Welcome to the State Health Plan’s 80/20 PPO Plan, also referred to in this benefits booklet simply as your health benefit plan, or the PPO Plan. Your health benefit plan is administered by Blue Cross and Blue Shield of North Carolina (Blue Cross NC). In North Carolina, the Plan has a custom network, the North Carolina State Health Plan Network. Outside of North Carolina, you have access to a national network through Blue Cross NC.

Please read this benefits booklet carefully so that you will understand your benefits. Your doctor or medical professional is not responsible for explaining your benefits to you.

As a member of the State Health Plan, you will enjoy quality health care from the Plan’s network of health care providers and easy access to specialists. Blue Cross NC provides administrative services only and does not assume any financial risk or obligation with respect to claims. You also have the freedom to choose health care providers who do not participate in the North Carolina State Health Plan Network.

You may receive, upon request, information about your health benefit plan, its services and doctors, including this benefits booklet with a benefit summary. An online “Find a Doctor Tool” is available to assist you with finding a health care provider. Visit www.shpnc.org to access this tool.

If any information in this booklet conflicts with North Carolina state law or it conflicts with medical policies adopted under your health benefit plan, North Carolina law will prevail, followed by medical policies. If any of the Blue Cross NC medical policies conflict with the State Health Plan medical policies or benefits, including the exclusions list, the State Health Plan medical policies and benefits will be applied. The availability of benefits is described in this booklet and member benefit language should be reviewed before applying the terms of any medical policy.

The benefit plan described in this booklet is subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). A summary of benefits, conditions, limitations, and exclusions is set forth in this benefits booklet for easy reference.

The information contained in this booklet is supported by medical policies, which are used as guides to make coverage determinations. For specific detailed information, or medical policies, please call State Health Plan Customer Service at 888-234-2416, or visit Blue Cross NC’s web site at bluecrossnc.com To obtain a copy of the General Statutes visit the North Carolina General Assembly at https://www.ncleg.gov/Laws/GeneralStatutes and search for Article 3B in Chapter 135.

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

Aviso Para Miembros Que No Hablan Ingles

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

Notice for Members Not Conversant in English: This benefits booklet contains a summary in English of your rights and benefits under your health benefit plan. If you have difficulty understanding any part of this booklet, contact Customer Service to obtain assistance.

