

North Carolina
State Health Plan

Teachers' and State Employees' Comprehensive Major Medical Plan

North Carolina State Health Plan
Benefits Booklet
for Your
NC *SmartChoice* Standard^{SM1}
Blue OptionsSM PPO Plan



**BlueCross BlueShield
of North Carolina**

Blue Cross and Blue Shield of North Carolina is an independent
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North Carolina
HEALTH
Smart

www.shpnc.org

North Carolina
State Health Plan
Teachers' and State Employees' Comprehensive Major Medical Plan

Dear Member,

The North Carolina State Health Plan is pleased that you have chosen **North Carolina SmartChoice**, a Blue Cross and Blue Shield of North Carolina Blue Options product made available by the North Carolina State Health Plan. To assist you in understanding your health care benefits, we have created the North Carolina *SmartChoice* Blue Options Benefit Booklet. Think of it as your personal member guide with everything you need to know at your fingertips.

The **North Carolina SmartChoice** Blue Options Benefit Booklet will guide you through your plan information with ease. To help you locate what you need quickly, we've divided the book into the following sections:

- Quick Reference – easy access to the information that's most frequently needed.
- PPO Benefits – detailed information about your health benefit plan.
- NC Health*Smart* – information on wellness, disease prevention and chronic illness management.
- Blue ExtrasSM – information about discounts on certain non-covered services such as laser eye surgery and hearing aids.
- Privacy Notice – describes how medical information about you may be used and disclosed and how you can get access to this information.

For your convenience, we have additional ways for you to access your member information. Our web site, www.shpnc.org, offers a variety of health-related resources – including online forms, search tools to help you find a doctor, as well as general information about your plan. Our Customer Service department number is **1-888-234-2416**, if you need assistance.

We are happy to have you as a **North Carolina SmartChoice** Blue Options PPO member.



George C. Stokes
Executive Administrator

Quick Reference - Toll Free Phone Numbers, Web Sites and Addresses

SERVICES AND INFORMATION

State Health Plan Web Site To obtain information on contracting pharmacies, mental health and chemical dependency medical policies, search for a provider, obtain claim forms, obtain "proof of coverage" portability certificates, request ID cards, NC HealthSmart and more.
www.shpnc.org

My Member Services To enroll in a safe and secure customer service web site to: Check claim status, verify benefits and eligibility, change your address or request a new ID card.
www.shpnc.org

State Health Plan Customer Service For questions regarding your benefits, claim inquiries and new ID card requests.
 1-888-234-2416
 8 a.m.-6 p.m., Monday-Friday, except holidays

Medco Customer Service For questions regarding your prescription benefits, to obtain information on Special Care Pharmacy, obtain a preferred drug list, information on prior authorizations, refills, and more.
 1-800-336-5933
 9 a.m.- 9 p.m., Monday - Friday
 9 a.m. - 7:30 p.m., Saturday
 Closed - Sunday

NC HealthSmart For information on wellness, disease prevention and chronic illness management for you and your family.
 For more general information: 1-888-234-2416
 8 a.m -6 p.m., Monday-Friday, except holidays
 To speak with a Health Coach: 1-800-817-7044
 24 hours a day, 7 days a week

BlueCard[®] PPO Program To find a participating provider outside of North Carolina and worldwide.
 1-800-810-2583
 1-804-673-1177 (Outside USA)

PRIOR AUTHORIZATION (CERTIFICATION)

Certification To request prior authorization (certification) for certain out-of-network or out-of-state services.
 1-800-214-4844

Mental Health Case Manager: For mental health and substance abuse precertification.
 Value Options
 1-800-367-6143

CLAIMS FILING

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

Prescription Drug Claims Filing Mail completed prescription drug claim forms to:
 Medco
 PO Box 14711
 Lexington, KY 40512

APPEALS

Medical and Pharmacy Appeals See "Appeals Correspondence" in "What If You Disagree With A Decision?"
 1-800-672-7897 (in USA for inquiries)
 1-919-765-4409 FAX

Mental Health Appeals See "Appeals Correspondence" in "What If You Disagree With A Decision?"
 1-800-367-6143

North Carolina
HEALTHSmart

NC HealthSmart Customer Service
1-888-234-2416
8 a.m.-6 p.m., Monday - Friday, except holidays
NC HealthSmart Health Coach
1-800-817-7044
24-hours a day, 7 days a week

For information on wellness, disease prevention, and chronic illness management for you and your family. "Tools for better health."
www.shpnc.org click on NC HealthSmart

BCBSNC Blue Extras

AltMedBlueSM Customer Service
1-888-336-2583 or **bcbsnc.com**
8 a.m.-5 p.m., Monday - Friday, except holidays

For information about discounts on alternative medicine services and a practitioner directory.

AudioBlueSM Customer Service
1-877-979-8000 or **bcbsnc.com**
8 a.m.-6 p.m., Monday - Friday, except holidays

For information about discounts on hearing aids.

BluePointsSM Customer Service
1-888-705-7050 or **bcbsnc.com**
8 a.m.-6 p.m., Monday - Friday, except holidays

For information about the physical activity incentive program.

BluePointsSM for Kids Customer Service
1-888-705-7050 or **bcbsnc.com**
8 a.m.-6 p.m., Monday - Friday, except holidays

For information about the physical activity incentive program for kids ages 6-12.

CosmeticDentistryBlueSM Customer Service
1-877-269-1097 or **bcbsnc.com**
8 a.m.-5 p.m., Monday - Friday, except holidays

For information about discounts on cosmetic dentistry services and a practitioner directory.

CosmeticSurgeryBlueSM Customer Service
1-877-755-1111 or **bcbsnc.com**
24-hour pre-recorded information line

For information and discounts on cosmetic surgery.

OpticBlueSM Customer Service
1-800-755-0507 or **bcbsnc.com**
8 a.m.-6 p.m., Monday - Friday, except holidays

For information about discounts on corrective laser eye surgery.

VitaBlueSM Customer Service
1-888-234-2413 or **bcbsnc.com**
9 a.m.-5 p.m., Monday - Friday, except holidays

For information about discounts on vitamins, minerals and herbal supplements.

Tips for Getting the Most Out of Your Health Care Benefits

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 drugs

Remind your physician to prescribe generic drugs that provide the same benefit as the brand name counterpart whenever possible. In many cases you will pay a lower drug copayment — sometimes two to three times lower!

Pick a primary care physician

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

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 web site (www.shpnc.org), toll free Customer Service lines (1-888-234-2416), and your *NC SmartChoice* benefit booklet.

Take charge of your health

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

- Health Coaches — 24 hours a day, 7 days a week provides support on a variety of conditions
- WebMD[®] — Find information on treatment options, prevention tips, lifestyle changes and healthy living and the tools to make the information work for your life
- Worksite Wellness Programs — Wellness choices at work! Stay healthy at home and at work.

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 benefit booklet, benefit summary and directory of in-network providers
- Receive courteous service from the State Health Plan and its representatives
- Receive considerate and respectful care from your in-network providers
- Receive the reasons for the denial of a requested treatment or health care service, including (upon request) an explanation of the Utilization Management criteria and treatment protocol used to reach the decision
- Receive (upon request) information on the procedure and medical criteria used to determine whether a procedure, treatment, facility, equipment, drug or device is investigational, experimental or requires prior approval
- Receive accurate, reader friendly information to help you make informed decisions about your health care
- Participate actively in all decisions related to your health care
- Discuss all treatment options candidly with your health care provider regardless of cost or benefit coverage
- 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 benefit booklet and all other member materials
- Call State Health Plan Customer Services if you have a question or do not understand the material provided by them
- Follow the course of treatment prescribed by your doctor. If you choose not to comply, tell your doctor.
- Provide complete information about any illness, accident or health care issues to the State Health Plan or its representatives and providers
- Make and keep appointments for non-emergency medical care. If it is necessary to cancel an appointment, give the doctor's office adequate notice.
- Ensure any advance certifications have been received for out-of-network services (see "Prospective Reviews" section for information on certifications)
- File claims for out-of-network services in a complete and timely manner
- Participate in understanding your health problems and the medical decisions regarding your health care
- Be considerate and courteous to Blue Options providers, their staff and State Health Plan representatives
- Notify your employer and the State Health Plan if you have any other group coverage
- Notify your employer and the State Health Plan of any changes regarding dependents and marital status as soon as possible
- Use My Member Services 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.

PPO STANDARD PLAN SUMMARY OF BENEFITS

The following is a summary of your *PPO* Standard Plan benefits. A more complete description of your benefits is found in "*Covered Services*." General exclusions may also apply. Please see "What Is Not Covered?"

- The *copayment* amounts are fixed dollar amounts the *member* must pay for some *covered* services
- Multiple *office visits* or *emergency* room visits on the same day may result in multiple *copayments*
- *Coinsurance* percentages shown in this section are the portion of the *allowed amount* that you pay
- *Deductible* and *coinsurance* amounts are based on the *allowed amount*
- Services applied to the *deductible* also count toward any visit or day maximums
- To receive *in-network* benefits, you must receive care from a Blue Options *in-network provider*. **However, in an emergency, or when *in-network providers* are not reasonably available as determined by BCBSNC's access to care standards, you may also receive *in-network* benefits for care from an *out-of-network provider*.** Please see "*Out-Of-Network Benefits*" and "*Emergency And Urgent Care Services*" for additional information on *emergency* care. Access to care standards are available on our web site at www.shpnc.org or by calling the State Health Plan Customer Services number given in "Whom Do I Call?"
- If you see an *out-of-network provider*, you will receive *out-of-network* benefits unless otherwise approved by the *State Health Plan* or its representative.

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

PPO STANDARD PLAN SUMMARY OF BENEFITS

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

	<i>In-Network</i>	<i>Out-of-Network*</i>
Physician Office Services		
See <i>Outpatient Services</i> for <i>outpatient clinic</i> or <i>hospital</i> -based services. <i>Office visits</i> for the evaluation and treatment of obesity are limited to a combined in- and <i>out-of-network</i> maximum of four visits per <i>benefit period</i> . Nutritional counseling for diabetes management is limited to six visits per <i>benefit period</i> .		
Office Services		
<i>Primary Care Provider</i>	\$20 <i>copayment</i>	40% after <i>deductible</i>
<i>Specialist</i>	\$40 <i>copayment</i>	40% after <i>deductible</i>
Includes office <i>surgery</i> , x-rays and lab tests. For MRIs, MRAs, CT scans and PET scans, see <i>Outpatient Diagnostic Services</i> .		
CT Scans, MRI's, MRA's, and PET Scans	20% after deductible	40% after deductible
Preventive Care		
<i>Primary Care Provider</i>	\$20 <i>copayment</i>	Benefits not available¹
<i>Specialist</i>	\$40 <i>copayment</i>	Benefits not available¹
Includes routine physical exams, well baby, well child care, and immunizations.		
The following preventive care benefits are available both in- and out-of-network: gynecological exams, cervical cancer screening, ovarian cancer screening, screening mammograms, colorectal screening, and prostate specific antigen tests. See "Covered Services."		
Short-Term Rehabilitative Therapies	\$40 <i>copayment</i>	40% after <i>deductible</i>
Limited to rehabilitative speech, physical, and occupational therapy.		
Chiropractic Services	\$40 <i>copayment</i>	40% after <i>deductible</i>
Combined in- and <i>out-of-network benefit period maximum</i> of 30 visits per <i>benefit period</i> .		
Other Therapies	100%	40% after <i>deductible</i>
Includes chemotherapy, dialysis and cardiac rehabilitation provided in the office. See <i>Outpatient Services</i> for <i>other therapies</i> provided in an <i>outpatient</i> setting.		
Infertility and Sexual Dysfunction Services		
<i>Primary Care Provider</i>	\$20 <i>copayment</i>	40% after <i>deductible</i>
<i>Specialist</i>	\$40 <i>copayment</i>	40% after <i>deductible</i>
Combined in and <i>out-of-network lifetime maximum</i> of \$5,000 per <i>member</i> , provided in all places of service.		
Routine Eye Exam	\$20 <i>copayment</i>	Benefits not available
Routine Hearing Evaluation Test:		
<i>Primary Care Provider</i>	\$20 <i>copayment</i>	Benefits not available
<i>Specialist</i>	\$40 <i>copayment</i>	Benefits not available

*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 approval in advance. You are responsible for obtaining or having your *provider* obtain prior plan approval on your behalf if you go to an *out-of-network*, or out-of-state *provider*, or for mental health and chemical dependency visits 27 and beyond. Failure to obtain prior plan approval could result in partial or full denial of benefits.

PPO STANDARD PLAN SUMMARY OF BENEFITS

	<i>In-Network</i>	<i>Out-of-Network</i>
<u>Urgent Care Centers and Emergency Room</u>		
Urgent Care Centers	\$50 copayment	\$50 copayment
Emergency Room Visit	\$200 copayment, then 20% after deductible	\$200 copayment, then 20% after deductible
<p>If admitted to the <i>hospital</i> from the <i>emergency room</i>, <i>inpatient hospital</i> benefits apply to all covered services provided, and the <i>emergency room copayment</i> is waived. If held for observation, <i>outpatient</i> benefits apply to all covered services provided. If you are sent to the <i>emergency room</i> from an <i>Urgent Care Center</i>, you may be responsible for both the <i>emergency room copayment</i> and the <i>urgent care copayment</i>.</p>		
<u>Ambulatory Surgical Center</u>	20% after deductible	40% after deductible
<u>Outpatient Services</u>		
Physician Services	20% after deductible	40% after deductible
Hospital and Hospital Based Services	20% after deductible	40% after deductible
Outpatient Clinic Services	20% after deductible	40% after deductible
Outpatient Diagnostic Services:		
<i>Outpatient</i> lab tests and mammography, when performed alone	Covered at 100%	40% after deductible
<i>Outpatient</i> lab tests and mammography, when performed with another service	20% after deductible	40% after deductible
<i>Outpatient</i> x-rays, ultrasounds, and other diagnostic tests, such as EEGs, EKGs and pulmonary function tests	20% after deductible	40% after deductible
CT scans, MRIs, MRAs and PET scans received in any location, including in a physician's office	20% after deductible	40% after deductible
Therapy Services	20% after deductible	40% after deductible
<p>Includes <i>short-term rehabilitative therapies</i> and <i>other therapies</i>. See Physician Office Services for visit maximums.</p>		
<u>Inpatient Hospital Services</u>		
Physician Services	20% after deductible	40% after deductible
Hospital and Hospital based Services	\$150 copayment, then 20% after deductible	\$150 copayment, then 40% after deductible
<p>Includes maternity delivery, prenatal and post-delivery care. For <i>inpatient</i> mental health and chemical dependency services, refer to the "Mental Health And Chemical Dependency Services" section later in this summary.</p>		
<u>Skilled Nursing Facility</u>	20% after deductible	40% after deductible
<p>Combined in- and <i>out-of-network</i> maximum of 100 days per <i>benefit period</i>. Services applied to the <i>deductible</i> count towards this day maximum.</p>		

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PPO STANDARD PLAN SUMMARY OF BENEFITS

	<i>In-Network</i>	<i>Out-of-Network</i>
<u>Other Services</u>	20% after <i>deductible</i>	40% after <i>deductible</i>
Includes <i>ambulance, durable medical equipment, hospice services, medical supplies, orthotic devices</i> — Orthotic devices for correction of <i>positional plagiocephaly</i> limited to a <i>lifetime maximum</i> of \$600- <i>prosthetic appliances, and home health care.</i>		
<u>Private Duty Nursing</u>	20% after <i>deductible</i>	40% after <i>deductible</i>
There is a 4 hour per day limit on private duty nursing care for non-ventilated patients and a 12 hour per day limit on private duty nursing for ventilated patients.		

