correction, benefits for *surgery* will be subject to *medical necessity* review to examine whether or not the condition resulted in functional impairment. Examples of functional impairment include an impairment that affects speech or the ability to eat, or injury to soft tissue of the mouth.

In special cases, benefits are provided only for anesthesia and facility charges related to dental procedures performed in a *hospital* or *ambulatory surgical center*. This benefit is only available to *dependent children* below the age of nine years, persons with serious mental or physical conditions and persons with significant behavioral problems. The treating *provider* must certify that the patient's age, condition or problem requires hospitalization or general anesthesia in order to safely and effectively perform the procedure. Other dental services, including the charge for *surgery*, are not covered unless specifically covered by the *Plan*.

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

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

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

Dental Treatment Excluded Under Your Medical Benefit

Treatment for the following conditions:

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

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

- *Dental implants or root canals*

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

➢ Diabetes Related Services

The *Plan* covers all *medically necessary* diabetes-related services, equipment, supplies, medications and laboratory procedures including:

- 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 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 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*:

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

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

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

- Dietitian services or meals
- Homemaker services, such as cooking and housekeeping
- *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 examples of *covered services*:

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

The following are *covered services*:

- Professional services of an *RN* or *LPN*
- *Medical services*, equipment and supplies
- Prescribed medications

- 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

➢ Lymphedema-Related Services

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

Lymphedema-Related Services Exclusion

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

➢ *Medical Supplies*

Coverage is provided for *medical supplies* such as ostomy supplies, catheters, oxygen, and diabetic supplies (glucose monitoring strips, lancets, syringes and needles). Select diabetic supplies are covered under your *pharmacy* benefit. Your benefit payments are based on where supplies are received, either as part of your *medical supplies* benefit or your *pharmacy* benefit. See "Summary of Benefits" and "Pharmacy Benefits."

To obtain *medical supplies* and 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

➢ Obesity Treatment / Weight Management

The *Plan* provides coverage for *office visits* for the evaluation and treatment of obesity; see "Summary of Benefits" for visit maximums. You must go to a Blue Distinction Center for bariatric *surgery*. The *Plan* covers bariatric *surgery* when performed at a Blue Distinction Center (BDC). Surgeries performed at non-BDCs will not be a covered benefit and prior approval will not be granted to non-BDC facilities. Complications arising from surgeries performed at a

non-BDC will be covered under *emergency services* criteria. Bariatric surgeries for which prior approval is not obtained will not be covered regardless of the facility's BDC status. For a listing of Blue Distinction Centers (BDC), visit the *State Health Plan* website at **www.shpnc.org**, Find a *Doctor* and select "Obesity *Surgery* Blue Distinction Cener" The *Plan* also provides benefits for nutritional counseling visits to an *out-of-network provider* as part of your *preventive care* benefits. The nutritional counseling visits may include counseling specific to achieving or maintaining a healthy weight. Nutritional counseling visits are separate from the obesity-related *office visits* noted above.

Obesity Treatment / Weight Management Exclusion

- Services provided at non-Blue Distinction Center facilities.
- Removal of excess skin from the abdomen, arms or thighs
- Any costs associated with membership in a weight management program except as specifically described above
- Any treatment or regimen, medical or surgical for the purpose of reducing or controlling the weight of the *member* except as specifically described above

➢ 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, which is one per lifetime. Please see "Other Services" in the "Summary of Benefits."

Orthotic Devices Exclusions

- Pre-molded 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 *member*s and 12 hours per day for vented *member*s. 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 *member*s 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 requires *prior authorization* and *certification* or services will not be covered.

Private Duty Nursing Exclusion

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

➢ *Prosthetic Appliances*

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

Certain *prosthetic appliances* require *prior 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 the *Plan.*

Surgical Benefits

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

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

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

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

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

➢ Mastectomy Benefits

Under the Women's Health and Cancer Rights Act of 1998, 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 non-diseased 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 *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.

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 *State Health Plan* 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

Therapies

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

➢ ***Short-Term Rehabilitative Therapies***

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

- ***Occupational therapy*** and/or physical therapy up to a one-hour session per day (no visits or combined visit limits)
- **Rehabilitative speech therapy** (no visit limits)

➢ Chiropractic Therapy

Benefits are limited to a combined *in-network* and *out-of-network benefit period maximum* for chiropractic services. This visit limit applies in all places of service (e.g., *outpatient*, office and home therapies). There is a 30-visit limit for Chiropractic care. Any visits in excess of this *benefit period maximum* are not *covered services*.

In-network chiropractic *providers* file claims through Health Network Solutions (HNS). Your *in-network provider* is responsible for filing your claim. If you or your *provider* has a question, please call Customer Service at the number listed in "Who to Contact." Refer to "Summary of Benefits" for additional information.

➢ ***Other Therapies***

The *Plan* covers:

- Cardiac rehabilitation therapy
- Pulmonary and respiratory therapy
- Dialysis treatment
- Radiation therapy, including accelerated partial breast radiotherapy (breast brachytherapy).
- Breast brachytherapy is *investigational* but will be covered upon *prior authorization* and *certification*, based on meeting the American Society of Breast Surgeons (ASBS) criteria.
- Chemotherapy, including intravenous chemotherapy.
  Chemotherapy benefits are based on where services are received. For chemotherapy received in conjunction with bone marrow or peripheral blood stem cell *transplants*, follow transplant guidelines described in "*Transplants*." Also see "Pharmacy Benefits" regarding related covered *prescription medications*.

Therapy Exclusions

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

Transplants

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

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

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

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

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

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

Transplants Exclusions

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

Mental Health and Substance Abuse Benefits

The *Plan* provides benefits for the treatment of *mental illness* and *substance abuse* by a *hospital*, *doctor* or *other provider*. See "Summary of Benefits," and information below.

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

➢ *Office Visit* Services

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

- Evaluation and diagnosis
- Preventive *office visits*
- *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 *substance abuse* 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 *substance abuse*

Prior Authorization must be requested and *certification* must be obtained in advance for *inpatient* services or services will not be covered, except for *emergencies*. *In-network providers* in North Carolina are responsible for requesting *prior review* and obtaining *certification.* If *prior review* is not requested and *certification* is not obtained for covered *out-of-network inpatient* admissions, services will be denied.

➢ *Residential Treatment Facility Services*

Prior authorization must be requested and *certification* must be obtained in advance for mental health and *substance abuse* services received in a *residential treatment facility*. *In-network providers* in North Carolina are responsible for requesting *prior authorization* and obtaining *certification.* If *prior authorization* is not requested and *certification* is not obtained for covered *out-of-network residential treatment facility services*, services will be denied.

➢ 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
- 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*
- Treatment is determined by the *Mental Health Case Manager* to be *medically necessary*

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

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

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

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

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

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

Coverage of ABA services is limited to:

- Mental health *provider*s who are currently licensed in the state in which services are delivered
- Whomever 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 provider*s 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 *Substance Abuse* Services

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

Certification for *Inpatient* and *Outpatient Services*

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

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

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

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

Outside of North Carolina

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 *substance abuse* 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 *substance abuse* services other than *office visits* or in *emergencies*. 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*."

