

North Carolina
State Health Plan

for Teachers and State Employees

www.shpnc.org

**The North Carolina State Health Plan
for Teachers and State Employees**

Basic Plan Summary of Benefits

Effective July 1, 2009

www.shpnc.org



An independent licensee of the Blue Cross and Blue Shield Association.

North Carolina
HEALTH
Smart

PPO Basic Plan Summary of Benefits

IMPORTANT NOTICE

According to the applicable provisions and limitations of North Carolina General Statutes Chapter 135, the State of North Carolina provides health care benefits to North Carolina teachers, state employees, retirees, members of boards and commissions, and their eligible dependents, as well as others eligible such as employees of certain counties and municipalities, firemen, rescue squad or emergency medical workers, members of the North Carolina Army and Air National Guard, and their eligible dependents.

This health benefit plan summary describes essential features of the PPO Basic Plan effective July 1, 2009. It is not intended to be a full description of benefits. The complete plan is described in the 2009 North Carolina State Health Plan Benefits Booklet for your PPO Basic Plan that is available on the State Health Plan Web site at www.shpnc.org or you may request a hard copy by calling Customer Services at **1-888-234-2416**. To obtain a copy of the General Statutes or medical policies, please call Customer Services, or visit the State Health Plan Web site.

The following is a summary of your Basic Plan benefits.

- 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 Blue Cross Blue Shield of North Carolina's (BCBSNC) 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 at 1-888-234-2416.
- 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 1-888-234-2416.

PPO Basic Plan Summary of Benefits

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

	In-Network	Out-of-Network*
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Physician Office Services

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

Office Services

Primary Care Provider	\$30 copayment	50% after deductible
Specialist	\$70 copayment	50% after deductible

Includes office surgery, x-rays and lab tests. For MRIs, MRAs, CT scans and PET scans, see **Outpatient Diagnostic Services**.

CT Scans, MRI's, MRA's, and PET Scans	30% after deductible	50% after deductible
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Preventive Care

Primary Care Provider	\$30 copayment	Benefits not available¹
Specialist	\$70 copayment	Benefits not available¹

Includes routine physical exams, well baby, well child care, and immunizations.

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

Nutrition Counseling

Diabetes (first 6 visits)	100%	50% after deductible
After 6th visit	30% after deductible	50% after deductible
All other conditions (effective January 1, 2010) limited to a combined in-and out-of-network maximum of four visits per benefit period.	\$30 copayment	50% after deductible

Short-Term Rehabilitative Therapies

Limited to rehabilitative speech, physical, and occupational therapy.

Evaluation and Management

Primary Care Provider	\$30 copayment	50% after deductible
Specialist	\$70 copayment	50% after deductible

Therapy Services	\$55 copayment	50% after deductible
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Chiropractic Services	\$55 copayment	50% after deductible
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Combined in- and out-of-network benefit period maximum of 30 visits per benefit period.

Other Therapies	100%	50% after deductible
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Includes chemotherapy, dialysis and cardiac rehabilitation provided in the office. See **Outpatient Services** for other therapies provided in an outpatient setting.

Infertility and Sexual Dysfunction Services

Primary Care Provider	\$30 copayment	50% after deductible
Specialist	\$70 copayment	50% after deductible

Combined in- and out-of-network lifetime maximum of \$5,000 per member, provided in all places of service.

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	In-Network	Out-of-Network*
Routine Eye Exam ²	\$30 copayment	Benefits not available

² Effective January 1, 2010, routine eye exams will no longer be covered.