Lifetime Maximum, Deductible, and Coinsurance Maximum

The following *deductibles* and maximums apply to the services listed above in the "Summary Of Benefits" unless otherwise noted.

<u>Lifetime Maximum</u>	Unlimited	Unlimited
Unlimited for all services, except orthotic devices for <i>positional plagiocephaly, infertility and sexual dysfunction</i> and chemical dependency treatment, and where otherwise specifically excluded.		

Deductible

Individual, per <i>benefit period</i>	\$300	\$600
Family, per <i>benefit period</i>	\$900	\$1800

Charges for the following do not apply to the *benefit period deductible*:

- *Office visit copayments, emergency room copayments and inpatient admissions copayments.*
- *Inpatient newborn care for well-baby*
- *Prescription drugs*

Coinsurance Maximum

Individual, per <i>benefit period</i>	\$1,750	\$3,500
Family, per <i>benefit period</i>	\$5,250	\$10,500

Charges for the following do not apply to the *benefit period coinsurance maximum*:

- *Prescription drugs*
 - *Deductible*
 - *Office visit copayments*
 - *Emergency room copayments*
 - *Inpatient admission copayments*
-

Penalty for Failure to Obtain Certification

Certain services require *prior review and certification* by the *State Health Plan* in order to receive benefits. You are responsible for obtaining *certification* for mental health and chemical dependency for *office visits* beyond the 26th visit. For all other *in-network* services provided in North Carolina, your *provider* will request *prior review* when necessary. **If you go to an *out-of-network provider* in North Carolina or any *provider outside of North Carolina*, you are responsible for requesting or ensuring that your *provider* requests *prior review* by the *State Health Plan*. Failure to request *prior review* and receive *certification* may result in allowed charges being reduced by 25% or a full denial of benefits. *Certification* is not a guarantee of payment. See "*Covered Services*" and "*Prospective Review/Prior Review*" in "*Utilization Management*."**

*The following notice applies only when you are responsible for obtaining *certification*. NOTICE: Your actual expenses for *covered services* may exceed the stated *coinsurance* percentage or *copayment* amount because actual *provider* charges may not be used to determine the plan's and *member's* payment obligations. For *out-of-network* benefits, you may be required to pay for charges over the *allowed amount* in addition to any *copayment* or *coinsurance amount*. In addition, certain services require prior approval in advance. You are responsible for obtaining or having your *provider* obtain prior plan approval on your behalf if you go to an *out-of-network, or out-of-state provider, or for mental health and chemical dependency visits 27 and beyond*. Failure to obtain prior plan approval could result in partial or full denial of benefits.

PPO STANDARD PLAN SUMMARY OF BENEFITS

In-Network

Out-of-Network

Mental Health And Chemical Dependency Services

Mental Health/Chemical Dependency Office Services

\$40 copayment

40%

First 26 combined mental health and chemical dependency visits each *benefit period* do not require *prior review* by the *Mental Health Case Manager*. (The first 26 visits can include 6 preventive visits per *benefit period*.) For visits 27 and beyond each *benefit period* it is your responsibility to obtain prior approval from the *Mental Health Case Manager*. Medication checks do not require prior approval.

Mental Health/Chemical Dependency Outpatient Services

20% after deductible

40% after deductible

Mental Health/Chemical Dependency Inpatient Services

\$150 copayment, then 20% after deductible

\$150 copayment, then 40% after deductible

\$150 copayment, then 20% after deductible

\$150 copayment, then 40% after deductible

Residential Treatment Centers

Requires *certification* and *prior review* in advance by the *Mental Health Case Manager*, and must be an approved residential treatment center.

Prescription Drugs

Prescription drug benefits are administered by Medco. See "*Prescription Drug Copayment And Benefits*" in "*Covered Services*" for more information. Diabetic supplies are covered under the pharmacy benefit but once limits have been met, supplies are then covered under the medical supply benefit. Contact Medco at the number given in "Whom Do I Call?"

	0-34 Days Supply	35-68 Days Supply	69-102 Days Supply
Generic	\$10	\$20	\$30
Preferred Brand (without <i>generic</i> available)	\$30	\$60	\$90
Preferred Brand (with <i>generic</i> available)	\$40	\$80	\$120
Non-Preferred Brand	\$50	\$100	\$150
Diabetic Testing Supplies			
Preferred brand	\$10	\$20	\$30
Non-preferred brand	\$25	\$50	\$75

Prescription drug 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 drug* charges.

For *certification* for certain *prescription drugs*, your physician may call Medco at 1-800-753-2851 to initiate a *certification* request, or obtain a *certification* review form on the State Health Plan's web site and fax it directly to Medco at the number listed on the form.

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NC SMARTCHOICE BLUE OPTIONS PPO PLAN

NC SMARTCHOICE BLUE OPTIONS PPO PLAN

Welcome to the North Carolina *State Health Plan's NC SmartChoice* Blue Options PPO plan, also referred to in this benefit 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 Blue Shield of North Carolina (BCBSNC)*.

The *State Health Plan* has contracted with *BCBSNC* to use its Blue Options network. As a *member* of the *PPO* plan, you will enjoy quality health care from the Blue Options network of healthcare *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. You may receive, upon request, information about your health benefit plan, its services and *doctors*, including this benefit booklet with a benefit summary, and a directory of *in-network providers*.

How To Use Your NC SmartChoice Blue Options PPO Plan Benefit Booklet

This benefit booklet provides important information on benefits and the procedures necessary to receive them. Please read it carefully.

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
- "Utilization Management" for important information on when *prior review* and *certification* are required
- "What Is Not Covered?" to see general exclusions from coverage.

As you read this benefit booklet, keep in mind that any word you see in **italics (*italics*) is a defined term** and will appear in "Definitions" at the end of this benefit booklet.

If you still have questions, you can call Customer Services at the number given in "Whom Do I Call?" and get further information.

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

- "How The *PPO* Plan Works" explains the coverage levels available to you
- "When Coverage Begins And Ends" tells you, among other things, how and when to enroll in your health benefit plan
- "What If You Disagree With A Decision?" explains the rights available to you when the *State Health Plan* or its representative makes a decision and you do not agree.

Aviso Para Miembros Que No Hablan Ingles

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

Notice For Members Not Conversant In English

This benefit 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 Services to obtain assistance.

WHOM DO I CALL?

WHOM DO I CALL?

State Health Plan Web Site

To get general health benefit plan information, search for a *provider*, obtain information on contracting pharmacies, NC HealthSmart, mental health and chemical dependency, medical policies and more, visit the *State Health Plan* web site at: www.shpnc.org

North Carolina HealthSmart

For information on wellness, disease prevention and chronic illness management for you and your family.

NC HealthSmart Information. 1-888-234-2416

NC HealthSmart Health Coach 1-800-817-7044

My Member Services

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

State Health Plan Customer Services

For questions relating to your benefits, claims inquiries, new *ID card* requests, or general questions call:

State Health Plan Customer Services. 1-888-234-2416

Mental Health And Chemical Dependency Services

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

ValueOptions. 1-800-367-6143

Pharmacy Benefit Manager

The current *Pharmacy Benefit Manager (PBM)* is:

Medco. 1-800-336-5933

Out Of North Carolina Care

For assistance in obtaining care outside of North Carolina, including outside of the U.S., visit the national BCBS web site at www.bcbs.com or call:

BlueCard™ PPO Program. 1-800-810-2583

BlueCard™ (outside USA) 1-804-673-1177

Prior Review

Some services require *prior review* and *certification* by the *State Health Plan* or its representative. The list of these services may change from time to time. Please visit our web site at www.shpnc.org or call *State Health Plan* Customer Services at the number given above for current information about which services require *prior review*. See “Prospective Review/Prior Review” in “Utilization Management” for information about the review process. To request *prior review*, call:

Prior Review (Certification) 1-800-422-1582

HOW THE PPO PLAN WORKS

HOW THE PPO PLAN WORKS

The PPO Plan gives you the freedom to choose any *provider* — the main difference will be the cost to you.

The Role Of A Primary Care Provider (PCP)

A *Primary Care Provider (PCP)* can help you manage your health and make decisions about your health care needs. It is important for you to maintain a relationship with a *PCP*. If you change *PCPs*, be sure to have your medical records transferred, especially immunization records, to provide your new *doctor* with your medical history. You may participate actively in all decisions related to your health care and discuss all treatment options with your health care *provider* regardless of cost or benefit coverage. *PCPs* are trained to deal with a broad range of health care issues and can help you to determine when you need a *specialist*.

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

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

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* web site at www.shpnc.org or call *State Health Plan* Customer Services 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 Services at the number in "Whom Do I Call?" 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 review* when necessary. You may want to check with your *in-network provider* to make sure that *prior review* has been requested. Your *in-network provider* is required to use the Blue Options network *hospital* where he/she practices, unless that *hospital* cannot provide the services you need. *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. *In-network providers* include:

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

You do not need a referral to see a Blue Options *provider*. To see which *providers* are available *in-network*, please refer to a Blue Options *provider* directory, Find A *Doctor*, on our web site at www.shpnc.org or call *State Health Plan* Customer Services at the number given in "Whom Do I Call?" **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 review*.

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 *coinsurance maximums*.

HOW THE PPO PLAN WORKS

Out-Of-Network Benefits

With the PPO Plan, you may choose to receive *covered services* from an *out-of-network provider* and benefits will be paid at the lower *out-of-network* level. However, if the condition is an *emergency*, or if *in-network providers* are not reasonably available to the *member* as determined by *BCBSNC's* access to care standards, benefits will be paid at the *in-network* benefit level. For more information on *BCBSNC's* access to care standards, see the *State Health Plan* web site at www.shpnc.org or call Customer Services at the number given in "Whom Do I Call?" 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 Services before receiving care from an *out-of-network provider*. See the number for "Prior Review (Certification)" in "Whom Do I Call?"

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 review* 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 review* by the *State Health Plan* or its representative. Failure to request *prior review* and obtain *certification* may result in a partial or 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 Review" in "Utilization Management" for additional information.

* Note: Some services may not be covered *out-of-network*. See "Summary Of Benefits" and "Covered Services." For *out-of-network* benefits, you may be required to pay for charges over the *allowed amount*, in addition to any *copayment* or *coinsurance* amount. For *emergencies* or if *in-network providers* are not reasonably available as determined by *BCBSNC's* access to care standards, you may receive *in-network* benefits for care from an *out-of-network provider*. See "Out-Of-Network Benefits" and "Emergency And Urgent Care Services." Access to care standards are available on our web site at www.shpnc.org or by calling the *State Health Plan* Customer services at the number given in "Whom Do I Call?" Also see "Mental Health And Chemical Dependency Services" for additional information on *prior review* and *certification* requirements for these services.

How To File A Claim

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

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

For your *prescription drugs*:
Medco
PO Box 14711
Lexington, KY 40512

Mail claims in time to be received within 18 months of the date the service was provided. Claims not received within 18 months from the service date will not be covered, except in the absence of legal capacity of the *member*. You may obtain a claim form, including international claim forms, by visiting the *State Health Plan* web site at www.shpnc.org or calling *State Health Plan* Customer Services at the number listed in "Whom Do I Call?" For help filing a claim, call *State Health Plan* Customer Services or write to:

State Health Plan
c/o BCBSNC
Attn: Customer Services
PO Box 30085
Durham, NC 27702

HOW THE PPO PLAN WORKS

Identification Card

Your *ID card* identifies you as a *PPO member*. If any information on your *ID card* is incorrect, or if you need additional cards, please visit our web site at www.shpnc.org or call *State Health Plan* Customer Services at the number listed in "Whom Do I Call?" or on the back of your *ID card*. **Be sure to carry your *ID card* with you at all times and present it each time you seek health care.**

Making An Appointment

Call the *provider's* office and identify yourself as a *Blue Options member*. Please ask the receptionist whether the *provider's* office is *hospital*-owned or operated or provides *hospital*-based services. This may subject your *in-network medical services* to the *Outpatient Services* benefit. Your *provider* directory will also help you make this determination. *Provider* directories are available on-line at our web site or by calling *State Health Plan* Customer Services at the number given in "Whom Do I Call?" If you need nonemergency services after your *provider's* office has closed, please call your *provider's* office for their recorded instructions. If you cannot keep an appointment, call the *provider's* office as soon as possible. Charges for missed appointments, which *providers* may require as part of their routine practice, are not covered.

UNDERSTANDING YOUR SHARE OF THE COST

UNDERSTANDING YOUR SHARE OF THE COST

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

Copayments

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

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

Deductibles

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

The following special rules apply:

- *Copayments* are not credited to the *benefit period deductible*
- These services do not apply to the *benefit period deductible*:
 - Mental Health and Chemical Dependency
 - *Inpatient* newborn care for well baby
 - *Prescription drugs*.
- Amounts applied to your *out-of-network deductible* are credited to your *in-network deductible*
- However, amounts applied to your *in-network deductible* are not credited to your *out-of-network deductible*.

Coinsurance

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

Coinsurance Maximum

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

The following special rules apply:

- Charges for *prescription drugs* do not apply to the *benefit period coinsurance maximum*.
- *Copayments*, *deductibles*, amounts over *allowed amounts* and non-covered services are not included in the *coinsurance maximum*.
- Amounts applied to your *out-of-network coinsurance* are credited to your *in-network coinsurance maximum*; however
- Amounts applied to your *in-network coinsurance* are not credited to your *out-of-network coinsurance maximum*.
- For *out-of-network* services, *members* are responsible for the difference between the *allowed amount* and the total billed amount even after the *coinsurance maximum* has been met, except for *emergency* room services.

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 Services at the number listed in "Whom Do I Call?"

Also keep in mind as you read this section:

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

Office Services

Care you receive from a *doctor*, physician 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 benefit booklet. Some *providers* may receive items such as supplies or drugs from third parties. In these cases, you may be billed directly by the supplier. Benefit payments for these services will be based on the type of supplier and how the services are billed.

Some *doctors* or *other providers* may practice in *outpatient clinics* or provide *hospital*-based services in their offices. In these cases, services may be subject to the *Outpatient Services* benefit. See *Outpatient Clinic Services* in the "Summary Of Benefits." These *providers* are identified in the *provider* directory, which is available on our web site at www.shpnc.org or by calling *State Health Plan* Customer Services at the number in "Whom Do I Call?"

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

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

Office Services Exclusion

Services not covered when billed as an office service include:

- Services in free-standing surgical facilities, independent laboratories, therapy facilities or *outpatient hospital* departments
- Certain self-injectable *prescription drugs* that can be self-administered. The list of these excluded drugs may change from time to time. See our web site at www.shpnc.org or call *State Health Plan* Customer Services for a list of these drugs excluded in the office. Also see "Prescription Drug Benefits" for information about purchasing *prescription drugs* at the pharmacy.

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 received with any

COVERED SERVICES

other service or 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.

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 review* and *certification* or services will not be covered.