➢ 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**
Substance Abuse Inpatient Hospital	**X**		**X**
***Inpatient* Medical Detoxification**	**X**		**X**
Psychiatric Residential Treatment Center		**X**	**X**
***Substance Abuse* Residential Treatment Center**		**X**	**X**
Psychiatric Partial Hospitalization Program		**X**	**X**
***Substance Abuse* Partial Hospitalization Program**		**X**	**X**
Psychiatric Intensive *Outpatient* Program		**X**	**X**
***Substance Abuse* 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 Substance Abuse 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.
- *Substance Abuse* residential treatment facilities are covered for all ages.
- Marriage counseling
- *Inpatient* psychiatric care rendered in a *hospital* not accredited by JCAHO
- *Inpatient Substance Abuse* 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 nationally recognized organization approved by the *Mental Health Case Manager*
- Outdoor components of a residential *substance abuse* treatment program, when such program is licensed as a *substance abuse* 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 *substance abuse* or *substance abuse* disorder in a *residential treatment center* (RTC) unless the RTC is licensed as a *substance abuse* 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 *substance abuse* 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 *substance abuse* or *substance abuse* residential treatment center (RTC) unless the program is licensed as a *substance abuse* 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 nurse*s 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 *substance abuse* 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
- 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
- Assertive Community Treatment Team Program
- Community Support Team
- Psychosocial Rehabilitation
- Day Treatment programs license for day treatment by the NC Division of Health Service Regulation but not licensed as a Partial Hospitalization Program
- Multi-Systematic Therapy
- Residential treatment services described as follows:
  - Level I and Level II therapeutic foster care *provider*s licensed under the NC Division of Social Services (131-D) as family setting homes
  - Level II program type, Level III, and Level IV residential *provider*s/group homes licensed by the NC Division of Health Service Regulation as a Mental Health Facility under 10A NCAC 27G.
  - *Substance Abuse* Non-Medical Community Residential Program
  - Developmental Testing **(unless this is covered under the physical health benefits)**

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 commonly used covered medications, see the information listed under the *Preferred Medication List* section below. A complete list of covered medications can be found on the *State Health Plan*'s website.

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

Certain *prescription medications* may either require *certification* (also known as prior approval) or be subject to step therapy, quantity limits or other forms of *formulary* coverage review in order to be covered based on criteria developed by the *State Health Plan* or its representative. It is very important to make sure that prior approval is received 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.

Prescription medication synchronization as follows:

If you have multiple *prescription*s 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 pharmacy 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
- not have quantity limits or dose optimization criteria that would be affected by aligning refill dates

Prescription medication indicated to treat *infertility* will be included in this benefit limit as they are approved by the U.S. Food and Drug Administration (FDA). Visit **www.shpnc.org** for the most up-to-date information or call *State Health Plan* Customer Service.

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.

➢ *Affordable Care Act* Preventive Medications

Medications that are identified as preventive by the *Affordable Care Act* are covered for *members* on this plan at 100%. *Members* must meet certain criteria for these medications to be covered at 100% and a *provider* must write a *prescription* for the medication to be filled at a participating pharmacy in order for a $0 *copay* to be applied.

➢ Covered Medication List

The *State Health Plan*, with guidance from the Pharmacy and Therapeutics Committee (P & T Committee), compiles the list of covered medications also known as the Comprehensive *Formulary* Document. The Comprehensive *Formulary* Document can be obtained from the *State Health Plan's* website or by calling the *PBM* at the number listed in "Who to Contact" The Comprehensive *Formulary* Document is subject to change without notification.

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

The Comprehensive *Formulary* Document is divided into six categories or tiers: (Tier 1), the most cost-effective non-*specialty medication*s, which would include mostly *generic medication*s; (Tier 2), preferred brand non-*specialty medication*s, including some high-cost *generic medication*s; (Tier 3), non-preferred brand non-*specialty medication*s and compounds ; (Tier 4), the most cost-effective *specialty medications*, including *generic*s and some *biosimilar*s; (Tier 5), preferred brand *specialty medications*, and (Tier 6) non-preferred brand *specialty medication*s. Refer to the *State Health Plan* website for a list of *specialty medications*. The placement of *medicaiton*s in a *formulary* tier determines what *copayment* or *coinsurance* will be charged for a 30-day supply. Tiers 3 and 6 are subject to *deductible*/*coinsurance* and do not have a *copayment*.

Tiers 3 and 6 *prescription*s are subject to the *benefit period deductible* and *coinsurance* amounts and are applied to the pharmacy out-of-pocket maximums

Charges for *prescription medications* do not apply to the *medical out-of-pocket limit* but apply to the *benefit period* ***total*** *out-of-pocket limit*.

Please remember that if you regularly order a medication when only 75 percent of the quantity has been used, you will accumulate an excess supply and the refill date may be adjusted. To avoid having a refill delayed, please follow these guidelines:

- For a 30-day retail *prescription*, order a refill when you have no more than a 7-day supply remaining. (For a 30-day mail order *prescription*, you may order the refill a few days earlier, to ensure you received the refill before the medication on hand has been used.)
- For a 90-day retail or mail order *prescription*, request the refill when you have no more than a 14-day supply remaining.

If a *prescription* reflects a change in dosage, it is treated like a new *prescription*s and the look back period starts over from zero. However, if a new *prescription* is identical to the previous one, the system will continue to look back 180 days to determine if the refill can be approved.

If you order a refill at a participating retail pharmacy too soon, you will be asked to wait until the allowable refill date. If you order the refill through the CVS Mail Order Pharmacy, the pharmacy may hold the refill until the allowable date.

Exceptions to this refill policy can be made under certain circumstances.

➢ Specialty Pharmacy

Specialty and *biosimilar* medications are designated and classified by the *Plan* as medications that meet the following criteria and are listed on the *Specialty Medication* List, which is located on the *State Health Plan's* website at www.shpnc.org.

- 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."

Prescription Medication Exclusions

- Any *prescription medications* not covered in the *formulary*
- Any *prescription medications* not FDA approved
- Any *prescription medications* that are not federal legend
- Any *prescription medications* not specifically covered by the *State Health Plan*
- Any *prescription medications* prescribed for *sexual dysfunction*.
- Any *prescription medications* prescribed for hair growth
- Any *prescription medications* prescribed for *cosmetic* purposes
- Any *prescription medications* prescribed in conjunction with artificial reproductive technology
- Any *prescription medication* in excess of the stated quantity limits
- Any *prescription medication* requiring *certification* if *certification* is not obtained
- Any medication 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 active ingredient contained within a *compound medication* in which that active ingredient is not a covered *prescription medication* including bulk chemicals.

- Any *prescription medication* that has a therapeutic equivalent available over-the-counter as determined by the *State Health Plan*
- Any *prescription* medical foods
- 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 is purchased to replace a lost, broken, or destroyed *prescription medication* except under certain circumstances during a state of *emergency* or disaster
- Also see "What is Not Covered" for additional *prescription medication* exclusions

➢ Diabetic Testing Supplies

Certain diabetic testing supplies are covered under your medical and pharmacy benefit. Certain supplies 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."

➢ 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.

➢ 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 Medication* 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 medication 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.