Routine Hearing Evaluation Test:

Primary Care Provider	\$30 copayment	Benefits not available
Specialist	\$70 copayment	Benefits not available

Urgent Care Centers and Emergency Room

Urgent Care Centers	\$75 copayment	\$75 copayment
Emergency Room Visit	\$250 copayment, then 30% after deductible	\$250 copayment, then 30% after deductible

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

Ambulatory Surgical Center	30% after deductible	50% after deductible
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Outpatient Services

Nutritional Counseling (See Physician Office Services for visit maximums)	30% after deductible	50% after deductible
Physician Services	30% after deductible	50% after deductible
Hospital and Hospital Based Services	30% after deductible	50% after deductible
Outpatient Clinic Services	30% after deductible	50% after deductible
Outpatient Diagnostic Services: Outpatient lab tests and mammography, when performed alone	Covered at 100%	50% after deductible
Outpatient lab tests and mammography, when performed with another service	30% after deductible	50% after deductible
Outpatient x-rays, ultrasounds, and other diagnostic tests, such as EEGs, EKGs and pulmonary function tests	30% after deductible	50% after deductible
CT scans, MRIs, MRAs and PET scans received in any location, including in a physician's office	30% after deductible	50% after deductible
Therapy Services Includes short-term rehabilitative therapies and other therapies.	30% after deductible	50% after deductible

Inpatient Hospital Services

Physician Services	30% after deductible	50% after deductible
Hospital and Hospital based Services	\$250 copayment, then 30% after deductible	\$250 copayment, then 50% after deductible

Includes maternity delivery, prenatal and post-delivery care. For inpatient mental health and chemical dependency services, refer to the "Mental Health And Substance Abuse Services" section later in this summary.

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	In-Network	Out-of-Network*
Skilled Nursing Facility	30% after deductible	50% after deductible

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

Other Services	30% after deductible	50% after deductible
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Includes ambulance, durable medical equipment, hospice services, medical supplies, orthotic devices — Orthotic devices for correction of positional plagiocephaly limited to a lifetime maximum of \$600 – prosthetic appliances, and home health care.

Private Duty Nursing	30% after deductible	50% after deductible
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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.

Lifetime Maximum	Unlimited	Unlimited
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Unlimited for all services, except orthotic devices for positional plagiocephaly, infertility and sexual dysfunction, and where otherwise specifically excluded.

Deductible

Individual, per benefit period	\$800	\$1,600
Family, per benefit period	\$2,400	\$4,800

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 benefit period	\$3,250	\$6,500
Family, per benefit period	\$9,750	\$19,500

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

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 partial or a full denial of benefits. Certification is not a guarantee of payment.**

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	In-Network	Out-of-Network*
Mental Health and Chemical Dependency Services		
Mental Health / Chemical Dependency Office Services	\$55 copayment	50%
Mental Health / Chemical Dependency Outpatient Services	30% after deductible	50% after deductible
Mental Health / Chemical Dependency Inpatient Services	\$250 copayment, then 30% after deductible	\$250 copayment, then 50% after deductible
Residential Treatment Centers	\$250 copayment, then 30% after deductible	\$250 copayment, then 50% after deductible

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.

Prescription Drugs

Prescription drug benefits are administered by Medco. See "Prescription Drug Copayment And Benefits" in "Covered Services" for more information.

	0-30 Day Supply	31-60 Day Supply	61-90 Day Supply
Generic	\$10	\$20	\$30
Preferred Brand (without generic available)	\$35	\$70	\$105
Non-Preferred Brand (without generic available)	\$55	\$110	\$165

Note: For brand name drugs with an available generic, members will be required to pay the generic copayment, plus the difference between the Plan's cost of the brand name drug and the Plan's cost of the generic drug.

Specialty Medications	25% coinsurance up to \$100 for each 30-day supply
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All non-acute specialty drugs covered under the pharmacy benefit, excluding cancer medications, must be obtained through Accredo Specialty Pharmacy.

Diabetic Testing Supplies

For a single copayment, insulin dependent members receive 153 test strips and non-insulin dependent members receive 51 test strips per 30 day supply. **Additional test strips are covered under your medical supply benefit.**

	0-30 Day Supply	31-60 Day Supply	61-90 Day Supply
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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