Bone Mass Measurement Services

Your health benefit plan covers one scientifically proven and approved bone mass measurement for the diagnosis and evaluation of osteoporosis or low bone mass during any 23 month period for certain qualified individuals only. Additional follow-up bone mass measurement tests will be covered if *medically necessary*. Qualified individuals include *members* who have any one of the following conditions:

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

See *Outpatient* Services in the "Summary Of Benefits."

Emergency And Urgent Care Services

Emergency Care

In the case of an *emergency*, your health benefit plan provides benefits for *emergency services*.

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

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

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

What To Do In An Emergency

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

If you go to an *emergency* room for treatment of an *emergency*, your benefit level will be the same, regardless of whether you use an *in-network* or *out-of-network* provider. However, when you receive services from an *out-of-network* provider you may be required to pay the entire bill at the time of service, and file a claim with the *State Health Plan*. In these situations, you will be reimbursed the billed amount minus the applicable *copayment* or *coinsurance*. If you are admitted to the *hospital* from the *emergency* room, *inpatient* *hospital* benefits apply to all *covered services* provided. Non-emergency services

COVERED SERVICES

provided in an *emergency* room will be covered as an *outpatient* service instead of an *emergency* room service.

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

Care Following *Emergency Services*

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

Urgent Care

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

What To Do When You Need *Urgent Care*

When you need *urgent care*, you may call your *PCP*, a *specialist* or go to an *urgent care provider*.

Family Planning

Maternity Care

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

Delivery

Your health benefit plan covers an *inpatient hospital* stay for you and your newborn for 48 hours for a vaginal delivery or 96 hours for a cesarean section, without *prior review* by the *State Health Plan*.

However, the *State Health Plan* may pay for a shorter stay if the attending *provider* (e.g., your *doctor* or nurse midwife), after consultation with the mother, discharges the mother or newborn earlier. If the mother chooses a shorter stay, coverage is available for a *home health* visit for post-delivery follow-up care if received within 72 hours of discharge. In order to avoid penalty, *prior review* and *certification* are required for *inpatient* stays extending beyond 48 hours following vaginal delivery or 96 hours following cesarean section.

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

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

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

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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 Services* at the number given in "Whom Do I Call?"

Termination Of Pregnancy (Abortion)

Benefits for abortion, whether therapeutic or elective, are available through the first 16 weeks of a pregnancy for all female *subscribers* and enrolled *spouses* of *subscribers*.

Complications Of Pregnancy

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

Newborn Care

Inpatient newborn care of a well baby 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 (well baby) requires only one admission *copayment* and *benefit period deductible* for both mother and baby. Benefits also include 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* (sick baby) 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 their individual *benefit period deductible* if applicable and *prior review* and *certification* are required to avoid a penalty.

Infertility And Sexual Dysfunction Services

Benefits are provided for certain services related to the diagnosis, treatment and correction of any underlying causes of *infertility* and *sexual dysfunction* for all *subscribers* and enrolled *spouses* of *subscribers*. Refer to "Summary Of Benefits" for limitations that may apply.

Sterilization

This benefit is covered for all *members*. Sterilization includes female tubal ligation and male vasectomy. *Prescription drugs* related to male or female *sexual dysfunction* are not covered except when *medically necessary*. See *Prescription Drug Exclusions*.

Contraceptive Drugs And Devices

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

Family Planning Exclusions

- Artificial means of conception, including, but not limited to, artificial insemination, invitro fertilization (IVF), ovum or embryo placement, intracytoplasmic sperm insemination (ICSI), and gamete intrafallopian tube placement (GIFT) and associated services
- Donor eggs and sperm
- Surrogate mothers
- Care or treatment of the following:
 - Maternity for *dependent children*
 - Termination of pregnancy for *dependent children*
 - *Infertility* and *sexual dysfunction* services for *dependent children*
 - Reversal of sterilization.
- Elective abortions after 16 weeks of a pregnancy
- 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.

COVERED SERVICES

Facility Services

Outpatient Services

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

The following are *covered services*:

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

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

Inpatient Hospital Services

Your health benefit plan provides coverage when you are admitted to a *hospital* as an *inpatient*. If you are admitted before the *effective date*, benefits will not be available for services received prior to the *effective date*. If you are in the *hospital* as an *inpatient* at the time you begin a new *benefit period*, you may have to meet a new *deductible* for *covered services* from *doctors* or *other professional providers*. You should work with your *doctor* to make sure *prior review* has been requested. *Certification* must be obtained in advance from the *State Health Plan* or its representative to avoid a penalty.

The following are *covered services*:

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

Ambulatory Surgical Centers

Benefits are provided for surgical services received in an *ambulatory surgical center*.

The following are *covered services*:

- *Medical care* provided by a *doctor* or *other professional provider*
- General nursing care
- Drugs administered by the facility
- Diagnostic services
- *Medical supplies*
- Use of appliances and equipment ordinarily provided by the facility for the care and treatment of surgical procedures
- Operating, recovery room and related services.

COVERED SERVICES

Skilled Nursing Facilities

Your health benefit plan provides benefits for *covered services* received in a *skilled nursing facility*. You should work with your *doctor* to make sure *prior review* has been requested. *Certification* must be obtained in advance from the *State Health Plan* or its representative to avoid a penalty. *Skilled nursing facility services* are limited to a combined *in-network* and *out-of-network* day maximum per *benefit period*. Refer to "Summary Of Benefits."

Other Services

Ambulance Services

Your health benefit plan covers services in a ground *ambulance* traveling:

- From a *member's* home or scene of an accident or *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 your condition. Benefits may also be provided for *ambulance* services from a *hospital* or *skilled nursing facility* to a *member's* home when *medically necessary*. Nonemergency *ambulance* services require *prior review* and *certification* by the *State Health Plan* or its representative or services will not be covered.

Your health benefit 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 your condition and ground transportation is not medically appropriate due to the severity of the illness or the pick-up point is inaccessible by land.

Ambulance Service Exclusion

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

Blood

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

Blood Exclusion

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

Clinical Trials

Your health benefit plan provides benefits for participation in clinical trials phases 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 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* drugs and devices and services that are not for the direct clinical management of the patient.

COVERED SERVICES

Dental Treatment Covered Under Your Medical Benefit

Your health benefit 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 is related to one of the following conditions:

- Accidental injury of the natural teeth, jaw, cheeks, lips, tongue, roof and floor of the mouth
- *Congenital* deformity, including cleft lip and cleft palate
- Disease due to infection or tumor, including tumors, cysts and exostosis
- Temporomandibular joint (TMJ) disease.

When the condition requires surgical correction, the *medical necessity* review of the *surgery* will examine whether or not the condition resulted in functional impairment. Examples of functional impairment include an impairment that affects speech or the ability to eat, or injury to soft tissue of the mouth. Reconstructive *dental services* following accidental injury are only covered when provided within two years of the accident.

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, then benefits are provided for correction of malocclusion if surgical management of the TMJ is *medically necessary*. Please have your *provider* contact the *State Health Plan* or its representative before receiving treatment for TMJ.

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

Dental Treatment Not Covered Under Your Medical Benefit

- Orthodontic braces
- Crowns and bridges
- Extractions
- Injury related to chewing or biting
- No other *dental services* are covered except as specifically stated elsewhere in "*Covered Services*."
- Dentures and dental implants
- Treatment for periodontal disease
- Dental root form implants or root canals

Diabetes Related Services

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

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*. Certain *durable medical equipment* requires *prior review* and *certification* or services will not be covered.

The following are examples of covered *durable medical equipment*:

- Wheel chairs
- Traction equipment
- *Hospital* beds
- Respiratory (inhalation) or suction machines.

Durable Medical Equipment Exclusions

- Appliances 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.

COVERED SERVICES

Home Health Care

Home health care services are covered by the *State Health Plan* when the *member* is *homebound* due to illness or injury. Home health care, including nursing and home infusion, requires *prior review* and *certification* or services will not be covered. Benefits for the following will 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.

Home Health Care Exclusions

- Personal comfort or convenience items
- Dietitian services or meals
- Homemaker services, such as cooking and housekeeping
- Maintenance therapy/*custodial care*
- Services that are provided by a close relative or a member of your household.

Home Infusion Therapy Services

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

The following are *covered services*:

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

Hospice Services

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

The following are *covered services*:

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

COVERED SERVICES

- Bereavement services
- Educational services
- *Home health* aide services, provided by someone other than a professional nurse, which are medical or therapeutic in nature and furnished to a *member* who is receiving covered nursing or therapy services.

Hospice Services Exclusions

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

Medical Supplies

Coverage is provided for *medical supplies* such as ostomy supplies, catheters, oxygen, and diabetic supplies (glucose monitoring strips, lancets, syringes and needles). Select diabetic supplies are covered under your *prescription* drug benefit. Your benefit payments are based on where supplies are received, either as part of your *medical supplies* benefit or your *prescription drug* benefit. See “Summary Of Benefits” and “*Prescription Drug* Benefits.” To obtain *medical supplies/equipment*, please find a *provider* on our web site at www.shpnc.org or call *State Health Plan* Customer Services.

Medical Supplies Exclusion

- *Medical supplies* not ordered by a *doctor* for treatment of a specific diagnosis or procedure.

Orthotic Devices

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

Orthotic Devices Exclusions

- Premolded foot orthotics
- Over-the-counter supportive devices.

Private Duty Nursing

Your health benefit plan provides benefits for private duty services of an *RN* or *LPN*. These services must be ordered by your *doctor* and be *medically necessary*. You should work with your *doctor* to make sure *prior review* 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*, regardless of location of service.

Private Duty Nursing Exclusion

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

Prosthetic Appliances

Your health coverage provides benefits for the purchase, fitting, adjustments, repairs, and replacement of *prosthetic appliances* following permanent loss of a body part. The *prosthetic appliances* must replace all or part of a body part or its function in order to be covered. The type of *prosthetic appliance* will be based on the functional level of the *member*. Benefits include a one-time replacement of eyeglass or contact lenses because of a *prescription* change after cataract *surgery*. Therapeutic contact lenses may be covered when used as a corneal bandage for a medical condition. Certain *prosthetic appliances* require *prior review* and *certification* or services will not be covered.

Prosthetic Appliances Exclusions

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

COVERED SERVICES

Preventive Care

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

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

Routine Physical Examinations

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

Well-Baby And Well-Child Care

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

Immunizations

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

Covered immunizations include the following:

- Diphtheria-Pertussis-Tetanus Toxoid (DPT)
- Polio
- Measles-Mumps-Rubella (MMR)
- Influenza
- Pneumococcal vaccine
- Human papilloma virus
- HiB
- Hepatitis B
- Meningococcal vaccine
- Chicken pox
- Rotavirus
- Shingles

Immunizations Exclusions

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

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

Gynecological Exam, Including Cervical Cancer Screening

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

Ovarian Cancer Screening

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

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

See Physician Office Services or *Outpatient* Services in the "Summary Of Benefits," depending on where services are received.

Screening Mammograms

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

A female *member* is "at risk" if she:

- Has a personal history of breast cancer
- Has a personal history of biopsy-proven benign breast disease

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- Has a mother, sister, or daughter who has or has had breast cancer, or
- Has not given birth before the age of 30.

Benefits may vary depending on where services are received and whether they are received alone. See Physician Office Services or *Outpatient* Diagnostic Services in “Summary Of Benefits.”

Colorectal Screening

Colorectal cancer examinations and laboratory tests for cancer are covered for any symptomatic or nonsymptomatic *member* who is at least 50 years of age, or is less than 50 years of age and at high risk for colorectal cancer. Increased/high risk individuals are those who have a higher potential of developing colon cancer because of a personal or family history of certain intestinal disorders. Some of these procedures are considered *surgery*, such as colonoscopy and sigmoidoscopy, and others are considered lab tests, such as Hemocult screenings. See Physician Office Services, *Ambulatory Surgical Center* or *Outpatient* Services in the “Summary Of Benefits,” depending on where services are received.

Prostate Screening

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

Routine Eye Exams

Benefits are only available *in-network*.

Coverage is provided for routine eye exams only when the *provider* is in the Blue Options network. Let the *doctor* know that you are a Blue Options *member*, and when you arrive for your visit, be sure to show your *ID card*. If you need assistance selecting a *doctor* who is a member of this network, you may visit our web site at www.shpnc.org or call *State Health Plan* Customer Services. See "Summary Of Benefits" for your *copayment* amount.

Your health benefit plan provides coverage for one routine comprehensive eye examination per *benefit period*. Discounts are provided for eyewear and contact lenses at *in-network provider's* offices with dispensaries. A 30% discount is available for eyewear and hard contact lenses and a 15% discount is available for soft contact lenses. Diagnosis and treatment of medical conditions of the eye are not considered to be routine eye exams and are subject to the benefits, limitations and exclusions in the remainder of your health benefit plan.

Routine Eye Exams Exclusions

- Fitting for contact lenses
- Diagnostic services that are not a component of a routine vision examination or are for medical or surgical treatment
- Drugs or medications not administered for the purpose of a visual examination
- Services or supplies received from a *doctor* other than a *member* of the Blue Options network.

Surgical Benefits

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

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

Multiple surgical situations, procedures performed on the same date of service and/or during the same patient encounter, may not be eligible for separate reimbursement. If you go to an *out-of-network provider*, you may be required to pay for charges over the *allowed amount* in addition to any *coinsurance* amount. For information about coverage of multiple surgical procedures, please refer to the Blue Options PPO medical policies,

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which are on our web site at www.shpnc.org, or call *State Health Plan* Customer Services at the number listed in "Whom Do I Call?"

Anesthesia

Your anesthesia benefit includes coverage for general, spinal block anesthetics or monitored regional anesthesia ordered by the attending *doctor* and administered by or under the supervision of a *doctor* other than the attending surgeon or assistant at *surgery*. Your coverage does not provide additional benefits for local anesthetics. The following services are included as part of the anesthesia charge: administration of an anesthetic, drugs, materials, diagnostic laboratory services and monitoring. Separate benefits are not available for related services.

Mastectomy Benefits

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

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

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

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

Therapies

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

Short-Term Rehabilitative Therapies

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

- Occupational therapy and/or physical therapy
- Rehabilitative speech therapy.

Chiropractic Therapy

Benefits are limited to a combined *in-network* and *out-of-network benefit period maximum* for chiropractic services. This visit limit applies in all places of service (e.g., *outpatient*, office and home therapies). Refer to "Summary Of Benefits" for additional information.

Other Therapies

Your health benefit plan covers:

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

Therapy Exclusion

- Cognitive therapy
- Speech therapy for stammering, stuttering, or developmental delay.

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Transplants

Your health benefit plan provides benefits for *transplants*, including *hospital* and professional services for only those *transplant* procedures listed below. Your health benefit plan provides care management for *transplant* services and will help you find a *hospital* or Blue Quality Center for *Transplants* that provides the *transplant* services required. Travel and lodging expenses may be reimbursed, based on guidelines that are available upon request from a *transplant* coordinator. Call *State Health Plan* Customer Services at the number listed in "Whom Do I Call?" to speak with a *transplant* coordinator and to request *prior review*. *Certification* must be obtained in advance for all *transplant*-related services in order to assure coverage of these services.