Medication 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 MEDICATION COVERAGE AND MEDICARE

Effective January 1, 2006, Medicare began offering *prescription medication* coverage for all persons enrolled in Medicare. The *State Health Plan* will continue to provide *prescription medication 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 medication* coverage is at least as good as Part D coverage.

If your current *prescription medication* 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 Medication* Plan.

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

**High income members may be subject to an income-related monthly adjustment amount by Social Security.*

WHAT IS NOT COVERED?

Exclusions for a specific type of service are stated along with the benefit description in "*Covered Services*." Exclusions that apply to many services are listed in this section, starting with general exclusions and then the remaining exclusions are listed in alphabetical order. To understand all of the exclusions that apply, read "*Covered Services*," "Summary of Benefits" and "What Is Not Covered?" The *Plan* does not cover services, supplies, medications or charges for:

- Anything specifically listed in this benefits booklet as not covered or excluded, regardless of *medical necessity*
- Any condition, disease, ailment, injury or diagnostic service to the extent that benefits are provided or persons are eligible for coverage under Title XVIII of the Social Security Act of 1965, including amendments, except as otherwise required by federal law
- Conditions that federal, state or local law requires to be treated in a public facility
- Any condition, disease, illness or injury that occurs in the course of employment, if the *member*, employer or carrier is liable or responsible for the specific medical charge (1) according to a final adjudication of the claim under a state's workers' compensation laws, or (2) by an order of a state Industrial Commission or other applicable regulatory agency approving a settlement agreement
- Basic life or work-related or medical disability examinations
- Benefits that are provided by any governmental unit except as required by law
- Services that are ordered by a court that are otherwise excluded from benefits under this Plan
- Any condition suffered as a result of any act of war or while on active or reserve military duty
- Services in excess of any *benefit period maximum* or *lifetime maximum*
- Received prior to the *member's effective date*
- Received after the coverage termination date, regardless of when the treated condition occurred, and regardless of whether the care is a continuation of care received prior to the termination
- Received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust or similar person or group
- Services provided at request of patient in a location other than physician's office which are normally provided in the physician's office
- Day care services, chore services, attendant care services, homemaker services, companion care services, foster care services
- Telephone consultations or web-based, online or other electronic evaluations
- Hair analysis, excluding arsenic
- Transportation of portable X-ray equipment and personnel to home or nursing home, transportation of portable EKG to facility or other location
- *Emergency* response systems
- *Alternative medicine* services, which are unproven preventive or treatment modalities, also described as alternative, integrative, or complementary medicine, whether performed by a physician or any *other provider*

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

A

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

- **Audiometric** testing of groups, Bekesy audiometry, ear protector attenuation measurements

B

- **Body** piercing
- Collection and storage of **blood** and stem cells taken from the umbilical cord and placenta for future use in fighting a disease
- **Bone** density wrist or heel radiology testing

C

- **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
- **Claims** not submitted to the *Plan* within 18 months of the date the charge was *incurred*, except in the absence of legal capacity of the *member*
- Side effects and **complications** of non-*covered services*, except for *emergency services* in the case of an *emergency*
- **Convenience** items such as, but not limited to, devices and equipment used for environmental control, urinary incontinence devices (including bed wetting devices) and equipment, heating pads, hot water bottles, ice packs and personal hygiene items
- ***Cosmetic*** services, which include the removal of excess skin from the abdomen, arms or thighs, skin tag excisions, cryotherapy or chemical exfoliation for active acne scarring, superficial dermabrasion, injection of dermal fillers, services for hair *transplants*, electrolysis and *surgery* for psychological or emotional reasons, except as specifically covered by the *Plan*
- Services received either before or after the ***coverage*** period of the Plan, regardless of when the treated condition occurred, and regardless of whether the care is a continuation of care received prior to the termination
- ***Custodial care*** designed essentially to assist an individual with activities of daily living, with or without routine nursing care and the supervisory care of a *doctor*. While some skilled nursing services may be provided, the patient does not require continuing skill services 24 hours daily. The individual is not under specific medical, surgical, or psychiatric treatment to reduce a physical or mental disability to the extent necessary to enable the patient to live outside either the institution or the home setting with substantial assistance and supervision, nor is there reasonable likelihood that the disability will be reduced to that level even with treatment. *Custodial care* includes, but is not limited to, help in walking, bathing, dressing, feeding, preparation of special diets and supervision over medications that could otherwise be self-administered. Such services and supplies are custodial as determined by the *Plan* without regard to the place of service or the *provider* prescribing or providing the services.
- **Camisoles**, or other clothing, post-mastectomy
- **Communication** boards or alternative communication devices

D

- **Dental care**, dentures, dental implants, oral orthotic devices, palatel expanders and orthodontics except as specifically covered by the *Plan*.
- **Dental services** provided in a *hospital*, except as specifically covered by the *Plan*.
- Evaluation and treatment of ***developmental dysfunction*** and/or learning disability.

- The following medications:
    - Injections by a health care professional of injectable *prescription medications* which can be self-administered, unless medical supervision is required
    - Medications associated with conception by artificial means.
    - For prescribed *sexual dysfunction* medications
    - Take home medications furnished by a *hospital* or *nonhospital facility*
    - *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 medications 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 nationally recognized medication reference guides:
        - The American Medical Association Drug Evaluations
        - The American *Hospital Formulary* Service Drug Information
        - The United States Pharmacopoeia Drug Information
        - 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.

E

- Services primarily for ***educational*** purposes including, but not limited to, evaluation, books, tapes, pamphlets, seminars, classroom, Web or computer programs, individual or group instruction, counseling, and vocational counseling, educational supplies such as books, tapes, and pamphlets for the patient's education at cost to physician or other qualified health care professional, educational services rendered to patients in a group setting by physician or other qualified health care professional, except as specifically covered by the *Plan*
- For **educational** or achievement testing for the sole purpose of resolving educational performance questions
- The following **equipment:**
    - Air conditioners, furnaces, humidifiers, vacuum cleaners, electronic air filters and similar equipment
    - Devices and equipment used for environmental accommodation requiring vehicle and/or building modifications such as, but not limited to, positioning seats, chair lifts, stair lifts, home elevators, and ramps
    - Physical fitness equipment, hot tubs, Jacuzzis, heated spas, whirlpools, pools or membership to health clubs
    - Personal computers
    - Pacemaker monitors and external defibrillators with integrated electrocardiogram analysis
    - Postural drainage boards and similar equipment
    - Standing frames.
- ***Experimental*** services including services whose efficacy has not been established by controlled clinical trials, or are not recommended as a preventive service by the U.S. Public Health Service except as specifically covered by the *Plan*

F

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

G

- **Genetic testing** for amyotrophic lateral sclerosis (ALS)
- **Genetic testing**, except for high risk patients when the therapeutic or diagnostic course would be determined by the outcome of testing

H

- Routine **hearing** examinations and hearing aids or examinations for the fitting of hearing aids except as specifically covered by the *Plan*
- Implantable bone-anchored **hearing aids** (BAHA), or examinations for the fitting of hearing aids for *members* over the age of 22.
- ***Holistic** or alternative medicine* services, which are unproven preventive or treatment modalities, generally described as alternative, integrative or complementary medicine, whether performed by a physician or any *other provider*, except as specifically covered by your health benefit plan
- **Hypnosis** except when used for control of acute or chronic pain.