For your convenience, we have additional ways for you to access your member information. Our website, www.shpnc.org, offers a variety of health-related resources – including online forms, search tools to help you find a doctor, and general information about your plan. Additionally, our prompt and knowledgeable Customer Service Center is just a phone call away at 888-234-2416.
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<tr>
<td><strong>State Health Plan Customer Service</strong></td>
<td>888-234-2416</td>
<td>For questions regarding your benefits, claim inquiries and new Identification Card (ID card) requests.</td>
</tr>
<tr>
<td>TTY and TDD: 800-442-7028</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 a.m. - 6 p.m., Monday-Friday, except holidays</td>
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</tr>
<tr>
<td><strong>Medical Certification or Prior Review</strong></td>
<td>800-672-7897</td>
<td>To request prior review (certification) for certain out-of-network or out-of-state services.</td>
</tr>
<tr>
<td><strong>Medical Claims Filing</strong></td>
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<tr>
<td><strong>State Health Plan Eligibility and Enrollment Center</strong></td>
<td>855-859-0966</td>
<td>For questions regarding member eligibility and enrollment.</td>
</tr>
<tr>
<td>8 a.m. - 5 p.m., Monday-Friday, except holidays</td>
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</tr>
<tr>
<td><strong>COBRA Administration and Individual Billing Services Customer Service</strong></td>
<td>877-679-6272</td>
<td>For questions relating to premium payments for Retirees/COBRA/Surviving Spouses.</td>
</tr>
<tr>
<td>8 a.m. - 5 p.m., Monday-Friday, except holidays</td>
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</tr>
<tr>
<td><strong>CVS Caremark PBM Customer Service</strong></td>
<td>888-321-3124</td>
<td>For questions regarding your pharmacy benefits, to obtain a preferred medication list, information on prior authorizations, refills, and more. Please note: Blue Cross NC does not administer your prescription drug benefits.</td>
</tr>
<tr>
<td>24 hours a day, 7 days per week</td>
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<tr>
<td><strong>CVS Caremark PBM Specialty Pharmacy</strong></td>
<td>800-238-7828</td>
<td>For information regarding the specialty pharmacy services offered or to obtain specialty medications.</td>
</tr>
<tr>
<td><strong>CVS Caremark PBM - Prior Authorization Number</strong></td>
<td>800-294-5979</td>
<td>To initiate a prior authorization request for a prescription medication.</td>
</tr>
<tr>
<td><strong>Prescription Medication Claims Filing</strong></td>
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<tr>
<td>Mail completed prescription medication claim forms to: CVS/Caremark P.O. Box 52136 Phoenix, Arizona 85072-2136</td>
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<tr>
<td><strong>Medical and Pharmacy Appeals</strong></td>
<td>888-234-2416</td>
<td>See “Appeals Correspondence” in “What If You Disagree with A Decision?”</td>
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<tr>
<td><strong>Behavioral Health</strong></td>
<td>800-367-6143</td>
<td>For questions about your behavioral health and substance use disorder benefits and claims.</td>
</tr>
<tr>
<td>TTY and TDD: 800-442-7028</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service</td>
<td>Contact Information</td>
<td>Description</td>
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</tr>
<tr>
<td>Behavioral Health Appeals</td>
<td>800-367-6143</td>
<td>See &quot;Appeals Correspondence&quot; in &quot;What If You Disagree with A Decision?&quot;</td>
</tr>
<tr>
<td>CVS MinuteClinic Tobacco Cessation Program</td>
<td>888-321-3124 24 hours a day, 7 days per week</td>
<td>In-person tobacco cessation assistance including obtaining nicotine replacement therapy.</td>
</tr>
<tr>
<td>BlueCard PPO Program</td>
<td>800-810-2583 (Inside USA) 804-673-1177 (Call collect outside USA)</td>
<td>To find a participating provider outside of North Carolina and worldwide.</td>
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<tr>
<td>Blue365</td>
<td>1-855-511-2583 8 a.m. - 6 p.m. Monday-Friday, except holidays</td>
<td>Health and wellness information support and services, and special Member savings available 365 days a year.</td>
</tr>
<tr>
<td>N.C. Department of State Treasurer, Retirement Systems Division</td>
<td>3200 Atlantic Avenue Raleigh, NC 267604 919-814-4000 or 1-877-NCSECURE (1-877-627-3287) <a href="http://www.myncretirement.com">www.myncretirement.com</a></td>
<td>If you are a benefit recipient (Retirees, Beneficiaries, Disability recipients) and you have questions about your retirement benefits.</td>
</tr>
<tr>
<td>Blue Connect</td>
<td><a href="http://www.shpnc.org">www.shpnc.org</a></td>
<td>To enroll in a safe, secure customer service website in order to: Check claim status, verify benefits and eligibility, change your address, or request a new ID card.</td>
</tr>
<tr>
<td>State Health Plan Website</td>
<td><a href="http://www.shpnc.org">www.shpnc.org</a></td>
<td>To obtain information on Pharmacy benefits, search for a provider, obtain claim forms, obtain &quot;proof of coverage&quot; portability certificates, and more.</td>
</tr>
<tr>
<td>State Health Plan Office</td>
<td>919-814-4400</td>
<td>Enrollment exceptions for Non-Active Members (Retirees, Disabled Members, RIF Members, COBRA Members, former Members of the General Assembly, and other 100% contributory Members). Active members must contact their HBR for enrollment exceptions.</td>
</tr>
</tbody>
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MEMBER RIGHTS AND RESPONSIBILITIES

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

- Receive, upon request, information about your health benefit plan including its services and doctors, a benefits booklet and benefit summary. Access to an online 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 the reasons why Blue Cross NC denied a request for treatment or health care service, and the rules used to reach those results.
- Receive, upon request, information on the procedure and medical criteria used to determine whether a procedure, treatment, facility, equipment, medication, or device is investigational, experimental, or requires prior approval.
- Receive accurate, reader friendly information to help you make informed decisions about your health care.
- Expect that measures will be taken to ensure the confidentiality of your health care information.
- File a grievance and expect a fair and efficient appeals process for resolving any differences you may have with the coverage determination of your health benefit plan.
- Be treated with respect and recognition of your dignity and right to privacy.
- Voice complaints or appeals about the organization or the care it provides.
- Make recommendations regarding the organization's members' rights and responsibilities policies.