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

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

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

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

Transplants Exclusions

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

Mental Health And Chemical Dependency Benefits

Your health benefit plan provides benefits for the treatment of *mental illness* and chemical dependency by a *hospital*, *doctor* or *other provider*. Your coverage for *inpatient* and *outpatient* services and office visits beyond 26 visits is coordinated through your *Mental Health Case Manager*. See "*Prior Review* or *Certification*" for more information on *certifications*. See "Summary Of Benefits," and information below.

Office Visit Services

Prior review by your *Mental Health Case Manager* is not required for the first 26 combined mental health and chemical dependency *office visit* services. The following professional services are covered when provided in an office setting:

- Evaluation and diagnosis
- 6 preventive office visits (must be received within the first 26 visits)
- Medication checks (do not count toward your first 26 visits and do not require prior review after 26 visits)
- *Medically necessary* biofeedback and neuropsychological testing
- Individual and family counseling
- Group therapy.

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The following rules apply to mental health and chemical dependency *office visits*:

- Each service provided by a mental health *provider* will count as one visit
- Any mental health or chemical dependency therapy services provided by a non-mental health *provider* during the course of an *office visit* will count as one visit.

Outpatient Services

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

- Each service listed in the section under *office visit* services
- Partial-day/night hospitalization services (minimum of four hours per day and 20 hours per week)
- Intensive therapy services (less than four hours per day and minimum of nine hours per week).

Inpatient Services

Covered *inpatient* treatment services also include:

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

Please note benefits for *inpatient* and *outpatient medical care* are limited to one visit per day.

How To Access Mental Health And Chemical Dependency Services

When you need mental health or chemical dependency treatment, you should call a *Mental Health Case Manager* customer service representative at the number given in "Whom Do I Call?" 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.

Certification for Inpatient and Outpatient Services

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

If you choose to go to an *out-of-network provider* without *certification* for services, or you go to any *provider* outside of North Carolina without obtaining *certification* for services, you may be subject to a 25% penalty off the *allowed amount* prior to the application of any applicable *coinsurance*.

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 situations do not require *certification*. However, you should notify the *Mental Health Case Manager* of your *inpatient* admissions as soon as reasonably possible.

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

Certification for Office Services

The first 26 combined *mental health* and *chemical dependency office visits* in and *out-of-network* per *benefit period* do not require *prior review* and *certification*. *Certification* is required for mental health and chemical dependency *office visits* beyond the 26th visit. You are responsible for keeping track of your first 26 *office visits* per *benefit period*, and seeking *prior review* for all *office visits* after 26 *office visits*. Although the first 26 *office visits* do not require *prior review* and *certification*, services for additional *office visits* will be denied and the *member* will be responsible for the total cost of each visit beyond 26 if *certification* is not obtained. Medication checks are not subject to these requirements.

COVERED SERVICES

You should work with your *doctor* or other professional *provider* to make sure that *certification* has been obtained for *office visits* after the first 26 *office visits* per *benefit period*. Contact the *Mental Health Case Manager* at the number given in "Whom Do I Call?" for *certification*.

Mental Health and Chemical Dependency Services Exclusions And Limitations

- Psychoanalysis
- Counseling with relatives about a patient with *mental illness*, alcoholism, drug addiction or substance abuse
- *Office visits* beyond the first 26 when *prior review* was not obtained
- *Inpatient* confinements that are primarily intended as a change of environment
- Mental health services received in residential treatment facilities beyond age 18. Residential treatment facilities are covered for chemical dependency.
- Benefits for psychiatric diagnostic interview are limited to one per year per *provider*.

Pharmacy Benefits

Prescription Drug Copayment And Benefits

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

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

The *State Health Plan* and the *PBM* will not provide coverage for male and female *sexual dysfunction* drugs and idiopathic short stature drugs. Some *prescription drugs* may require *certification*, also known as *prior approval*, in order to be covered. It is very important to make sure that prior approval is received before going to the pharmacy.

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

For certification of your *prescription drugs*, your physician may call the *PBM* at 1-800-753-2851 to initiate a certification request or obtain a certification review form on the *State Health Plan's* web site and fax it directly to the *PBM* at the number listed on the form.

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* web site, or
- Calling the *PBM* at the number listed in "Whom Do I Call?"

When you use a pharmacy **not contracting with the *PBM***, you will be responsible for paying the total amount of the *prescription* at the time of purchase. You or the pharmacy will be required to file a paper claim with the *PBM* for reimbursement. You may obtain a claim form on the *State Health Plan's* web site 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 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* web site or by calling the *PBM* at the number in "Whom Do I Call?"

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

COVERED SERVICES

Preferred Drug List

The *State Health Plan*, with guidance from the Pharmacy and Therapeutics Committee (P & T Committee), compiles the Preferred Drug List. This committee consists of a group of North Carolina physicians and pharmacists in active practices who assist the *State Health Plan* in carefully reviewing the performance and safety of medications. The Preferred Drug List can be obtained from the *State Health Plan's* web site or by calling the *PBM* at the number listed in "Whom Do I Call?"

- When there is more than one *brand name* drug available for your medical condition, it is suggested that you ask your physician to prescribe a drug on the preferred list. This will reduce your copay.
- *Generic* drugs are often an effective alternative to brand drugs. All *generic* drugs are preferred drugs. Ask your physician to authorize a *generic* substitution whenever a *generic* equivalent is available and appropriate for your medical condition. If a *generic* drug is not available or appropriate for your medical condition, you will be responsible for paying the higher *copayment* based on the tier placement for that drug.

Your *prescription drug* benefit offers an open *formulary* (or a list of covered *prescription drugs*). In the *formulary*, *prescription drugs* are divided into four categories or tiers: *generic* (Tier 1), preferred *brand name drugs* with no *generic* equivalent (Tier 2), preferred *brand name drugs* with a *generic* equivalent (Tier 3) and non-preferred *brand name drugs* (Tier 4). The placement of drugs in the *formulary* determines what *copayment* will be charged for each 34-day supply.

If you would like an updated copy of the *formulary* or you want to check the tier placement of a specific drug, please call the *PBM* at the number listed in "Whom Do I Call?" or visit the *State Health Plan* web site. *Prescription drug 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 drug* charges.

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

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

Prescription Drug Exclusions

- Any *prescription drugs* not FDA approved
- Any *prescription drugs* not specifically covered by the *State Health Plan*
- Any *prescription drugs* prescribed for male or female *sexual dysfunction* unless determined by the *State Health Plan* to be *medically necessary*, *cosmetic* purposes and hair growth
- Any *prescription drugs* prescribed in conjunction with artificial reproductive technology
- Any *prescription drug* in excess of the stated quantity limits
- Any *prescription drug* requiring *certification* if *certification* is not obtained
- Any drug that can be purchased over the counter without a *prescription*, even though a written *prescription* is provided, except for insulin and other approved over-the-counter drugs
- Any compound drug that does not contain at least one ingredient that requires a *prescription*.

Diabetic Testing Supplies

Diabetic testing supplies are covered under your pharmacy benefit. For a single *copayment*, insulin dependent *members* will receive 150 test strips and non-insulin dependent *members* will receive 50 test strips per 34-day supply. Additional test strips that are needed, are covered under your medical supply benefit.

Over-The-Counter Generic Nicotine Replacement Therapy Patches

Coverage is provided for *generic* over-the-counter nicotine replacement therapy patches as part of your pharmacy benefit. Coverage is limited for a 10 week therapy per course per year. A *copayment* of \$5 for each strength of therapy will be required.

Specialty Pharmacy

Specialty medications are injectable products that require special handling and patient monitoring. Some conditions, such as anemia, hepatitis C, multiple sclerosis, growth hormone deficiency and rheumatoid

COVERED SERVICES

arthritis are treated with specialty medications. If you use specialty medications, you may obtain them through the Medco Special Care Pharmacy. For more information call 1-800-803-2523.

A list of the available specialty medications is available on the *State Health Plan's* web site. Some of the Medco Special Care Pharmacy extras include:

- access to nurses who are trained in specialty medications
- answers to your questions about specialty medications from a pharmacist 24 hours a day, 7 days a week
- free expedited shipping
- free supplies necessary to administer your medication (needles, syringes)
- refill reminders.

How To File A Claim For *Prescription Drugs*

When you use a pharmacy contracting with the *PBM*, present your *ID card* to the pharmacist and you will not be required to pay more than the appropriate *copayment* for each 34-day supply. The pharmacist will file the claim.

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

Medco
PO Box 14711
Lexington, KY 40512

If you are sending the original pharmacy receipts, make sure the following information is included:

- pharmacy name
- *prescription* number
- drug name and National Drug Code (NDC)
- date purchased
- strength
- quantity
- drug charge
- pharmacist's signature
- days supply.

Complete a separate form for each family member and pharmacy.

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

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Medicare Part D

IMPORTANT INFORMATION REGARDING YOUR MEDICARE BENEFITS

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

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

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

SPECIAL PROGRAMS

SPECIAL PROGRAMS

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

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

Health Risk Assessment (HRA)	The HRA is a simple and easy-to-complete survey that identifies your personal health risks and provides you with a comprehensive personal action plan. You can complete the HRA online at www.shpnc.org , by logging into your Personal Health Portal, or by calling a health coach at 1-800- 817-7044.
Health Coaches	<p>Health Coaches are specially trained healthcare professionals (nurses, respiratory therapists, and dietitians) who are available by phone 24 hours a day, seven days a week to talk with you. They can discuss a variety of conditions and lifestyle issues such as:</p> <ul style="list-style-type: none"> • Tobacco cessation • Nutritional and weight management • <i>Surgery</i> <p>They can also provide:</p> <ul style="list-style-type: none"> • One-on-one goal setting, monitoring and support to help you increase your physical activity • One-on-one support for managing health conditions such as: <ul style="list-style-type: none"> • Asthma • Coronary Artery Disease • Back pain • Joint pain • Obesity / bariatric <i>surgery</i> • Hypertension • Migraine/other headache • Osteoporosis • End of life issues • Chronic Obstructive Pulmonary Disease (COPD) includes chronic bronchitis and emphysema • Congestive Heart Failure (CHF) • Diabetes • Depression and stress • Acute respiratory conditions • General arthritis • TMJ syndrome • Stroke • Renal failure
Health Education Programs and Tools	<ul style="list-style-type: none"> • The HEAR[®] audio library which provides information on hundreds of health topics. To access the library call 1-800-817-7044 and press 4. • Health videos provided at no charge, as appropriate through your Health Coach • Printed materials mailed to your home
WebMD[®] on the NC HealthSmart web site	<ul style="list-style-type: none"> • HRA and personal action plan • Personal health web page • Symptom diary and medication list • Interactive tools and lifestyle programs for nutrition, physical activity and smoking cessation • Free Internet-based programs designed to provide assistance and support to help you stop smoking, eat smarter, live healthier, as well as offering the "Life Exercise Adherence Program (LEAP)" • E-mail updates and screening reminders

SPECIAL PROGRAMS

Worksite Wellness	<p>The <i>State Health Plan</i> is committed to helping work places develop on-site wellness committees, lifestyle management activities, and "health-friendly" policies. The purpose is to encourage and support <i>members</i> trying to live healthy lifestyles. Eligible worksites include state agencies and boards, universities, community colleges and public schools.</p> <ul style="list-style-type: none"> • Ask if your worksite has a wellness initiative. • Join or start a wellness committee. • Participate in the work-based healthy living programs.
Tobacco Cessation Support	<p>The <i>State Health Plan</i> is committed to helping <i>members</i> quit tobacco. Members may call and talk to a Healthcoach, the North Carolina Quitline and/or their <i>provider</i> about quitting tobacco. There is a \$5 <i>copayment</i> on over the counter <i>generic</i> nicotine patches; however, if a member gets counseling from the Quitline or their <i>provider</i> the \$5 <i>copayment</i> can be waived. Additional details of the benefit and resources are listed below in the Tobacco Cessation Section.</p>

In order to participate in NC HealthSmart, the *State Health Plan* must be your primary health benefit plan. *Members* who have COBRA or who are Medicare *retirees* are not eligible. Eligibility and services may change from time to time. Check the *State Health Plan* web site at www.shpnc.org for the most current program information.

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

For more information on these programs or to obtain further information on NC HealthSmart, call the number listed in "Whom Do I Call?" 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.

Case Management

Case management services are available to *State Health Plan members* who have a catastrophic illness or who are at risk for such conditions. Case management services are also available after *hospital* discharge for certain major surgeries. Specialty case managers are available to *State Health Plan* members with Chronic Kidney Disease (CKD) and End Stage Renal Disease (ESRD). To inquire about case management services, call *State Health Plan* Customer Services at the number in "Whom Do I Call?"

Tobacco Cessation Support

Generic, over-the-counter nicotine replacement therapy patches are covered as part of your pharmacy benefit. A 10-week course of therapy is covered annually at a cost of \$5 per *prescription* (number of *prescriptions* may vary by individual); however there are two ways to receive the over-the-counter patches for free.

- You can receive smoking cessation counseling from your health care *provider* (Tobacco cessation counseling is covered as part of a physician office visit). Then, have your *provider* complete the *copayment* override form from the *State Health Plan* web site at www.shpnc.org. The form can be faxed to Medco at 319-896-5904.
- Enroll thru the NC Quitline program at 1-800-QUIT-NOW. A request for a *copayment* override will then be faxed from the Quitline to our *PBM*.

In both circumstances, your *copayment* waiver will be active at a local participating network pharmacy in about two business days after the *copayment* waiver form is faxed. A participating network pharmacy is a pharmacy that contracts with your *PBM* to provide *prescription* benefits to *State Health Plan members*.

A participating network pharmacy agrees to participate in the programs that are available as part of the *State Health Plan's* pharmacy benefit. Most chain and independent pharmacies contract with your *PBM*. You can locate a participating pharmacy in your area by calling your *PBM* Customer Service at the number found in

SPECIAL PROGRAMS

“Whom Do I Call?,” or simply go to www.medco.com and click on “Locate a Pharmacy” located on the navigation list on the left.

If you want to verify that your copayment override form has been received, you can call your *PBM* Customer Service number listed in “Whom Do I Call?”

Tools and Resources

- **Hotlines**

NC HealthSmart Health Coaches Support Line.....1-800-817-7044
See Description of Health Coaching Services

NC Quitline is available at no cost to all North Carolinians.....1-800-QUIT-NOW
Available 8am-12am, 7 days a week, English and Spanish-speaking

Quit tobacco specialists assist with quitting, goal setting, medication questions and locating local tobacco cessation resources. They can send educational materials by mail, and can make follow-up support calls with *members*.

- **Web-based Programs**

Designed by an ex-smoker, the internet-based Stop Smoking program gently guides eligible members through the quitting process over four weeks. This program and numerous educational materials are available through the NC HealthSmart web site at www.shpnc.org.

- **Worksite Wellness Initiatives**

The NC HealthSmart Worksite Wellness Toolkit, now online at www.shpnc.org, gives worksite wellness committees resources to promote healthy living. One component of the Toolkit, “Quit Now,” provides step-by-step instructions on setting up tobacco cessation educational campaigns and support systems. It also makes recommendations for environmental policy changes that may support the *member* in quitting.

Other Special Programs

The *State Health Plan* and *BCBSNC* may agree to add programs that are outside your regular benefits. These programs may be changed from time to time. Following are examples of programs that may be included outside your regular benefits.

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

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

WHAT IS NOT COVERED?

WHAT IS NOT COVERED?