I

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

L

- Extracorporeal shockwave **lithotripsy** (ESWL) of gallbladder and other sites
- **Low density lipoprotein** (LDL) apheresis using heparin-induced extracorporeal LDL precipitation

M

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

N

- **Necropsies**
- 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*. This includes any services, procedures or supplies associated with *cosmetic* services, *investigational* services, services deemed not *medically necessary*, or elective termination of pregnancy, if not specifically covered by the *Plan*.

O

- Any treatment or regimen, medical or surgical, for the purpose of reducing or controlling the weight of a *member* or for treatment of **obesity,** except for surgical treatment of morbid obesity, or as specifically covered by the *Plan.* Bariatric *surgery*, that is not performed at a Blue Distinction Center (BDC).

P

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

- Is not recognized by the *Plan* as an eligible *provider*

R

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

S

- **Services** or **supplies** that are:
  - Not performed by or upon the direction of a *doctor* or *other provider*
  - Compression stockings, garter belts, except as specifically covered by your health benefit plan
  - Available to a *member* with charge.
- ***Sexual dysfunction*** unrelated to organic disease.
- **Shoe** lifts, shoe accessories, attachment, equipment, inserts and other modifications, and shoes of any type unless part of a brace, and except as specifically covered by your health benefit plan
- Services, supplies, medications or equipment used for the control or treatment of **stammering or stuttering.**
- **Safety** equipment, devices or accessories, including but limited to helmets with face guards and soft interfaces and any type of restraints

T

- **Telehealth** services originating site facility fees
- The following types of **therapy:**
  - Applied Behavior Analysis (ABA) therapy except as specifically identified by the *Plan*
  - Music therapy, recreational or activity therapy, and all types of animal therapy. Remedial reading and all forms of special education and supplies or equipment used similarly, except as specifically covered by the *Plan*
  - Maintenance therapy
  - Massage therapy
  - Alternative therapy
  - Hypothermia therapy
- **Thermography** or **thermograph** examination
- **Travel**, whether or not recommended or prescribed by a *doctor* or other licensed health care professional, except as specifically covered by the *Plan*.
- Treatment or studies to or in connection with sex changes or modifications and related care

V

- The following **vision** services:
  - Radial keratotomy and other refractive eye *surgery*, and related services to correct vision except for surgical correction of an eye injury. Also excluded are premium intraocular lenses or the services related to the insertion of

premium lenses beyond what is required for insertion of conventional intraocular lenses, which are small, lightweight, clear disks that replace the distance-focusing power of the eye's natural crystalline lens.
- 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.

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

W

- **Wigs**, hair pieces and services for hair implants and electrolysis for any reason.

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
- You were not eligible for these services under your health benefit plan due to termination of coverage
- Nonpayment of premiums.

Rights and Responsibilities Under the UM Program

➢ Your *Member* Rights

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

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

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

➢ The *State Health Plan's* Responsibilities

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

- Provide you and your *provider* with a toll-free telephone number to call *UM* review staff when *certification* of a health care service is needed. See "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.

Prior Authorization (Pre-Service)

The *State Health Plan* requires that certain health care services receive *prior authorization* as noted in "*Covered Services*." These types of reviews are called pre-service reviews. If neither you nor your *provider* requests *prior authorization* and receives *certification*, this will result in a complete denial of benefits. The list of services that require *prior authorization* may change from time to time.

General categories of services with this requirement are noted in "*Covered Services*." You may also visit our website at **www.shpnc.org** or call Customer Service at the number listed in "Who to Contact" for a detailed list of services.

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*.

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

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

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*."

- **Urgent *Prior Authorization***

  You have a right to an urgent authorization 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. The *State Health Plan* 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 authorization, 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 authorization may be requested by calling Customer Service at the number given in "Who to Contact."

Concurrent Authorization

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

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

In the event of an *adverse benefit determination*, the *Plan* will let you, your *hospital*'s or other facility's UM department and your *provider* know within three business days after receipt of all necessary clinical information, but no later than 15 days after receiving the request. Written confirmation of the decision will also be sent to your home by U.S. mail.

For concurrent reviews, the *Plan* will remain responsible for *covered services* you are receiving until you or your representatives have been notified of the *adverse benefit determination*.

- ***Urgent Concurrent Authorization***

  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 a request for an extension of treatment is urgent, and the request is received at least 24 hours before the expiration of a previously approved *inpatient* stay or course of treatment at the requesting *hospital* or other facility, a decision will be made and communicated to the requesting *hospital* or other facility as soon as possible, but no later than 24 hours after we receive the request.

  If a request for extension of treatment is urgent, and the request is not received at least 24 hours before the expiration of a previously approved *inpatient* stay or course of treatment at the requesting *hospital* or other facility, a decision will be made and communicated as soon as possible but no later than 72 hours after we receive the request.

  If the *State Health Plan* or its representative need more information to process your urgent review, the *Plan* will notify the requesting *hospital* or other facility of the information needed as soon as possible but no later than 24 hours after we receive the request. The requesting *hospital* or other facility will then be given a reasonable amount of time, but not less than 48 hours, to provide the requested information. The *Plan* or its representative will make a decision within 48 hours after receipt of the requested information, or within 48 hours after the deadline given to the requesting *hospital* or other facility to provide the information, whichever comes first.

Retrospective Authorization **(Post-Service)**

The *State Health Plan* or its representative also reviews the coverage of health care services after you receive them (retrospective reviews). Retrospective review may include a review to determine if services received in an *emergency* setting qualify as an *emergency*. The *State Health Plan* or its representative will make all retrospective review decisions and notify you of its decision within a reasonable time but no later than 30 days from the date the *State Health Plan* or its representative received the request.

In the event of an *adverse benefit determination*, the *Plan* or its representative will notify you and your *provider* in writing within five business days of the decision. All decisions will be based on *medical necessity* and whether the service received was a benefit under the *Plan*. If more information is needed before the end of the initial 30-day period, the *Plan* or its representative will notify you of the information needed. You will then have 90 days to provide the requested information. As soon as the *Plan* or its representative receives the requested information, or at the end of the 90 days, whichever is earlier, the *Plan* or its representative will make a decision within 15 days.

Services that were approved in advance by the *Plan* or its representative will not be subject to denial for *medical necessity* once the claim is received, **unless the *certification* was based on a material**

misrepresentation about your health condition or you were not eligible for these services under your health benefit plan due to termination of coverage or nonpayment of premiums. All other services may be subject to retrospective review and could be denied for *medical necessity* or for a benefit limitation or exclusion.

Care Management

Members with complicated and/or chronic medical needs may be eligible for care management services. Care management, also known as case management, encourages *members* with complicated or chronic medical needs, their *providers*, and the *State Health Plan* or its representative to work together to identify the appropriate services to meet the individual's health needs and promote quality outcomes. To accomplish this, *members* enrolled in or eligible for care management programs may be contacted by the *State Health Plan* or by a representative of the *State Health Plan*.