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

- Present your ID card each time you receive services.
- Give your doctor permission to ask for medical records from other doctors you have seen. You will be asked to sign a transfer of medical records authorization form.
- Read your benefits booklet and all other member materials.
- Call State Health Plan Customer Service if you have a question or do not understand the material provided by the State Health Plan.
- 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 North Carolina State Health Plan Network providers, their staff, and State Health Plan representatives.
- Use Blue Connect to manage claims and related benefit issues.
- Protect your ID card from unauthorized use.
- Notify your employing unit and the State Health Plan of any address or phone number changes.
- Notify your employer and the State Health Plan if you have any other group coverage or become eligible for Medicare.
- Update eBenefits, the Plan’s enrollment system with any change in a dependent’s status.
- Play an active part in your health care.
UNDERSTANDING YOUR STATE HEALTH PLAN COVERAGE

This benefits booklet provides important information about your benefits and can help you understand how to maximize them. To help you become familiar with some common insurance terms concerning what you may owe after visiting your Provider, see the chart below:

| **Copayment** | The fixed-dollar amount that is due and payable by the member at the time a covered service is provided. Copayments are not credited to the deductible; however, they are credited to the out-of-pocket limit. See “Summary of Benefits” for your specific copayment amount. |
| **Deductible** | The dollar amount you must incur for covered services in a benefit period before benefits are payable under the Plan. The deductible does not include coinsurance, charges in excess of the allowed amount, amounts exceeding any maximum, or expenses for non-covered expenses. This plan has an embedded deductible, which means you have an individual deductible and if dependents are covered, you also have a combined family deductible. You must meet your individual deductible before benefits are payable under the Plan. Once the family deductible is met, it is met for all covered family members. Amounts applied to your out-of-network deductible are credited to your in-network deductible. Amounts applied to your in-network deductible are not credited to your out-of-network deductible. Copayments are not credited to the benefit period deductible. See “Summary of Benefits” for your specific deductible amounts. |
| **Coinsurance** | Your share of the cost of a covered service, after you have met your benefit period deductible. This is stated as a percentage of the allowed amount. The coinsurance percentage shown in “Summary of Benefits” is the portion the member pays. |
| **Out-of-Pocket Limit** | The out-of-pocket limit is the dollar amount you pay for covered services in a benefit period before the Plan pays 100%. Your out-of-pocket limit is determined by your type of coverage. The individual out-of-pocket limit applies to each family member covered by the Plan. All family members (subscriber, spouse and/or dependent child(ren)) enrolled together contribute to the same family out-of-pocket limit. When either the family in-network or out-of-network out-of-pocket limit is met, the family out-of-pocket limit is met for all family members on the same 80/20 plan. Coinsurance, copayments and deductibles, are included in the out-of-pocket limit. Non-covered services and amounts over allowed amounts (are not included in the out-of-pocket limit. Charges for prescription medications also apply to the benefit period out-of-pocket limit. Amounts applied to your out-of-network out-of-pocket are credited to your in-network out-of-pocket; however, amounts applied to your in-network out-of-pocket are not credited to your out-of-network out-of-pocket. For out-of-network services, members are responsible for the difference between the allowed amount and the total billed amount even after the out-of-pocket limit has been met, except for emergency room services. |

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

If you are trying to determine whether coverage will be provided for a specific service, you may want to review all of the following:

- “Summary of Benefits” to get an overview of your specific benefits, such as deductible, coinsurance, copayments, and maximum amounts.
- “Covered Services” to get more detailed information on what is covered and what is excluded from coverage.
- “What Is Not Covered?” to see general exclusions from coverage.
- “Utilization Management” for important information on when prior review and certification are required.
GET THE MOST OUT OF YOUR HEALTH CARE BENEFITS

Understand Your Health Benefit Plan
The more you know about your benefits, the easier it will be to take control of your health. Let the State Health Plan help you understand your plan and use it effectively through our customer friendly website (www.shpnc.org), Customer Service (888-234-2416), and your benefits booklet.

Manage Your Out-of-Pocket Costs by Managing the Locations in which You Receive Care
Generally speaking, care received in a doctor’s office is the most cost effective for you, followed by hospital outpatient services. Hospital inpatient and emergency room services often bear the highest cost. In addition, remember that in-network care (services from a North Carolina State Health Plan Network in-network provider who agrees to charge specified rates) will cost you less than similar care provided by an out-of-network provider. You should ask the receptionist whether the provider’s office is hospital owned or operated or provides hospital-based services. This may subject your medical services to the outpatient services benefit, which requires deductibles and coinsurance. Know what your financial responsibility is before receiving care.

Save on Prescription Medications
Print out the preferred medication list and take it with you when visiting your doctor. Ask your doctor to authorize a generic substitute whenever a generic is available and appropriate. You are more likely to save money using generics since they typically have the lowest copayment. When there is more than one brand name medication available and appropriate for your medical condition, it is suggested that you ask your physician to prescribe a medication in a lower brand Tier.