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

- Not *medically necessary*
- *Investigational* in nature or obsolete, including any service, drugs, procedure or treatment directly related to an *investigational* treatment
- Any *experimental* drug or any drug 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 drugs* used in covered phases II, III and IV clinical trials, or drugs approved by the FDA for treatment of cancer, if prescribed for the treatment of any type of cancer for which the drug has been approved as effective in any one of the three nationally recognized drug reference guides:
 1. The American Medical Association Drug Evaluations
 2. The American Hospital Formulary Service Drug Information
 3. The United States Pharmacopoeia Drug Information
- Side effects and complications of noncovered services, except as specifically covered by your health benefit plan or except for *emergency services* in the case of an *emergency*
- Not prescribed or performed by or upon the direction of a *doctor* or *other provider*
- For any condition, disease, illness or injury that occurs in the course of employment, if the *employee*, employer or carrier is liable or responsible (1) according to a final adjudication of the claim under a state's workers' compensation laws, or (2) by an order of a State Industrial Commission or other applicable regulatory agency-approving a settlement agreement
- For a health care professional to administer injectable *prescription drugs* which can be self-administered, unless medical supervision is required
- For *inpatient* admissions primarily for the purpose of receiving diagnostic services or a physical examination. *Inpatient* admissions primarily for the purpose of receiving therapy services are excluded except when the admission is a continuation of treatment following care at an *inpatient* facility for an illness or accident requiring therapy
- For care in a self-care unit, apartment or similar facility operated by or connected with a *hospital*
- For *custodial care*, domiciliary care or rest cures, care provided and billed for by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility, home for the aged, infirmary, school infirmary, institution providing education in special environments, in residential treatment facilities, except for chemical dependency treatment, or any similar facility or institution
- For respite care except as specifically covered by your health benefit plan
- Received prior to the *member's effective date*
- Received after the coverage termination date, regardless of when the treated condition occurred, and regardless of whether the care is a continuation of care received prior to the termination
- For telephone consultations, charges for failure to keep a scheduled visit, charges for completion of a claim form, charges for obtaining medical records, and late payment charges
- *Incurred* more than 18 months prior to the *member's* submission of a claim, except in the absence of legal capacity of the *member*
- For *cosmetic* purposes. For removal of excess skin from the abdomen, arms or thighs, except as specifically covered by your health benefit plan
- For any services that would not be necessary if a noncovered service had not been received, except for *emergency services* in the case of an *emergency*
- For benefits that are provided by any governmental unit except as required by law
- For services that are ordered by a court that are otherwise excluded from benefits under this health benefit plan
- For care that the *provider* cannot legally provide or legally charge or is outside the scope of license or *certification*
- Provided and billed by a licensed health care professional who is in training

WHAT IS NOT COVERED?

- For any services provided and billed by a lactation consultant
- Available to a *member* without charge
- For care given to a *member* by a *provider* who is in a *member's* immediate family
- For any condition suffered as a result of any act of war or while on active or reserve military duty
- In excess of the *allowed amount* for services usually provided by one *doctor*, when those services are provided by multiple *doctors*
- For palliative, *cosmetic* or *routine foot care*
- For dental care, dentures, dental implants, oral orthotic devices, palatal expanders and orthodontics except as specifically covered by your health benefit plan
- *Dental services* provided in a *hospital*, except when a hazardous condition exists at the same time or covered oral *surgery* services are required at the same time as a result of a bodily injury
- For any treatment or regimen, medical or surgical, for the purpose of reducing or controlling the weight of a *member* or for treatment of obesity, except for surgical treatment of morbid obesity, or as specifically covered by your health benefit plan
- Wigs, hair pieces and hair implants for any reason
- Received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust or similar person or group
- For *sexual dysfunction*
- Treatment or studies leading to or in connection with sex changes or modifications and related care
- Music therapy, remedial reading, recreational or activity therapy, all forms of special education and supplies or equipment used similarly
- Hypnosis except when used for control of acute or chronic pain
- Acupuncture and acupressure
- *Surgery* for psychological or emotional reasons
- Travel, whether or not recommended or prescribed by a *doctor* or other licensed health care professional, except as specifically covered by your health benefit plan
- Heating pads, hot water bottles, ice packs and personal hygiene and convenience items such as, but not limited to, devices and equipment used for environmental control, and urinary incontinence devices (including bed wetting devices) and equipment
- Devices and equipment used for environmental accommodation requiring vehicle and/or building modifications such as, but not limited to, chair lifts, stair lifts, home elevators, and ramps
- Air conditioners, furnaces, humidifiers, dehumidifiers, vacuum cleaners, electronic air filters and similar equipment
- Physical fitness equipment, hot tubs, jacuzzis, heated spas, pool or memberships to health clubs
- Eyeglasses or contact lenses, except as specifically covered in "*Prosthetic Appliances*"
- Orthoptics, vision training, and low vision aids
- Fitting for eyewear, radial keratotomy and other refractive eye *surgery*, and related services to correct vision except for surgical correction of an eye injury. Also excluded are accommodating intraocular lenses or the services related to the insertion of accommodating intraocular lenses that are not required for insertion of standard intraocular lenses
- Hearing aids or examinations for the fitting of hearing aids except as specifically covered by your health benefit plan
- Routine hearing examinations except as specifically covered by your health benefit plan
- Evaluation and treatment of *developmental dysfunction* and/or learning differences
- *Medical care* provided by more than one *doctor* for treatment of the same condition
- Take home drugs furnished by a *hospital* or *nonhospital facility*
- Clomiphene (e.g., Clomid), menotropins (e.g., Repronex) or other drugs associated with conception by artificial means
- For maintenance therapy. Maintenance therapy includes therapy services that are provided over a long period of time in order to keep your condition stable
- For massage therapy services

WHAT IS NOT COVERED?

- For *holistic medicine* services
- For services primarily for educational purposes including, but not limited to, books, tapes, pamphlets, seminars, classroom, web or computer programs, individual or group instruction and counseling, except as specifically covered by your health benefit plan
- For genetic testing, except for high risk patients when the therapeutic or diagnostic course would be determined by the outcome of the testing
- Services whose efficacy has not been established by controlled clinical trials, or are not recommended as a preventive service by the U.S. Public Health Service, except as specifically covered by your health benefit plan
- Shoe lifts, and shoes of any type, including therapeutic shoes, unless part of a brace
- For any condition, disease, ailment, injury or diagnostic service to the extent that benefits are provided or persons are eligible for coverage under Title XVIII of the Social Security Act of 1965, including amendments, except as otherwise provided by federal law
- For conditions that federal, state or local law requires to be treated in a public facility
- For vitamins, food supplements or replacements, nutritional or dietary supplements, formulas or special foods of any kind
- Not specifically listed in this benefit booklet as a covered benefit, drug, service or supply.

UTILIZATION MANAGEMENT

UTILIZATION MANAGEMENT

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

Rights And Responsibilities Under The UM Program

Your Member Rights

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

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

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

The *State Health Plan's* Responsibilities

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

- Provide you and your *provider* with a toll-free telephone number to call *UM* review staff when *certification* of a health care service is needed. See "Whom Do I Call?"
- Limit what the *State Health Plan* or its representative requests from you or your *provider* to information that is needed to review the service in question
- Request all information necessary to make the *UM* decision, including pertinent clinical information
- Provide you and your *provider* prompt notification of the *UM* decision consistent with your health benefit plan.

In the event the *State Health Plan* or its representative does not receive sufficient information to approve coverage for a health care service within specified time frames, your health benefit plan will notify you in writing that benefit coverage has been denied. The notice will explain how you may pursue a review of the *UM* decision.

Prospective Review/ Prior Review

The *State Health Plan* requires that certain health care services receive *prior review* as noted in "Covered Services." These types of reviews are called prospective reviews. **If neither you nor your *provider* requests *prior review* and receives *certification*, this may result in a partial or complete denial of benefits. General categories of services with this requirement are noted in "Covered Services." You may also visit our web site at www.shpnc.org or call *State Health Plan* Customer Services at the number listed in "Whom Do I Call?" for a detailed list of services. The list of services that require *prior review* may change from time to time.**

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

UTILIZATION MANAGEMENT

The *State Health Plan* or its representative will make a decision on your request for *certification* within a reasonable amount of time taking into account the medical circumstances. The decision will be made and communicated within three business days after the *State Health Plan* or its representative receives all necessary information, but no later than 15 days from the date your request has been received. If your request is incomplete, then within five days of receipt of your request, you and your *provider* will be notified of how to properly complete your request. The *State Health Plan* or its representative may also take an extension of up to 15 days, if additional information is needed. The *State Health Plan* or its representative will notify you and your *provider* before the end of the initial 15-day period of the information needed and the date by which the *State Health Plan* or its representative expects to make a decision. You will have 45 days to provide the requested information. As soon as the *State Health Plan* or its representative receives the requested information, or at the end of the 45 days, whichever is earlier, a decision will be made within three business days. If the *State Health Plan* or its representative does not approve benefit coverage of a health care service, the *State Health Plan* or its representative will notify you and your *provider* by written or electronic confirmation.

Expedited Certification

You have a right to an 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. The *State Health Plan* or its representative will notify you and your *provider* of its decision as soon as possible, taking into account the medical circumstances. The *State Health Plan* or its representative will notify you and your *provider* of its decision within 72 hours after receiving the request. If the *State Health Plan* or its representative needs additional information to process your expedited review, they will notify you and your *provider* of the information needed as soon as possible but no later than 24 hours following the receipt of your request. You will then be given a reasonable amount of time, but not less than 48 hours, to provide the requested information. As soon as the *State Health Plan* or its representative receives the requested information, or at the end of the time period specified for you to provide the information, whichever is earlier, the *State Health Plan* or its representative will make a decision on your request within a reasonable time but no later than 48 hours. An expedited review may be requested by calling *State Health Plan* Customer Services at the number listed in "Whom Do I Call?"

Concurrent Reviews

The *State Health Plan* or its representative will also review health care services at the time you receive them. These types of reviews are concurrent reviews. The *State Health Plan* or its representative will communicate concurrent review decisions to the *hospital* or other facility within three business days after the *State Health Plan* or its representative receives all necessary information but no later than 15 days after the request. If the *State Health Plan* or its representative does not provide *certification*, the *State Health Plan* or its representative will notify you, your *hospital's* or other facility's *UM* department and your *provider*. Written confirmation of the decision will also be sent to your home by U.S. mail. For concurrent reviews, your health benefit plan will remain responsible for *covered services* you are receiving until you or your representatives have been notified of the denial of benefit coverage.

Expedited Concurrent Review

You have a right to an expedited review when the regular time frames for a decision: (i) could seriously jeopardize your or your *dependent's* life, health, or ability to regain maximum function; or (ii) in the opinion of your *provider*, would subject you or your *dependent* to severe pain that cannot be adequately managed without the requested care or treatment. If you request an extension of treatment that the *State Health Plan* or its representative has already approved at least 24 hours before the current approved treatment ends, the *State Health Plan* or its representative will notify you and your *provider* of its decision as soon as possible taking into account the medical circumstances, but no later than 24 hours after receiving the request.

Retrospective Reviews

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

UTILIZATION MANAGEMENT

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

Care Management

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

Continuity of Care

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

An ongoing special condition means:

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

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

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

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

UTILIZATION MANAGEMENT

Further Review Of Utilization Management Decisions

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

Delegated Utilization Management

For *UM* and the first level *grievance* review for *inpatient* and *outpatient* mental health and chemical dependency services, your *Mental Health Case Manager* is responsible. Claim determinations and second level *grievance* reviews are provided by the *State Health Plan* or its representative.

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?

WHAT IF YOU DISAGREE WITH A DECISION?

In addition to the *UM* program, your health benefit plan offers a *grievance* procedure for *members*. *Grievances* include dissatisfaction with a claims denial or any decisions (including an *appeal* of a *noncertification* decision), policies or actions related to the availability, delivery or quality of health care services. If you have a *grievance*, you have the right to request that the *State Health Plan* or its representative review the decision through the *grievance* process. *Grievances* are not allowed for benefits or services that are clearly excluded by this benefits booklet. 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 Managed Care Patient Assistance Program offered by the North Carolina Department of Justice by contacting:

Managed Care Patient Assistance Program

9001 Mail Service Center

Raleigh, NC 27699-9001

Tel: (919) 733-6272

Tel (toll free in NC): 1-866-867-6272

Email: MCPA@ncdoj.gov

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* web site or call *State Health Plan* Customer Services at the number given in "Whom Do I Call?"

Any request for review should include:

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

Although you are not allowed to attend 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 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
 - attend the second level *grievance* review meeting
 - present your case to the review panel
 - submit supporting material before and at the review meeting
 - ask questions of any member of the review panel

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- 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 location at least 15 days before the meeting. You have the right to a full review of your *grievance* even if you do not attend the meeting. A written decision will be issued to you within five business days of the review meeting.

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 Services at the number listed in "Whom Do I Call?" An expedited review will take place in consultation with a medical *doctor*. All of the same conditions for a first level or second level *grievance* review apply to an expedited review, except that the review meeting will take place through a conference call or through written communication. The *State Health Plan* or its representative will communicate the decision by phone to you and your *provider* as soon as possible, taking into account the medical circumstances, but no later than 72 hours after receiving the request. A written decision will be communicated within four days after receiving the request for the expedited *appeal*. Information initially given by telephone must also be given in writing.

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

External Review

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

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

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

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

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

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

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

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

Standard External Review

For all requests for a standard external review, you must file your request with the NCDOI within 60 days of receiving one of the notices listed above. If the request for an external review is related to a retrospective

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noncertification (a *noncertification* which occurs after you have already received the services in question), the 60-day time limit for receiving the *State Health Plan's* second level determination does not apply. You will not be eligible to request an external review until you have exhausted the internal *appeal* process and have received a written second level determination from the State Health Plan or its representative.

Expedited External review

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

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

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

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

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

Mail

NC Department of Insurance
Healthcare Review Program
1201 Mail Service Center
Raleigh, NC 27699-1201
Fax: (919)-807-6865

In person

NC Department of Insurance
Dobbs Building
430 N. Salisbury Street, Suite 4105
Raleigh, NC 27603
Tel: (919)-807-6860
Tel (toll free in NC): 1-877-885-0231

Web

www.ncdoi.com for external review information and request form.

The Healthcare Review Program provides consumer counseling on utilization review and *grievance* issues. Within ten business days (or, for an expedited review, within three business days) of receipt of your request for an external review, the NCDOI will notify you and your *provider* of whether your request is complete and whether it has been accepted. If the NCDOI notifies you that your request is incomplete, you must provide all requested, additional information to the NCDOI within 90 days of the written notice from the *State Health Plan* or its representative, upholding a *noncertification* (generally the notice of a second level *grievance* review decision), which initiated your request for an external review. If the NCDOI accepts your request, the acceptance notice will include: (i) name and contact information for the IRO assigned to your case; (ii) a copy of the information about your case that the *State Health Plan* or its representative has provided to the NCDOI; and (iii) a notification that you may submit additional written information and supporting documentation relevant to the initial *noncertification* to the assigned IRO within seven days after the receipt of the notice. It is presumed that you have received written notice two days after the notice was mailed. Within seven days of the *State Health Plan's* receipt of the acceptance notice (or, for an expedited review, within the same day), the *State Health Plan* or its representative shall provide the IRO and you, by the same or similar expeditious means of communication, the documents and any information considered in making the *noncertification appeal* decision or the second level *grievance* review decision. If you choose to provide any additional information to the IRO, you must also provide that same information to the *State Health Plan* at the same

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time and by the same means of communication (e.g., you must fax the information to BCBSNC if you faxed it to the IRO).