Care Management services are provided solely at the option of the *State Health Plan* or its representative, and the *State Health Plan* is not obligated to provide the same benefits or services to a *member* at a later date or to any other *member*. Information about these services can be obtained by calling *State Health Plan* Customer Service.

Continuity of Care

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.

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

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
- Second trimester pregnancy which shall extend through the provision of 60 days of postpartum care
- 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. In these situations, benefits are based on the billed amount. However, you may be responsible for charges billed separately by the *provider* which are not eligible for additional reimbursement. If your continuity of care request is denied, you may request a review through our *appeal*s process (see "What if I Disagree with a Decision"). 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 *non-certification* 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 *UM* and the first level *grievance* review for *inpatient* and *outpatient* mental health and *substance abuse* services. The Case Manager's decision making is based on the appropriateness of care and service as well as existence of coverage. Claim determinations and second level *grievance* reviews are provided by the *State Health Plan* or its representative. The *Mental Health Case Manager* does not reward *practitioners*, or other individuals, for issuing denials of coverage or service. Financial incentives are not given that would encourage decisions resulting in less care than needed.

Evaluating New Technology

In an effort to allow for continuous quality improvement, the *State Health Plan* or its representative has processes in place to evaluate new medical technology, procedures and equipment. These policies allow the *State Health Plan* or its representative to determine the best services and products to offer *members*. They also help the *State Health Plan* or its representative to keep pace with the ever-advancing medical field. Before implementing any new or revised policies, the *State Health Plan* or its representative 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 *non-certification* decision), policies or actions related to the availability, delivery or quality of health care services. If you have a *grievance*, you have the right to request that the *State Health Plan* or its representative review the decision through the *grievance* process.

***Grievances* are not allowed for benefits or services that are clearly excluded by this benefits booklet or for *deductibles*, *coinsurance* or *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.

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

North Carolina Department of Insurance

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

Steps To Follow In the *Grievance* Process

➢ First Level *Grievance* Review

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

Any request for review should include:

- *Member's ID number*
- *Member's* name
- 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 *non-certification* decisions by an external, independent review organization (IRO). The relevant statutory provision is 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 *non-certification* decision or,
- An *appeal* decision upholding a *non-certification* 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 *non-certification;*

- You had coverage with the *State Health Plan* when the *non-certification* was issued;
- The service for which the *non-certification* 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.

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 *non-certification* (a *non-certification* 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 *grievance* determination from the *State Health Plan* or its representative.

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
- 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.

➢ 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 *non-certification* 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 *non-certification* 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 *non-certification* 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 *non-certifications*.

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	For the physical address, please visit www.ncdoi.com/Smart Toll-Free Telephone: 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 *non-certification* (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 *non-certification* 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 *non-certification 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 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 *non-certification*, 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 *non-certification* 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 *non-certification*, 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 *non-certification* 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 N.C.G.S. § 135-48.24 identify 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 Chapter 150B of the North Carolina General Statutes. 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 *Appeal*s

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

➢ Pharmacy *Appeal*s

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 *Appeal*s

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

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

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

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

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

Administrative Discretion

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

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 *provider*s that you are a *member* of the *Plan.* While the *Plan* maintains its contractual obligation to provide benefits to *member*s 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 medication* 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*, or *coinsurance,* is usually based on the **lesser** of:

- The billed charges for your *covered services*
- 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 *provider*s 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 *providers'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.

➢ Blue Cross Blue Shield Global Core® Program:

If you are outside the United States (hereinafter "BlueCard service area"), you may be able to take advantage of the Blue Cross Blue Shield Global Core® Program when accessing *Covered Services*. The Blue Cross Blue Shield Global Core Program is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although the Blue Cross Blue Shield Global Core 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 Blue Cross Blue Shield Global Core Service Center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, and 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 Blue Cross Blue Shield Global Core Service Center for assistance, *hospital*s 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 Blue Cross Blue Shield Global Core 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 pre*certification* for non-*emergency inpatient* services.

Outpatient Services

Physicians, *urgent care* centers and other *outpatient provider*s 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 Blue Cross Blue Shield Global Core 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 Blue Cross Blue Shield Global Core International claim form and send the claim form with the *provider's* itemized bill(s) to the Blue Cross Blue Shield Global Core 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 Blue Cross Blue Shield Global Core Service Center or online at www.bcbsglobalcore.com. If you need assistance with your claim submission, you should call the Blue Cross Blue Shield Global Core Service Center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week.

North Carolina Provider Reimbursement

BCBSNC has contracts with certain *provider*s of health care services for the provision of, and payment for, health care services provided to all *member*s entitled to health care benefits. *BCBSNC*'s payment to *provider*s 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 *provider*s. 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 provider*s have other agreements with *BCBSNC* that affect their reimbursement for *covered services* provided to Plan *member*s. These *provider*s agree not to bill *member*s for any charges higher than their agreed upon, contracted amount. In these situations, *member*s will be responsible for the difference between the *Plan's allowed amount* and the contracted amount. *Out-of-network provider*s 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 *appeal*s 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 *Member*s and *Retiree*s Under Age 65

Please note that payment by the *State Health Plan* under your health benefit plan takes into account whether the *provider* is a participating *provider*. If the *State Health Plan* is the secondary plan, and you use a

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

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

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

Medicare consists of two parts:

Part A: Pays *inpatient hospital* bills and *skilled nursing facility* bills. It is normally provided at no charge to those eligible for Medicare.

Part B: Pays *outpatient hospital*, *doctor* and other professional bills and requires a monthly payment from the person eligible for Medicare.

If you or your covered *dependent* are 65 and are not eligible for either part of Medicare, the *State Health Plan* requires written documentation from the Social Security Administration (SSA) explaining the reason for ineligibility. Benefits cannot be paid unless this documentation is received. An *employee*, *retiree*, or *dependent* who becomes eligible for Medicare may remain covered under the *State Health Plan*. For proper coordination 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 actively employed and eligible for Medicare, the *State Health Plan* is primary and Medicare is secondary for you and your *dependents*. The only exception is if you are Medicare primary due to End Stage Renal Disease (ESRD) 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*, including the last month that a *retiree* is still covered by the active group prior to being enrolled by the Retirement System.
    - *Dependents* of *retirees* who also have Medicare.
    - Disability *retirees*.
    - *Dependents* of disability *retirees* who also have Medicare.
    - *Members* with End Stage Renal Disease (ESRD) following the 30-month *State Health Plan* primary period.
    - Individuals with "dual" Medicare entitlement. Dual entitlement occurs when Medicare is already paying as primary because of disability or age and the *member* also becomes eligible because of ESRD. In this case, the 30-month *State Health Plan* primary period is waived and Medicare continues paying as primary.
    - Individuals who have Medicare because of disability and who are not actively working or those who are *spouses* of non-working *employees* who also have Medicare.

- Former *members* and/or Medicare-eligible *dependents* covered under COBRA.
- Former *employees* who are receiving the reduction in force (RIF) health benefit continuation coverage.

All covered charges not paid by Medicare are subject to the terms and conditions of your health benefit plan, including the *benefit period deductible*, *coinsurance*, and d*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 for *Member*s Eligible for Medicare

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 *Employee*s, 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 *Employee*s, 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 *Dependent*s, 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 *Dependent*s qualify for coverage under Medicaid:

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

WHEN COVERAGE BEGINS AND ENDS

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

Eligibility

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

- All permanent full-time teachers and state *employees* who are either (1) paid from general or special state funds or (2) paid from non-state funds and the employing unit has agreed to provide coverage.
- *Employees* of state agencies, departments, institutions, boards and commissions, not otherwise covered by the *State Health Plan*, who are employed in permanent job positions on a recurring basis and who work 30 or more hours per week for nine or more months per calendar year.
- Retired teachers and State *employees*, *member*s 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.
- *Retiree*s employed by an employing unit that elects to provide this coverage and the *retiree* does not qualify for coverage as a permanent *employee* and are determined to be "full-time" by their employing unit in accordance with section 4980H of the Internal Revenue Code.

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

- School *employees* in a job sharing position as described in G.S. 115C-326.5.

- Retired former *employees* with 10, but less than 20 years of retirement service who were first hired on or after October 1, 2006.

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

- Former *members* of the General Assembly who enrolled before October 1, 1986.
- Former *members* of the General Assembly who are enrolled in the *State Health Plan* at termination of membership in the General Assembly and elect to continue coverage within 30 days of the end of their term of office.
- Surviving *spouses* of deceased *members* of the General Assembly who enrolled before October 1, 1986.
- *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* 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's* 80/20 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.

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 the Plan's Eligibility and Enrollment Support Center 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.

➢ Qualifying Life Events that Allow Coverage Changes

If you have one of the following qualifying life events during the year, you will be able to make a coverage change that is on account of and corresponds with the qualifying life event. You are required to provide supporting documentation. Documentation can be uploaded in the Document Center of eEnroll, the Plan's enrollment system, or provided to your *Health Benefits Representative* to verify the qualifying life event in accordance to the *State Health Plan* policy.

- 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 group health benefit plan.
- You or your *dependents* become Medicare eligible
- Your *dependent* ceases to be an eligible *dependent* (*dependent* child turns 26).
- You, your *spouse*, or your *dependents* commence or return from an unpaid leave of absence such as Family and Medical Leave or military leave.
- You receive a qualified medical child support order (as determined by the *Plan* administrator) that requires the *Plan* to provide coverage for your children.
- If you, your *spouse* or *dependents* experience a cost or coverage change under another group health plan for which an election change was permitted, you may make a corresponding election change under the Flex Plan (e.g. your *spouse*'s *employee* significantly increases the cost of coverage and as a result, allows the *spouse* to change his/her election)

- If you change employment status such that you are no longer expected to average 30 hours of service per week but you do not lose eligibility for coverage under the *State Health Plan* (e.g. you are in a stability period during which you qualify as full-time), you may still prospectively revoke your election provided that you certify that you have or will enroll yourself (and any other covered family members) in other coverage providing minimum essential coverage (e.g. the Marketplace) that is effective no later than the first day of the second month following the month that includes the date the original coverage is revoked
- You may prospectively revoke your *State Health Plan* election if you certify your intent to enroll yourself and any covered *dependents* in the Marketplace for coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked
- You or your *dependents* 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.
- If you, your spouse or your dependent loses eligibility for coverage (as defined by HIPAA) under any group health plan or health insurance coverage (e.g., coverage in the individual market, including the marketplace), you may change your participation election.

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 may continue coverage as long as 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*.

The coverage change request must occur within 30 days of the qualifying life event (except as specifically described above) or you will have to wait until the next Open Enrollment period. *Retiree*s and surviving *spouse*s 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.

Please note: Losing individual coverage doesn't qualify as a qualifying life event if you voluntarily drop coverage, if you lose coverage because you didn't pay your premiums, or if you lose coverage because you didn't provide required documentation when asked for more information.

Enrollment Exceptions

To make an enrollment exception request, active *member*s must contact their *HBR* and request that the *HBR* file an enrollment exception request with the *State Health Plan*. Non-Active *Member*s (*Retiree*s, Disabled *Member*s, RIF *Member*s, COBRA *Member*s, former *Member*s of the General Assembly and other 100% contributory *Member*s) must contact the *State Health Plan* office at 919-814-4400 to file an enrollment exception request. Enrollment exception requests must be submitted to *State Health 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 the **www.shpnc.org** and click "Enroll Now/Access Benefits." Failure to remove a *dependent* timely could result in loss of eligibility for continuation of coverage.

To add a dependent, the coverage change must occur within 30 days of the qualifying life event unless otherwise specified or you must wait until the next Open Enrollment period. The *effective date* of coverage

for the *dependent* will be the first day of the month following the qualifying life event, except in the case of a newborn child or adopted child.

If you are adding a newborn child, the coverage *effective date* must be the first day of the month in which the child is born. A newborn child must be enrolled within 30 days of their date of birth. A *subscriber* changing from *employee*-only or *employee*-spouse coverage will be required to pay any additional premiums for *employee*/child(ren) or *employee*-family coverage retroactive to the first of the month in which the child is born.

The effective date for an adopted child can be the date of adoption, or date of placement in the adoptive parents' home, or the first of the month following the date of adoption or placement. An adopted child must be enrolled within 30 days of the date of adoption or placement. A *subscriber* changing from *employee*-only or *employee*-spouse coverage will be required to pay any additional premiums for *employee*/child(ren) or *employee*-family coverage retroactive to the first of the month in which the date of adoption or placement occurred if either is the effective date.

If you are an active *member* you may remove *dependents* from your coverage within 30 days of a qualifying life event. Coverage for *dependents* will end at the last day of the month in which the qualifying life event occurred. *Dependents* **must** be removed from coverage when they are no longer eligible, such as when a child is no longer eligible due to age, enters active military service, or when the *spouse* is no longer eligible due to divorce or death.

If you are a retired *member* or surviving *spouse* you may remove *dependents* from your coverage without a qualifying life event. To add *dependent*s 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* 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, entering active military service, and termination of employment. For additional ineligibility events, contact the Plan's Eligibility and Enrollment Support Center at the number in "Who to Contact." You must make the change request through eEnroll when there is a change of eligibility for a *dependent*. If notification is not made within the 30 days following the *dependent's* ineligibility event, the *dependent* will be removed from coverage on the last day of the month in which the notification is received, and the coverage type change will be the first of the month following 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.

Premium payments are due by the first day of the effective month. The premium payment grace period ends thirty (30) days after the due date. *Member*s who do not pay their premiums in full by the end of the grace period will have their coverage canceled. If the premium payment is received after the coverage is canceled for nonpayment, but the postmark is on or before the end of the grace period, the coverage may be reinstated. This applies to *member*s in a category that requires the member to be responsible for paying the full premium or a portion of the premium directly to the employing unit or the Plan's billing vendor.

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 *dependent*s, all *member*s 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 for you or your *dependents* may also end on the date through which premiums have 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 regarding eligibility or enrollment information or 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

NC Health*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.

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 "Health and Wellness NC Health*Smart"* for the most current program information.