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

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

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

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

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

Third Level Grievance Review

If you do not agree with the second level decision, you may be able to *appeal* this decision by filing a Petition for Administrative Review with the North Carolina Office of Administrative Hearings (OAH). This *appeal* must be received and filed with OAH within sixty (60) days of the date of the second level decision. Your second level decision and North Carolina General Statute (NCGS) 135-39.7 identifies those *appeals* that may be filed at OAH, OAH's address, and the time period for filing an *appeal*. N.C.G.S. 135-39.7, as well as all *State Health Plan* statutes and medical policies, can be found at www.shpnc.org. The OAH statute is found in the North Carolina General Statutes at Chapter 150B.

Appeals Correspondence

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

Medical Appeals

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

Pharmacy Appeals

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

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

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Mental Health Appeals

Your *Mental Health Case Manager* is responsible for the first level *grievance* review for *inpatient* and *outpatient* mental health and chemical dependency services. Please forward *grievances* to:

State Health Plan
C/o ValueOptions
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 ValueOptions
3800 Paramount Parkway, Suite 300
Morrisville, NC 27560-6901
Attn: Appeals

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

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

ADDITIONAL TERMS OF YOUR COVERAGE

ADDITIONAL TERMS OF YOUR COVERAGE

Benefits To Which Members Are Entitled

The benefits described in this benefit booklet are provided only for *members*. These benefits and the right to receive payment cannot be transferred to another person. At the option of the *State Health Plan* or its representative, payment for services will be made to the *provider* of the services, or the *State Health Plan* or its representative may choose to pay the *subscriber*.

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

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

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

Providers are independent contractors, and they are solely responsible for injuries and damages to *members* resulting from misconduct or negligence.

Disclosure Of Protected Health Information (PHI)

The *State Health Plan* and its representatives takes your privacy seriously and handles all PHI as required by state and federal laws and regulations. The *State Health Plan* has developed a privacy notice that explains the procedures. The *State Health Plan* privacy notice is included in the back of this booklet.

Administrative Discretion

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

Receiving Care When You Are Outside Of North Carolina

Your health benefit plan offers you the choice of receiving either *in-network* or *out-of-network* benefits while outside of North Carolina. Your *ID card* gives you access to participating *providers* outside the state of North Carolina through the BlueCard[®] PPO program. When you use a *provider* participating in the local Blue Cross or Blue Shield Plan's *provider* network, you will receive the higher *in-network* benefit level. If you are in an area that has participating *providers* and you choose a *provider* outside the network, you will receive the lower *out-of-network* benefits. However, if participating *providers* through the BlueCard[®] PPO program are not reasonably available to the *member* as determined by the access to care standards, which are available on our web site at www.shpnc.org or by calling *State Health Plan* Customer Services at the number given in "Whom do I call?," your benefits will be paid at the *in-network* benefit level. In an *emergency*, you should seek care from an *emergency room* or other similar facility. If you go to an *emergency room* for treatment of an *emergency*, your benefit level will be the same, regardless of whether you use an *in-network* or *out-of-network provider*. If you receive services outside of North Carolina, either *in-network* or *out-of-network*, you are responsible for requesting or ensuring that your *provider* requests *prior review* by the *State Health Plan* or its representative for those services that require *prior review*. For a list of services that require *prior review*, visit the *State Health Plan* web

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site at www.shpnc.org. Failure to request *prior review* and receive *certification* may result in a partial or full denial of benefits. For exceptions to *prior review* requirements, see "*Emergency And Urgent Care Services*" and "*Maternity Care*" in "*Covered Services*."

To see if an *in-network provider* is available in your location, you should call the BlueCard® PPO program number listed in "*Whom Do I Call?*" and on the back of your *ID card*.

Mental Health And Chemical Dependency Services

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

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

For more information on these services, see "*Covered Services*."

Provider Reimbursement

Services Received In North Carolina

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

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

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

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

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

Some *out-of-network providers* have other agreements with BCBSNC that affect their reimbursement for *covered services* provided to *members*. These *providers* agree not to bill *members* for any charges higher than their agreed upon, contracted amount. In these situations, *members* will be responsible for the difference between the *allowed amount* and the contracted amount. *Out-of-network providers* may bill you directly. If you are billed, you will be responsible for paying the bill and filing a claim. See "*How To File A Claim*."

Right Of Recovery Provision

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

In addition, if a *member* receives any payment from any potentially responsible party as a result of an injury or illness, the *State Health Plan* has the right to recover from, and be reimbursed by, the *member* for all amounts the

ADDITIONAL TERMS OF YOUR COVERAGE

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. The *member* agrees that if the *member* receives any payment from any potentially responsible party as a result of an injury or illness, the *member* will serve as a constructive trustee over the funds for the benefit of the *State Health Plan*. Failure to hold such funds in trust will be deemed a breach of the *member's* fiduciary duty to the *State Health Plan*.

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 including, but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers' compensation coverage, no-fault automobile insurance coverage, or any first party 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*, or as otherwise required by law.

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

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

The *member* shall do nothing to prejudice the *State Health Plan's* recovery rights as herein set forth. This includes, but is not limited to, refraining from entering into any settlement or recovery that attempts to reduce, waive, bar or exclude the full cost of all benefits provided by your health benefit plan as provided by law. In the event that any claim is made that any part of this right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the *member* and the *State Health Plan* or its representative agree that the *State Health Plan* shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

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

ADDITIONAL TERMS OF YOUR COVERAGE

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 representative within 18 months after the *member* incurs the *covered service*, except in the absence of legal capacity of the *member*. The notice must be on an approved claim form and include the data necessary for the *State Health Plan* or its representative as specifically set out in this benefit booklet to determine benefits.

Limitations Of Actions

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

Coordination Of Benefits (Overlapping Coverage)

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

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

Order Of Benefits Determination

Subscriber or Spouse:

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

Dependent Children:

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

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

Other Rules

- Benefits under a health benefit plan that covers a person other than as a laid-off or retired *employee* or as a *dependent* of other than a laid-off or retired *employee* are determined primary to a plan that covers the person as a laid-off or retired *employee* or the *dependent* of a laid-off or retired *employee*. (This rule does not apply if it results in a conflict in determining order of benefits.)
- 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

ADDITIONAL TERMS OF YOUR COVERAGE

- If the other health benefit plan does not have rules that establish the same order of benefits as under this health benefit plan, the benefits under the other plan will be determined primary to the benefits under this health benefit plan.

Benefit Coordination

Active Members and Retirees Under Age 65

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

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

When You Reach Age 65

The *State Health Plan* mails a Medicare eligibility letter approximately 60 days 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*. A Change Form must be submitted reporting the individual's Medicare eligibility.

State Health Plan Benefit Coordination with Medicare

- If you are actively employed and eligible for Medicare, the *State Health Plan* is primary and Medicare is secondary for you and your *dependents*. The only exception is if you are Medicare primary due to End Stage Renal Disease (ESRD).
- If you are retired and eligible for Medicare, the *State Health Plan* becomes secondary coverage. Medicare is also primary and the *State Health Plan* is secondary for the following **Medicare-eligible** individuals:
 - *Retirees*.
 - *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.

ADDITIONAL TERMS OF YOUR COVERAGE

- 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.

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

Important Information About Medicare Part B

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

WHEN COVERAGE BEGINS AND ENDS

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 Chapter 135 of the North Carolina General Statutes. If this summary of eligibility conflicts with the General Statutes, the General Statutes prevail.

Eligibility

The State of North Carolina pays for coverage under the *State Health Plan* for the following individuals:

- All permanent full-time teachers and state *employees* who are either (1) paid from general or special state funds or (2) paid from non-state funds and the employing unit has agreed to provide coverage.
- *Employees* of state agencies, departments, institutions, boards and commissions, not otherwise covered by the *State Health Plan*, who are employed in permanent job positions on a recurring basis and who work 30 or more hours per week for nine or more months per calendar year.
- Permanent hourly *employees* who work at least one half of the workdays each pay period.
- Retired teachers and State *employees*, members of the General Assembly, and retired law enforcement officers who retired under the Law Enforcement Officers' Retirement System prior to January 1, 1985.
- 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.
- *Employees* on approved leave of absence with pay, or receiving workers' compensation.
- *Employees* on approved leave under the Family and Medical Leave Act of 1993 (FMLA).
- Former *employees* who are receiving disability retirement benefits are eligible for the benefit provisions of the *State Health Plan* on the same basis as retired *employees*. Coverage for these people will cease, however, as of the end of the month in which the former *employee* is no longer eligible for disability retirement benefits.

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

- School *employees* in a job sharing position.

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.
- *Spouses* and eligible *dependent children* of enrolled *employees*, and former members of the General Assembly.
- *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.
- *Spouses* and eligible *dependent children* of enrolled teachers, State *employees*, *retirees* and former members of the General Assembly.

WHEN COVERAGE BEGINS AND ENDS

- Former *employees* whose jobs were eliminated because of reduction in funds beyond the initial 12-month separation period.
- Certain blind persons licensed by the state as operators (or former operators) of vending facilities under contract with the Department of Health and Human Services.
- Surviving *wives* of deceased *retirees* and surviving *wives* of deceased teachers, State *employees*, and members of the General Assembly if the *wife* was covered at the time of death and the death occurred after September 30, 1986.
- Certain surviving *dependent children* who are covered by the *State Health Plan* at the time of the *employee's* death are entitled to coverage as a surviving *dependent* who were covered under the *State Health Plan* on September 30, 1986. In the absence of an eligible surviving parent, each child is eligible for *member only* (individual) coverage until attaining one of the usual *dependent children* ineligibility events. If a surviving child was certified and covered as an incapacitated *dependent*, the *dependent* is eligible for life, or until the *dependent* marries or ceases to be incapacitated. When coverage ceases for a surviving *dependent child*, he or she may be eligible for continuation coverage.
- The *wives* and eligible *dependent children* of former *employees* whose jobs were eliminated because of reduction in funds.
- An *employee* on official leave of absence without pay.
- An *employee* with less than five years of retirement membership services, who is on leave without pay due to illness or injury for up to 12 months.

Under certain conditions the following are eligible:

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

Dependent Eligibility

For *dependents* to be covered under the *State Health Plan*, you must be covered and your *dependent* must be one of the following:

- *Spouse*
- A natural, legally adopted or *foster child* of the *subscriber* and/or *spouse*, who is unmarried until the end of the month following his or her 19th birthday, whether or not the child is living with the *subscriber*, as long as the *subscriber* is legally responsible for the child's maintenance and support. *Foster child* requires legal documentation.

Dependent child coverage may be extended beyond the 19th birthday under the following conditions:

- The *dependent* is covered until the end of the month following his or her 26th birthday, if unmarried and a full-time student at an accredited school.
- The *dependent* is physically or mentally incapacitated to the extent that he or she is incapable of earning a living and such handicap developed or began to develop before the *dependent's* 19th birthday or 26th birthday if the *dependent* was covered by the *State Health Plan* as a full-time student. When requesting extension of coverage, or for further information, *employees* should contact their *HBR*.

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 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 whether you apply for coverage and/or add *dependents* at your first opportunity or delay your application. When you apply for coverage will determine whether you and your *dependents* are timely or late enrollees and the length of any *waiting period* for *preexisting conditions*.

Waiting Periods For Preexisting Conditions

In accordance with North Carolina General Statutes 135-40.3(b)(2), *employees* or *dependents* not enrolling when first eligible may have a 12-month *waiting period* for *preexisting health conditions*.

WHEN COVERAGE BEGINS AND ENDS

If you do not enroll when first eligible, you are referred to as a late enrollee. A late enrollee who has a medical condition prior to being covered by the *State Health Plan* may have to wait a certain period of time before the health benefit plan will provide coverage for that condition.

A *preexisting health condition* is a condition, disease, illness or injury diagnosed and treated within six months prior to the *effective date* of coverage. The *preexisting health condition waiting period* does not apply to pregnancy, or to a child who is enrolled in the *State Health Plan* within 30 days after the birth, adoption, placement for adoption or placement in the foster home.

Other health care services determined by the *State Health Plan* to be related to a *preexisting health condition* are not covered during the *waiting period*. This *waiting period* may last up to 12 months from your first day of coverage.

However, you can reduce the length of this *waiting period* by the number of days of prior health coverage. Most prior health coverage is creditable and can be used to reduce the *preexisting health condition waiting period* if you have not experienced a break in coverage of more than 63 days in the previous 12-months prior to enrollment in the *State Health Plan*.

The *State Health Plan* will apply credit toward the *waiting period* for *preexisting conditions* by using all previous health coverage when an individual's prior health coverage does not completely cover the 12-month *waiting period* for *preexisting conditions*. The time span between the previous health coverages cannot exceed 63 days.

If health coverage was withheld under a previous employer because of a probationary period, the *State Health Plan* will not count this time period toward the 63-day limit. The *State Health Plan*, however, will apply the probationary time period toward the 12-month *waiting period* for *preexisting conditions*. Credit will be given for prior coverage even if the other coverage is still in effect.

To reduce the 12-month *waiting period*, give a copy of any Certificates of *Creditable coverage* to your *HBR* or the *State Health Plan*.

Dual Enrollment

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

Timely Enrollees

Timely enrollees are not subject to a *waiting period* for *preexisting conditions*. Newborns, adoptive children, *foster children* and eligible children who are added as a result of a court order are not subject to a *waiting period*. You are a timely enrollee if you apply for coverage and/or add *dependents* within a 30-day period following any of the events listed below.

- You are newly hired
- You get married or obtain a *dependent* through birth, adoption, placement in anticipation of adoption, or foster care placement of an eligible child
- You or your *dependents* lose coverage under another health benefit plan, and each of the following conditions is met:
 - You and/or your *dependents* are otherwise eligible for coverage under the *State Health Plan*, and
 - You and/or your *dependents* were covered under another health benefit plan at the time this coverage was previously offered and declined enrollment due to the other coverage, and
 - You and/or your *dependents* lose coverage under another health benefit plan due to i) the exhaustion of the COBRA continuation period, or ii) the loss of eligibility for that coverage for reasons including, but not limited to, divorce, loss of *dependent* status, death of the *employee*, termination of employment, or reduction in the number of hours of employment, or iii) the termination of the other plan's coverage, or iv) the offered health benefit plan not providing benefits in your service area and no other health benefit plans are available, or v) the termination of employer contributions toward the cost of the other plan's coverage, or vi) meeting or exceeding the *lifetime maximum*, or vii) the discontinuance of the health benefit plan to similarly situated individuals.

WHEN COVERAGE BEGINS AND ENDS

- Members of the General Assembly upon the convening of each Session of the General Assembly or within 30 days after the end of the term of office.

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

The Enrollment Application must be completed and returned to the *HBR* of the *employee's* employing unit within the first 30 days of employment. The Enrollment Application or Change Form and proof of prior coverage must be completed and returned to the *HBR* of the *employee's* employing unit within 30 days of losing other coverage.

Late Enrollees

If you are applying for coverage at a time which does not qualify you or your *dependents* as timely enrollees as stated above, then you are considered late enrollees. Late enrollees are subject to a 12-month *waiting period* for *preexisting conditions* and may enroll on the first day of any month.

Adding Or Removing A Dependent

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

To add a *dependent*, you must notify the *HBR*. For coverage to be effective on the date the *dependent* becomes eligible or the first day of the month following the eligibility event or the first day of the second month, the Change Form must be completed and submitted to the *HBR* within 30 days after the *dependent* becomes eligible.

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

For *members* with *employee-only* or *employee-spouse* coverage, a newborn child, a child legally placed for adoption or a *foster child* may be covered on their *effective date* without a *waiting period* for *preexisting conditions* as long as they are enrolled within 30 days of their *effective date* **and the subscriber changes to employee/child(ren) or employee-family coverage and pays any additional premiums required for the selected coverage type retroactive to the first of the month in which the child is born or to the first of the month in which the date of placement occurred for adoptive and foster children.**

You may remove *dependents* from your coverage by contacting your *HBR*. *Dependents* must be removed from coverage when they are no longer eligible, such as when a child is no longer eligible due to age, marriage, or loss of full-time student status, or when the *spouse* is no longer eligible due to divorce or death.

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* to avoid a *waiting period* for *preexisting conditions* unless there is a qualifying event.

WHEN COVERAGE BEGINS AND ENDS

Types Of Coverage

Your health benefit plan offers the following types of coverage:

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

Reporting Changes

Have you moved, added or changed other health coverage, changed your name or phone number? If so, contact your *HBR*. 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, marriage, no longer a full-time student, and termination of employment. For additional ineligibility events, contact Customer Services at the number in “Whom Do I Call?” You must notify your *HBR* when there is a change of eligibility. If notification is not made within the 30 days following the *dependent's* ineligibility event, the *dependent* will be retroactively removed the first of the month following the *dependent's* ineligibility event, and the coverage type change will be the first of the month following written notification, except in the case of death, in which case the coverage type change will be made retroactively to the first of the month following death.

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

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.

DEFINITIONS

DEFINITIONS

ALLOWED AMOUNT — the charge that *BCBSNC* determines is reasonable for *covered services* provided to a *member*. This may be established in accordance with an agreement between the *provider* and *BCBSNC*. In the case of *providers* that have not entered into an agreement with *BCBSNC*, the *allowed amount* will be the lesser of the *provider's* actual charge or a reasonable charge established by *BCBSNC* using a methodology that is applied to comparable *providers* for similar services under a similar health benefit plan. *BCBSNC's* methodology is based on several factors including the medical, payment and administrative guidelines. Under the guidelines, some procedures charged separately by the *provider* may be combined into one procedure for reimbursement purposes.

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

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

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

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

BCBSNC — Blue Cross and Blue Shield of North Carolina.

BENEFIT PERIOD — the period of time during which charges for *covered services* provided to a *member* must be *incurred* in order to be eligible for payment by the *State Health 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.

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

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

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*.

COINSURANCE MAXIMUM — the maximum amount of *coinsurance* that a *member* is obligated to pay for *covered services* per *benefit period*.

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*.

CONGENITAL — existing at, and usually before, birth referring to conditions that are present at birth regardless of their causation.

DEFINITIONS

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, drug, supply or equipment specified in this benefit booklet for which *members* are entitled to benefits in accordance with the terms and conditions of their health benefit plan.

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 *copayments*, *coinsurance*, charges in excess of the *allowed amount*, amounts exceeding any maximum and expenses for non-covered services.

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

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

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

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

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

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

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

DEFINITIONS

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 drugs* and insulin that are available to *members*.

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

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

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

HBR — see *Health Benefits Representative*.

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

HOLISTIC MEDICINE — unproven preventive or treatment modalities, generally described as alternative, integrative or complementary medicine, whether performed by a physician or any *other provider*.

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

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

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

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

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

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

IDENTIFICATION CARD (ID card) — the card issued to *subscribers* upon enrollment which provides your *member* identification numbers, names of the *members*, applicable *copayments* and/or *coinsurance*, and key phone numbers and addresses.

DEFINITIONS

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

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

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

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

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

INVESTIGATIONAL (EXPERIMENTAL) — the use of a service or supply including, but not limited to, treatment, procedure, facility, equipment, drug, or device that the *State Health Plan* or its representative does not recognize as standard *medical care* of the condition, disease, illness, or injury being treated. The following criteria are the basis for determination that a service or supply is investigational:

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

If a service or supply meets one or more of the criteria, it is deemed *investigational* except for clinical trials as described under this health benefit plan. Determinations are made solely by the *State Health Plan* or its representative after independent review of scientific data. Opinions of experts in a particular field and/or opinions and assessments of nationally recognized review organizations may also be considered but are not determinative or conclusive.

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

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

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

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

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

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

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

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

DEFINITIONS

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

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

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

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

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

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

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

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

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

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

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

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.

DEFINITIONS

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

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

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

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

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

Prescription drugs include:

- a) Insulin and other over-the-counter medications approved for coverage by the *State Health Plan*
- b) Self-administered injectable drugs
- c) Contraceptive devices
- d) Select diabetic supplies: insulin needles, syringes, glucose testing strips, ketone testing strips and tablets, lancets and lancet devices.

PREVENTIVE CARE — *medical services* provided by or upon the direction of a *doctor* or *other provider* related to the prevention of disease.

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

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

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

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

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

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

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

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

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

- a) Occupational therapy — treatment by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those required by the person's particular occupational role after such ability has been impaired by disease, injury or loss of a body part

DEFINITIONS

- b) Physical therapy — treatment by physical means, hydrotherapy, heat or similar modalities, physical agents, biomechanical and neurophysiological principles and devices to relieve pain, restore maximum function and prevent disability following disease, injury or loss of body part
- c) Speech therapy — treatment for the restoration of speech impaired by disease, *surgery*, or injury; or certain significant physical *congenital* conditions such as cleft lip and palate; or swallowing disorders related to a specific illness or injury.

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

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

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

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

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

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

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

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

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

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

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

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

Your Resource for Better Health

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

Health Risk Assessment (HRA)

Analyze your risk for disease

Health Coach

24/7 support from specially trained healthcare professionals

Health Education Programs and Tools

Receive health information

WebMD® Featured on the NC HealthSmart web site

Health management tools and services

Worksite Wellness Programs

Participate in the work-based healthy living programs

Lifestyle Programs

Stop smoking, lose weight, get fit, and MORE!

North Carolina
HEALTHSmart

Log on to www.shpnc.org or call 1-888-234-2416
TTY line: 1-800-817-6044

You must be a member of one of the health care plans offered by the State of North Carolina. Members eligible for NC HealthSmart are those members whose primary coverage is through one of the plans offered by the State Health Plan, who are not on COBRA and who are not Medicare retirees. 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.

Health Risk Assessment (HRA)

The HRA is a simple and easy-to-complete survey that identifies personal health risks and provides members with a comprehensive personal action plan. Available online, by telephone or in paper.

Health Coach

Health Coaches are specially trained healthcare professionals (nurses, respiratory therapists, and dietitians) with 10 to 15 years experience. They are available by phone 24 hours a day, seven days a week, at no additional charge, to help members understand health issues and provide support. Health Coaches provide:

- One-on-one tobacco cessation counseling
- One-on-one nutritional and weight management information
- One-on-one support for managing illness
- One-on-one goal setting, monitoring and support to help you increase your physical activity

Health Education Programs and Tools

NC HealthSmart offers a host of free resources to assist in managing your health needs and by promoting healthy living. These resources are:

- Telephone and audio library
- Health videos provided at no charge, as appropriate
- Free Internet-based programs designed to provide assistance and support to help you stop smoking, eat smarter, live healthier, as well as offering the "Life Exercise Adherence Program(LEAP)"
- E-mail updates and screening reminders
- Printed materials mailed to your home

WebMD® Featured On the NC HealthSmart web site

Powered by WebMD®, NC HealthSmart members can create their own health web page, maintain a symptoms diary and medication list, access interactive tools and lifestyle programs, and retrieve information on treatment tips, prevention tips, lifestyle changes, and healthy living.

North Carolina
HEALTHSmart

Log on to www.shpnc.org or call 1-888-234-2416
TTY line: 1-800-817-6044

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.

Worksite Wellness Programs

The State Health Plan is committed to helping work places develop onsite wellness committees, lifestyle management activities, and "health-friendly" policies. The purpose is to encourage and support members trying to live healthy lifestyles. Eligible worksites include state agencies and boards, universities, community colleges and public schools.

Lifestyle Programs

NC HealthSmart's programs are geared to help you stop smoking, lose weight, get fit, and more. One-on-one coaching is available for tobacco cessation, nutritional and weight management, goal setting, monitoring and support for physical activities. Information on these programs and more can be found by logging on to the NC HealthSmart web site.



Log on to www.shpnc.org or call 1-888-234-2416

TTY line: 1-800-817-6044

Federal law prohibits the State Health Plan or its representative from using your personal information to discriminate against you in any way or from giving this information to your employing agency/school or other unauthorized third party, unless required by law

Value-Added Programs

Blue Cross and Blue Shield of North Carolina offers Blue Extras 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. Blue Extras includes discounts, information and more on a variety of health related products, services and topics. Now that's value-added. That's your plan for better health. For more information, visit My Member Services at www.shpnc.org.

ALTMEDBlue™
Discounts on alternative medicine services

AUDIOBlue™
Hearing aid discount program

BluePOINTS™
Physical activity incentive program

BluePOINTS™
Physical activity incentive program for kids ages 6-12

COSMETICDENTISTRYBlue™
Information and discounts on cosmetic dentistry

COSMETICSURGERYBlue™
The cosmetic surgery information and discount resource

OPTICBlue™
Discounts on corrective laser eye surgery

VITABlue™
Discounts on vitamins, minerals and herbal supplements

ALT MED BlueSM

Discounts on alternative medicine services

AltMedBlueSM₁ is BCBSNC's alternative medicine discount₃ program. It's another way to help you take care of your body. Alternative medicine includes a variety of therapies that work to increase wellness, prevent illness and address existing conditions. The following are just a few discounted AltMedBlueSM services₂:

Massage Therapy	Personal Trainers	Chiropractic Services ₃	Yoga, and more!
Fitness Centers	Nutrition Counseling	Stress Management	
Somatic Education	Tai Chi	Biofeedback	
Guided Imagery	Acupuncture	Health Spas	

Present your member ID card at a participating provider locations and receive up to 25% off services from AltMedBlueSM practitioners.

AUDIO BlueSM

Hearing aid discount program

AudioBlueSM_{1,2} offers a 25% discount on manufacturers' suggested retail prices or \$250 off usual and customary fees, whichever provides greater savings. With AudioBlueSM, when you purchase a hearing aid you'll also get:

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

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

BluePOINTSSM

Physical activity incentive program

Recording at least 30 minutes of physical activity a day can earn you 10 points for that day. Earn 250 points or more and begin selecting prizes from the four prize levels B, L, U and E.

BluePOINTSSM for kids

Physical activity incentive program for kids ages 6-12

BluePointsSM for Kids₁ earns your child 10 points toward a prize of their choice for each day they are active for 30 minutes or more. Children must be registered by a parent or guardian.

Tent	Portable radio	Sleeping bag
Watch	Sports balls	And more!

For more information on these BlueExtrasSM programs, see the number in the Quick Reference BlueExtrasSM section in the front of this booklet.

1 The State Health Plan or BCBSNC reserves the right to discontinue or change these programs at any time.

2 These programs are not covered benefits under your health benefit plan contract. The State Health Plan does not accept claims or reimburse for these services and members are responsible for paying all bills.

3 Chiropractic services may be available as a covered benefit. If your health benefit plan includes chiropractic services, the AltMedBlueSM discount is available if you have met your benefit period visit limit or if your visit is for a non-covered service. Covered benefits and discounts cannot be combined. There are no discounts on copayments, coinsurance, deductibles, maximums or balance billing.

COSMETIC DENTISTRY Blue™

Information and discounts on cosmetic dentistry

Present your member ID card at a participating CosmeticDentistryBlueSM participating provider location and get up to 30% off cosmetic dentistry procedures. Some of the discounted services¹ are:

Implants
Veneers

Bonding
Teeth Whitening

Tooth-Colored Fillings
Tooth Reshaping and Contouring

COSMETIC SURGERY Blue™

The cosmetic surgery information and discount resource

Members will receive a 15% flat rate discount on the physician's regular surgical fees for procedures such as rhinoplasty, facelifts and liposuction. Since cosmetic surgery charges are typically divided into three parts (surgery, anesthesia and facility), your discount will apply to the surgery portion only. Additionally, your CosmeticSurgeryBlueSM discount applies to your initial consultation, even if you decide not to have the procedure.

OPTIC Blue™

Discounts on corrective laser eye surgery

Get corrective laser eye surgery at least 20% less than the market price. Just present your ID card and pay one low global fee that includes your consultation, the laser procedure and all follow-up visits.

VITA Blue™

Discounts on vitamins, minerals and herbal supplements

VitaBlueSM₂ is a program that gives you a broad selection of vitamins, minerals and herbal supplements all with big savings. With VitaBlueSM you'll get:

- Up to 40% off average drug store, retail and mail order prices
- 50% off the second bottle of select products
- Free-standing shipping on orders over \$15
- A great selection of over 100 supplements

For more information on these BlueExtrasSM programs, see the number in the Quick Reference BlueExtrasSM section in the front of this booklet.

¹ The State Health Plan or BCBSNC reserves the right to discontinue or change this program at any time.

² These services are not covered benefits under your health benefit plan contract. The State Health Plan does not accept claims or reimburse for these services and members are responsible for paying all bills.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Introduction

This information is included in all benefit booklets for employees covered under the North Carolina *SmartChoice* Blue Options PPO plans. This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under your health benefit plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family who are covered under your health benefit plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under your health benefit plan and under the federal law, you should review your benefit booklet or contact State Health Plan Customer Services.

What Is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of your health benefit plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under your health benefit plan is lost because of a qualifying event. Under your health benefit plan, qualified beneficiaries who elect COBRA continuation coverage must pay the full cost of COBRA continuation coverage.

What Is A Qualifying Event?

If you are a covered employee, you will become a qualified beneficiary if you lose your coverage under your health benefit plan because any of the following qualifying events happen:

- You enter military service
- Your hours of employment are reduced
- Your employment ends.

If you are the spouse of a covered employee, you will become a qualified beneficiary if you lose your coverage under your health benefit plan because any of the following qualifying events happen:

- You or your spouse enter military service
- Your spouse's hours of employment are reduced
- Your spouse's employment ends
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B or both)
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under your health benefit plan because any of the following qualifying events happen:

- The employee enters military service
- The employee's hours of employment are reduced
- The employee's employment ends
- The employee becomes entitled to Medicare benefits (under Part A, Part B or both)
- The parents become divorced or legally separated

CONTINUATION COVERAGE RIGHTS UNDER COBRA

- The child stops being eligible for coverage under your health benefit plan as a "dependent child" because of reaching the maximum child age of 19, because of marriage, because of reaching the maximum student age of 26 or entering military service.

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your health benefit plan, and the bankruptcy results in the loss of coverage of any retired employee covered under your health benefit plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy.

The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under your health benefit plan.

When Is COBRA Coverage Available?