NC Health*Smart* is completely voluntary. Eligible *members* can use the program tools and services 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 Hotline** **QuitlineNC…800-QUIT-NOW** (800-784-8669). Available 24 hours a day, 7 days a week, English/Spanish-speaking Quit Coaches®. QuitlineNC offers free telephonic and text support 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. **Nicotine Replacement Therapy Medications** Over the counter, *generic* nicotine replacement therapy (NRT) patches are available through QuitlineNC at no charge to *members.* (Nicotine gum will be provided as an alternative for members experiencing an adverse reaction to the nicotine patches.) *Members* do not need a *prescription* to receive NRT from QuitlineNC, but they do need to be enrolled in the multi-call program and be ready to quit within 30-days of their first call to be eligible. ***Prescription* Medications** *Prescription generic* extended-release bupropion 12 hour and brand Chantix (varenicline) will be covered at 100% for *member*s ≥ 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**.

Value Added Programs

Weight Management Support	**Tools and Resources** • **Nutrition Visits** Please see "*Covered Services*" for additional information about nutrition counseling benefits for *subscriber*s 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 and select "My Personal Health Portal."
Health Coaching	Health Coaches are specially trained and licensed health care professionals who are available by phone Monday-Friday, 8:30 a.m.-9 p.m., to help you manage your health. They can provide support for the following conditions: • Asthma • Coronary Artery Disease • Congestive Heart Failure (CHF) • Diabetes • Stroke • Peripheral Arterial and Vascular Diseases (PAD) • Chronic Obstructive Pulmonary Disease (COPD) ➢ Recommendations for health education programs, tools, and videos ➢ Printed health-related materials to your home ➢ Health Education Programs and Tools
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, renal disease 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.

Value Added Programs

NC Health*Smart* *Personal Health Portal*	• HA and personal health actions • Personal health record stores health information in one place • Symptom diary • Interactive tobacco cessation, weight management and a variety of chronic conditions • Health library—wellness webinars, healthy recipes, videos, and audio files on a wide range of topics
Wellness Champions (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 of the Wellness Champions program is to foster wellness programs throughout the state that support healthy environments and a culture that values health. The Wellness Champions program offers the opportunity for worksites to earn quarterly incentives to use at future wellness programs available to employees. The Plan believes through the Wellness Champion program, we can work together to create a healthier North Carolina, one worksite at a time. 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. To get started, go to the *Plan's* website at www.shpnc.org, click on *Member* Login in the green bar, then scroll down to the Blue Connect login. Once you are logged into Blue Connect, look for the Blue365 tile. *Member*s will need to register in order to receive access to the Blue365 program. You can also call *State Health Plan* Customer Service at 888-234-2416.

Keep your body – and budget – healthy

Staying healthy and active should be easy – and affordable. That's why Blue Cross and Blue Shield of North Carolina (*BCBSNC*) offers Blue365. It's a simple way to save on everything you need for a well-balanced lifestyle.

Get deals, discounts & more:

- Fitness: Gym memberships and fitness gear
- Personal Care: Vision and hearing care
- Healthy Eating: Weight loss and nutrition programs
- Lifestyle: Travel and family activities
- Wellness: Mind/body wellness tools and resources
- Financial Health: Financial tools and programs

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

The State Health Plan or BCBSNC reserves the right to discontinue or change these programs at any time. 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 member*s are responsible for paying all bills.*

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

ADVERSE BENEFIT DETERMINATION—a denial, reduction, or termination of, or failure to provide or make full or partial payment for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be *experimental* or *investigational* or not *medically necessary* or appropriate. Rescission of coverage and initial eligibility determination are also included as *adverse benefit determination*s.

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

AFFORDABLE CARE ACT (ACA) PREVENTIVE CARE PRESCRIPTION MEDICATIONS — *prescription medications* identified by the *Affordable Care Act* covered at 100%.

ALLOWED AMOUNT — the maximum amount that *BCBSNC* determines is reasonable for *covered services* provided to a *member*. The *allowed amount* includes any *BCBSNC* payment to the *provider*, plus any *deductible*, or *coinsurance*. 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 *provider*s 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 *provider*s who may have entered into an agreement with *BCBSNC* for similar services under a similar health benefit plan. Calculation of the *allowed amount* is based on several factors including *BCBSNC*'s medical, payment and administrative guidelines. Under the guidelines, some procedures charged separately by the *provider* may be combined into one procedure for reimbursement purposes.

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

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

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

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

ANCILLARY PROVIDER — independent clinical laboratories, durable/home medical equipment and supply *provider*s, or specialty pharmacies. *Ancillary provider*s are considered *in-network* if they contract directly with the Blue Cross or Blue Shield plan in the state where services are received, based on the following criteria.

a) For independent clinical laboratories, services are received in the state where the specimen is drawn
b) For durable/home equipment and supply *providers*, services are received in the state where the equipment or supply is shipped (receiving address) or if purchased at a retail store the vendor must be contracted with the *Plan* in the state where the retail store is located.
c) For specialty pharmacies, services are received in the state where the ordering physician is located.

APPEAL — a written request for a review of a denial of a *non-certification* and/or a denial based on *medical necessity*. See also the definitions for "*non-certification*" and "*medical necessity*."

BCBSNC — Blue Cross and Blue Shield of North Carolina.

BENEFIT PERIOD — the period of time, as stated in the "Summary of Benefits," during which charges for *covered services,* provided to a *member* must be *incurred* in order to be eligible for payment by the *Plan.* A charge shall be considered *incurred* on the date the service or supply was provided to a *member.*

BENEFIT PERIOD MAXIMUM — the maximum amount of 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. Services in excess of a *benefit period maximum* are not *covered services* and *members* may be responsible for the entire amount of the *provider's* billed charge.

BIOSIMILAR — *prescription medication* products approved by the U.S. Food and Drug Administration (FDA) that are chemically identical products to those previously approved biologic medications, but are manufactured after the patent for the medication has expired, allowing for a *generic*, *biosimilar* version of the medication to be produced.

BLUE CARD PROGRAM — BlueCard gives Blue members seamless national access to the 92 percent of physicians and 96 percent of hospitals that participate in Blue networks. The program links participating healthcare providers with the independent Blue Cross and Blue Shield Plans through a single electronic network for claims processing and reimbursement. No matter where they live, work, or travel, Blue members, through BlueCard, can receive care at consistent Home Plan contract benefit levels.

BLUE OPTIONS DESIGNATED HOSPITAL — A specific network of facilities that can be used to lower a *member's* out-of-pocket costs. These facilities are have been "designated" because they provide both quality and cost-effective care.

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

BRAND NAME — the proprietary name of the *prescription medication* that the manufacturer owning the patent places upon a medication 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* medication 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 medications 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.

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. Any services in excess of a *benefit period maximum* or *lifetime maximum* are not *covered services*.

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

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

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

DEPENDENT — a *member* other than the *subscriber* as specified in "When Coverage Begins And Ends."

DEPENDENT CHILD(REN) — the covered child(ren) of a *subscriber* or *spouse* up to the maximum *dependent* age, as specified in "When Coverage Begins And Ends."

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

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

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

EDUCATIONAL TREATMENT — services provided to foster acquisition of skills and knowledge to assist development of an individual's cognitive independence and personal responsibility. These services include academic learning, socialization, adaptive skills, communication, amelioration of interfering behaviors, and generalizations of abilities across multipole environments

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.