Your health benefit plan will offer COBRA continuation coverage to qualified beneficiaries only after the State Health Plan has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, entry into military service, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B or both), the employing unit must notify the State Health Plan of the qualifying event.

You Must Give Notice Of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the State Health Plan or its representative within 60 days after the qualifying event occurs. You must provide this notice in writing to the Health Benefits Representative.

How Is COBRA Coverage Provided?

Once the State Health Plan receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to the qualified beneficiaries within 14 days. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. However, each qualified beneficiary has an independent right to elect COBRA continuation coverage.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the employee's becoming entitled to Medicare benefits (under Part A, Part B or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage can last for up to 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). When the qualifying event is the employee going into military service, COBRA continuation coverage lasts up to 24 months. Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts up to 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension Of 18-Month Period Of Continuation Coverage

If you or anyone in your family covered under your health benefit plan is determined by the Social Security Administration to be disabled and you notify the State Health Plan in a timely fashion, you and your entire family

CONTINUATION COVERAGE RIGHTS UNDER COBRA

may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. If you qualify for this extension, send a copy of the Social Security Disability Determination notice to the State Health Plan prior to the expiration of your initial 18 months of continuation coverage.

Second Qualifying Event Extension Of 18-Month Period Of Continuation Coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if proper notice of the second qualifying event is provided to the State Health Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the former employee dies, becomes entitled to Medicare benefits (under Part A, Part B or both), or gets divorced or legally separated, or if the dependent child stops being eligible under your health benefit plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under your health benefit plan had the first qualifying event not occurred. If any of these events occur, notice should be provided to the State Health Plan within 60 days of the qualifying event.

If You Have Questions

Questions concerning your Plan or your COBRA continuation rights should be addressed to the State Health Plan at 1-888-234-2416. For more information about your rights under COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the US Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through the EBSA's web site.)

Keep Your Plan Informed Of Address Changes

In order to protect your family's rights, you should keep the State Health Plan informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the State Health Plan.

Plan Contact Information

State Health Plan
c/o BCBSNC
PO Box 30085
Durham, NC 27702
1-888-234-2416

PRIVACY NOTICE

North Carolina State Health Plan NOTICE OF PRIVACY PRACTICES

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

PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

By law, we are required to protect the privacy of the medical information and other personal information that we keep regarding our participants. We will call this information "**Protected Health Information**" or "**PHI**" for the rest of this notice. This notice will tell you how we may use and disclose your PHI and will tell you about your rights and our legal duties regarding your PHI. We are legally required to follow the terms of this notice while it is in effect. In other words, we are only allowed to use and disclose PHI in a manner that we have described in this notice. **This privacy practice notice took effect April 14, 2003 and will remain in effect until we replace it.**

Organizations Covered By This Notice

This notice applies to the privacy practices of all enrolled members of the State Health Plan.

How We Use And Disclose Your Protected Health Information

This section of our notice explains how we may use and disclose your PHI. Generally, we use and disclose your PHI only as permitted or required by law, or as authorized by you.

When The State Health Plan MUST Use Or Disclose Your PHI

We must use or disclose your PHI: (i) to you or someone who has the legal right to act for you (your personal representative); (ii) to the Secretary of the Department of Health and Human Services if necessary to make sure your privacy is protected; and (iii) when we are required by law. We do not need your authorization to use or disclose your PHI in these three situations.

When The State Health Plan Has The Right To Use Or Disclose Your PHI

We have the right to use or disclose your PHI for (i) our payment purposes, and (ii) to operate the State Health Plan. We do not need your authorization to use or disclose your PHI in these two situations.

PAYMENT. We may use and disclose your PHI to pay for your health care, or to otherwise meet our responsibilities for coverage and benefits. How we may use or disclose your PHI for payment purposes includes, but is not limited to: collecting your premiums; making decisions relating to coverage and payment for your treatment, such as determining if charges for treatment are correct and reasonable and if your treatment is covered by your health benefit plan (*including determination of medical necessity*); providing reimbursement for your treatment; deciding if you are eligible for coverage with the State Health Plan; coordinating benefits with other insurers; reviewing claims; determining if we can give you a precertification or preauthorization to get treatment; preparing your Explanation of Benefit Summary Notice; for subrogation purposes; or, for adjudicating claims.

Example of a Use or Disclosure for Payment: Let's say you have a broken leg. Your doctor may give us a bill to pay for treatment of your broken leg. We may review the bill and records about your doctor's visit, to make sure we are paying the right amount for the right treatment. The PHI we see may include the fact that you got a cast or got x-rays of your leg.

TO OPERATE THE STATE HEALTH PLAN. We may use and disclose your PHI to operate the State Health Plan and to carry out State Health Plan business. This allows us to do such things as improve the quality of care and reduce health care costs. How we may use or disclose your PHI to operate the State Health Plan includes, but is not limited to: making sure you and other State Health Plan participants get health care; for business management and administrative purposes, such as providing customer services to you and resolving any complaints you have; conducting quality assessment and improvement activities; for case management and coordination of care; conducting other activities relating to improving health or reducing health care costs; contacting health care providers with information about treatment alternatives; evaluating the performance of your health care provider; making sure the State Health Plan is operating properly and effectively; for underwriting, premium rating and other activities relating to the creation, renewal or replacement of health benefits; conducting or arranging for medical review, legal services, and auditing; giving you gifts of nominal value; for business planning and development; for transfer of or merger with another entity; or, to comply with this notice and applicable laws.

PRIVACY NOTICE

We may also use or disclose your PHI to: i) give very limited information to the sponsors of the State Health Plan (such as whether you are enrolled in the State Health Plan); or ii) contact you to give you appointment reminders, tell you about treatment alternatives or tell you about other health related benefits and services that may be of interest to you (such as to tell you about new or changed services under the State Health Plan, a disease management program or a new treatment or generic prescription).

Example of a Use or Disclosure to Operate the State Health Plan: We may decide, in the future, that a certain prescription will now cost you less money to fill. We may send you a letter to tell you that this prescription will now cost you less money.

When The State Health Plan Is PERMITTED To Use Or Disclose Your PHI

PUBLIC HEALTH: for public health purposes (such as reporting disease outbreaks);

ABUSE OR NEGLECT: when using or disclosing your PHI relates to victims of abuse, neglect or domestic violence;

STATE OR FEDERAL AGENCIES: to report to State or other federal agencies that have the right to investigate or oversee the State Health Plan, (such as to make sure we are making proper payments, fraud and abuse investigations or health oversight activities);

COURT PROCEEDINGS: for judicial and administrative proceedings (such as in response to a court order or to defend against a lawsuit);

LAW ENFORCEMENT: for law enforcement purposes (such as providing limited information to locate a missing person);

DECEDENTS: when it relates to decedents (such as, disclosing your PHI to a coroner for the purpose of identifying you, should you die);

ORGAN DONATION: for organ, eye or cadaver donation;

WORKERS' COMPENSATION: to comply with Workers' Compensation laws;

RESEARCH STUDIES: for research studies or other such programs that meet all privacy law requirements;

SAFETY: to avoid serious and imminent threat to health or safety (such as if disclosing your PHI may prevent injury to another);

GOVERNMENT FUNCTIONS: when it relates to special government functions (such as if your PHI relates to military and veteran's activities, national security and intelligence activities, protective services for the President, and medical suitability or determinations of the Department of State);

CORRECTIONAL INSTITUTIONS: to correctional institutions and to other law enforcement entities in custodial situations (such as, in certain situations, we may disclose your PHI to a correctional institution having lawful custody of you);

DISASTER RELIEF: for disaster relief (such as to the American Red Cross);

OTHER HEALTH PLANS OR HEALTH CARE PROVIDERS: generally, for another health care provider's or health plan's treatment, payment or health care operations (such as if your doctor needs information to assist in the treatment of you);

OUR BUSINESS ASSOCIATES: to our business associates (we may contract with other people or entities to provide certain services. To perform these services, the business associate may receive, create, maintain, use or disclose your PHI, but only after they agreed in writing to protect your PHI);

PERMITTED BY LAW: as we are otherwise permitted by applicable law; and

DE-IDENTIFICATION: to create a collection of information that can no longer be traced back to you.

Your Written Authorization

Except for the uses and disclosures that are described in this notice, we are not allowed to use or disclose your PHI without your written authorization. You may give us a written authorization to use or disclose your PHI for any purpose. To get a written authorization form, you may download a copy of it by going to our web site at www.shpnc.org. Or, you may call the State Health Plan Customer Services at **1-888-234-2416** to request that a copy be mailed to you. You must fill out the entire authorization form, sign it and send it to the State Health Plan at the address listed at the end of this notice. If you give us an authorization, you may take it back (revoke it) at any time, unless we have already acted based on your authorization. To take back your authorization, you must tell us in writing. You must mail your written authorization or your written revocation to the address listed at the end of this notice.

Family and Friends. As explained above, in many situations we are required by law to get your authorization before we can disclose your PHI to other people. This means we cannot disclose your PHI to your spouse, other family members or friends until we get your authorization permitting us to do so, except in limited situations (such as emergency situations or if you are available to agree verbally to that disclosure). Generally, we are still allowed to disclose PHI about a minor child to a parent, guardian or other person responsible for the minor child.

PRIVACY NOTICE

Your Rights

You have certain rights regarding your PHI. The following is a list of your rights:

See and Copy Your PHI

You have the right to ask (request) to see and get a copy of the PHI we have about you. Your request must be in writing. We must act on your request within the time period stated in the applicable law. If we deny your request, we will give you an explanation in writing. We may deny your request only for certain reasons, such as: if the PHI you request may endanger another person or is information compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative action or proceeding. You may visit our Business Associate's office or our office (*depending on where the PHI is located and the Business Associate's availability*) to see your PHI, or, you may ask us to mail this PHI to you. We will charge a reasonable fee to cover the cost of copying the PHI. If you wish to see or copy your PHI, please call State Health Plan Customer Services at **1-888-234-2416** to request an Access to PHI form.

Change, Correct or Delete Your PHI

You have the right to ask us to change, correct or delete your PHI, including medical, billing, enrollment and other records used to make decisions about you. Your request must be in writing and you must explain why you would like us to change, correct or delete your PHI. We must act on your request within the time period stated in the applicable law. If we accept your request, we will tell you and we will make reasonable efforts to tell others, including people you name, of the changes. We will include these changes in any future disclosures of this PHI. We do not have to agree to your request. We may deny your request only for certain reasons, such as if:

- i). We believe the information is correct and complete;
- ii). We did not create the information (*unless you prove that the person or entity that did create the information is no longer available to amend the information*);
- iii). The information is not a part of what is used to make decisions about you, or, is not a part of a group of records called a "designated record set;" or,
- iv). The information was compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative action or proceeding.

If we do not agree to your request, we will tell you in writing. You may then give us a statement in writing explaining why you disagree with our decision and stating what you believe is the correct, relevant and fair information. This statement must be of reasonable length. We will put this statement with your PHI and share it with anyone who receives this PHI in the future. You may also ask us to put your request and our denial with any future disclosures of this PHI. We are allowed to put our replies to your request with any future disclosures. To request a change to your PHI, please send it in writing to the State Health Plan at the address listed at the end of this notice.

Right To Request An Accounting Of Disclosures

You have a right to get a list of certain disclosures of your PHI that have been made by us or our Business Associates (this is called an "*accounting of disclosures*"). Your request must be in writing. We must act on your request within the time period stated in the applicable law. The list will not contain every type of disclosure (*such as, PHI that was given to you or your personal representative, that was given out to pay for your health care, for our operations, or for law enforcement purposes*). You have the right to this accounting of disclosures for the 6 years prior to the date you make the request, but not before April 14, 2003. This list will have the date on which the disclosure was made, the name of the person or entity that received your PHI, a description of the PHI that was disclosed, the reason for the disclosure, and certain other information. If you request this list more than once in a 12-month period, we may charge a reasonable fee for preparing the list. An appropriate State or federal agency may temporarily suspend your right to an accounting of disclosures. If you wish to get an accounting of disclosures, please call State Health Plan Customer Services at **1-888-234-2416** and request an Accounting of Disclosures form.

Right To Confidential Information

If you believe that a disclosure of your PHI may put you in danger, you have the right to ask us to communicate with you confidentially at a different location or by a different means (*for example, if we usually send your information to your home address, you may ask that we send your information to your work address*). Your request must be in writing. However, if you are in immediate danger, we may accept your verbal request. In order to agree to your request, we may require that you tell us how payment will be made in the future and specify where we can contact you. If you wish to request a confidential communication, please call State Health Plan Customer Services at **1-888-234-2416** and request a Confidential Communication Request form. You may call the number on the back of your identification card to request a confidential

PRIVACY NOTICE

communications form. **Once we have received your Confidential Communications Request, we will terminate all previous authorizations.**

Right To Request Restrictions

You have the right to ask us to limit (*restrict*) how PHI is used and disclosed for treatment, payment or State Health Plan operation purposes or when it is disclosed to those involved with your care or payment for care. Your request must be in writing. We are not required to agree to your request. In most instances, we will not agree to restrictions, other than the Confidential Communication Request as described above. If we agree to your request, we will comply with your restriction to the extent required by law. However, even if we agree to your request, there are certain situations where we are not allowed to follow your requested restriction (*such as for emergency situations, law enforcement purposes or to pay a health care provider for treatment provided to you*). Also, if we agree to your request, we may cancel (*stop*) the restriction at any time. We will inform you of any cancellation in writing. You may cancel the restriction at any time in writing. Please send your request or cancellation to the State Health Plan at the address listed at the end of this notice.

Right To Receive A Copy Of This Notice

You have a right to get a separate paper copy of this notice by calling the **State Health Plan Customer Services at 1-888-234-2416**. You may also get a copy of this notice by going to our web site at www.shpnc.org

Right To Submit A Complaint

If you believe your privacy rights have been violated, you may file a complaint with us at: **North Carolina State Health Plan, 4901 Glenwood Ave, Suite 150, Raleigh, NC 27612; Attention HIPAA Privacy Officer**. You may also file a complaint with the US Department of Health and Human Services. You will not be retaliated against for filing a complaint; in other words, doing this **will not** affect your benefits under the State Health Plan.

How To Request And Submit Forms Regarding Your Rights

- i). To request any forms to exercise your rights, an authorization form, or a copy of this notice please call **State Health Plan Customer Services at 1-888-234-2416**.
- ii). Once you fill out the appropriate form or authorization, you must then **mail** it to **the State Health Plan** at the address below.

Additional Information

For more information about matters covered in this notice or to submit a Member's Authorization Request Form, please call or write us at:

**State Health Plan
c/o BCBSNC Appeals Department
PO Box 30055
Durham, NC 277023055**

Or call **919-881-2300** and ask to speak to a representative about our privacy notice.

SM¹ NC *SmartChoice* Basic, NC *SmartChoice* Standard, and NC *SmartChoice* Plus, are marks of the North Carolina State Health Plan North Carolina *SmartChoice* Plans

SM Blue Options, Alt Med Blue, Audio Blue, Blue Points, Blue Points for Kids, Cosmetic Dentistry Blue, Cosmetic Surgery Blue, Optic Blue and Vita Blue are marks of the Blue Cross and Blue Shield Association



BlueCross BlueShield
of North Carolina



Teachers' and State Employees' Comprehensive Major Medical Plan

PO Box 30111 • Durham, NC 27702-3111

ADDRESS SERVICE REQUESTED