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,* insulin, and certain over-the-counter medications that may be available to *members*.

FOSTER CHILD(REN) — children under age 18 i) for whom a guardian has been appointed by an authorized clerk of court 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 medication 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* medication.

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

HBR — see *Health Benefits Representative*.

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

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

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

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

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

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

a) Is accredited, licensed or certified in the state where located
b) Is certified for participation in the Medicare program
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,* and key benefit information, phone numbers and addresses.

INCURRED — the date on which a *member* receives the service, medication, 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. *Ancillary providers* outside North Carolina are considered *in-network* only if they contract directly with the Blue Cross or Blue Shield plan in the state where services are received, even if they participate in the BlueCard Program.

INPATIENT — pertaining to services received when a *member* is admitted to a *hospital* or *nonhospital facility* as a registered bed patient for whom a room and board charge is made.

INVESTIGATIONAL (EXPERIMENTAL) — the use of a service or supply including, but not limited to, treatment, procedure, facility, equipment, medication, 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 medications 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. Services in excess of any *lifetime maximum* are not *covered services*, and *members* may be responsible for the entire amount of the *provider's* billed charge. See "Summary of Benefits" for any limits that may apply.

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
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 qualified representative of the company that is contracted to manage the mental health and *substance abuse* benefits.

MENTAL ILLNESS — mental disorders, psychiatric illnesses, mental conditions and psychiatric conditions (whether organic or nonorganic, whether of biological, non-biological, 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 *non-certification*. A *non-certification* is not a decision based solely on the fact that the requested service is specifically excluded under your benefits.

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

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. Examples may include physician assistants (PAs), nurse practitioners (NPs), or certified *registered nurse* anesthetics (CRNAs).

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*.

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 — the maximum amount listed in "Summary of Benefits" that is payable by the *member* in a *benefit period* before the *Plan* pays 100% of *covered services*. It includes *deductible*, *coinsurance*, but excludes premiums.

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

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

PHARMACY BENEFIT MANAGER (PBM) — the company with which the North Carolina *State Health Plan* contracts to manage the *pharmacy* benefit for its *members*.

PLAN — North Carolina *State Health Plan*

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.

PREFERRED PROVIDER ORGANIZATION (PPO) — a type of health insurance arrangement that allows plan participant relative freedom to choose the *doctor*s and *hospital*s they want to visit.

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. Certain services are identified by the *Affordable Care Act* as being "*Preventive Care*" and are covered at 100%. Examples are:

a) Immunizations
b) Medications
c) Screening Services
d) Counseling Services

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

PRIOR AUTHORIZATION — the consideration of benefits for an admission, availability of care, continued stay, or other services, supplies or medications, 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, nonhospital facility, doctor*, *other provider*, or *other professional providers* accredited, licensed or certified where required in the state of practice, performing within the scope of license or *certification.* All services performed must be within the scope of license or *certification* to be eligible for reimbursement.

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

RESIDENTIAL 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 *substance abuse* 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.

RESPITE CARE — services provided by an alternate caregiver or facility to allow the primary caregiver time away from those activities. *Respite care* is provided in-home or at an alternative location for a short stay. Services include support of activities of daily living such as feeding, dressing, bathing, routine administration of medicines, and can also include intermittent skilled nursing services that the caregiver has been trained to provide.

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.

- 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

- 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
- Speech therapy — treatment for the restoration of speech impaired by disease, *surgery*, or injury; or certain significant physical *congenital* conditions such as cleft lip and palate; or swallowing disorders related to a specific illness or injury

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

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

SPECIALTY MEDICATION — Specialty and *biosimilar* medications are designated and classified by the *Plan* as medications that meet the following criteria. 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. *Specialty medication*s are listed on the *Specialty Medication* List, which is located on the *Plan's* website at www.shpnc.org.

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.

SUBSTANCE ABUSE — 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.

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

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

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

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

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

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

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

WELLNESS PREMIUM CREDITS — the amount you save on your premium by completing *Wellness Activities* during enrollment.

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* 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 Regarding Wellness Premium Credits

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

Notice of Privacy Practices

Original *Effective Date*: April 14th, 2003

Revised *Effective Date*: September 23rd, 2013

Revised *Effective Date*: January 22nd, 2018

Your Information. Your Rights. Our Responsibilities.

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.

A federal law, the Health Insurance Portability and Accountability Act (HIPAA), requires that we protect the privacy of identifiable health information that is created or received by or on behalf of the Plan. This notice describes the obligations of the Plan under HIPAA, how medical information about you may be used and disclosed, your rights under the privacy provisions of HIPAA, and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information if we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services or sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan

- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information (including medical records, billing records, and any other records used to make decisions regarding your health care benefits) for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except: (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.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.

- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: The Plan may disclose your health information so that your doctors, pharmacies, hospitals, and other health care providers may provide you with medical treatment.

Run our organization

We can use and disclose your information to run our organization (healthcare operations), improve the quality of care we provide, reduce healthcare costs, and contact you when necessary.

Example: The Plan may use and disclose your information to determine the budget for the following year, or to set premiums.

We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with CVS Caremark to coordinate payment for your prescriptions.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your employer's Health Benefit Representative is provided information to help you understand your health benefits, and help make sure you are enrolled..

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications

- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research. Research done using Plan information must go through a special review process. We will not use or disclose your information unless we have your authorization, or we have determined that your privacy is protected.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Other uses and Disclosures

Some uses and disclosures of your will be made only with your written authorization. For example, your written 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.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

The Plan has the right to change this notice at any time. The Plan also has the right to make the revised or changed notice effective for medical information the Plan already has 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 919-814-4400.

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. You will not be penalized or retaliated against for filing a complaint.

To file a complaint with the Plan, contact the Privacy Contact identified in this Notice.

To file a complaint with the Secretary of the Department of Health and Human Services Office for Civil rights use this contact information:

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

Privacy Contact

The Privacy Contact at the Plan is:
State Health Plan
Attention: HIPAA Privacy Officer
3200 Atlantic Avenue Raleigh, NC 27604
919-814-4400

Effective date

This notice is effective as of January 20, 2018.

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 اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. 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 ភាសាម៉ែន, សេវាជំនួយម៉ែនភាសា 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: ຖ ້າ ອ ່ າ ທ ່ ານ ເ ວ ົ ້ າ ພ າ ສ າ ລ າ ວ, ກ ານ ບ ໍ ລ ິ ການ ຊ ່ ວ ຍ ເ ຫ ຼ ືອ ດ ້ ານ ພ າ ສ າ, ໂ ດ ຍ ບ ໍ ່ ເ ສ ັ ຽ ຄ ່ າ, ແ ມ ່ ນ ມ ີ ພ ້ ອ ມ ໃ ຫ ້ ທ ່ ານ. ໂ ທ ຣ 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.

Notice of Grandfather Status

The State Health Plan believes the 70/30 Plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Customer Service at **888-234-2416**. You may also contact the U.S. Department of Health and Human Services at **www.healthcare.gov**. As a plan “grandfathered” under the Affordable Care Act, cost sharing for preventive benefits may continue as it does currently and be based on the location where the service is provided.