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

THE CLEAR PRICING PROJECT
The State Health Plan’s Clear Pricing Project (CPP) was developed to secure the Plan’s financial future and to promote quality, accessible health care. The goal of this effort was to ensure that members have this valuable benefit for years to come, while bringing transparency to health care expenses and addressing the rising health costs that you and your family face every day.

This effort resulted in more than 28,000 providers partnering with the Plan for transparent and affordable health care. These providers are noted in the online “Find a Doctor” tool as CPP Providers.

In 2022, members will receive lower copays by visiting a CPP provider, which is outlined in this Benefit Booklet.

To learn more about the CPP, visit the Plan’s website at www.shpnc.org.
NC HEALTHCONNEX

North Carolina’s Health Information Exchange (HIE) system, NC HealthConnex, is a secure electronic network system for doctors, hospitals, and other health care providers to share information that can improve your care. The system links your key medical information from all your health care providers to create a single, electronic patient health record. The system intends to facilitate conversations between your authorized health care providers, allowing them to access and share your patient health records from across the State.

Due to new legislation (NCSL 2021-26), the deadline for most providers to connect to NC HealthConnex was extended to January 1, 2023.

This means that if you visit a non-compliant provider, your service will not be covered, you will not be able to submit a claim and you will be responsible for all costs.

More details on NC HealthConnex, including FAQs, are available at www.hiea.nc.gov.
HOW THE 80/20 PPO PLAN WORKS

The 80/20 PPO Plan gives you the freedom to choose any provider — the main difference will be the cost to you, depending on whether you see an in-network or out-of-network provider. This Plan also offers members the option to reduce their monthly premium via a Premium Credit and additional Wellness Incentives for seeking care from certain providers.

Wellness Activity

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

Wellness Premium Credit: Tobacco Attestation

During annual Open Enrollment and when enrolling within 30 days of being first eligible (initial enrollment), you will need to attest that you do not use tobacco or commit to attending at least one tobacco cessation counseling session to earn the tobacco premium wellness credit. When you are initially eligible, you have 90 days from your eligibility date to complete the tobacco cessation visit. The 2022 Open Enrollment tobacco cessation visit must be completed by November 30, 2021. You will need to log into eBenefits, the Plan’s enrollment system, to complete the attestation. Completing this attestation during your enrollment period will save you $60 per month off of your employee-only premium.

To complete the tobacco cessation program, you may visit a MinuteClinic or an in-network Primary Care Provider. You will need to verify if the Primary Care Provider offers cessation services (some do not). Providers must use one of the following codes when billing for this service: 99406 and 99407.

Wellness Incentive

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

<table>
<thead>
<tr>
<th>Wellness Incentive</th>
<th>Description</th>
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<tbody>
<tr>
<td>Visit the CPP PCP listed on your ID card</td>
<td>Free ($0)</td>
</tr>
<tr>
<td>Visit any other network PCP listed on your ID card</td>
<td>Your copay is reduced to $10 each visit</td>
</tr>
<tr>
<td>Visit a CPP Behavioral Specialist</td>
<td>Free ($0)</td>
</tr>
<tr>
<td>Visit a CPP Specialist</td>
<td>Your copay is reduced to $40 each visit</td>
</tr>
<tr>
<td>Visit a CPP Speech, Occupational or Physical Therapist or a Chiropractor</td>
<td>Your copay is reduced to $26 each visit</td>
</tr>
</tbody>
</table>

Availability of Wellness Activity Accommodation

Your health plan is committed to helping you achieve your best health and to making the wellness premium credit available to all employees that complete the tobacco attestation. For tobacco users, a reasonable alternative to the tobacco cessation program offered can be provided to you upon request. If your physician recommends a different alternative because he or she believes the program we make available is not medically appropriate, that recommendation may be accommodated to enable you to achieve the reward. Contact us at 855-859-0966 to make an accommodation request.
THE ROLE OF A PRIMARY CARE PROVIDER (PCP)

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

A Primary Care Provider can practice:

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

Please note, however, that not every provider in these specialties is available to be a PCP in the North Carolina State Health Plan Network. Please visit the State Health Plan website at www.shpnc.org or call State Health Plan Customer Service to be sure the provider you choose is available to be a North Carolina State Health Plan Network PCP. If you choose to use either the online “Find a Doctor” tool directory or the PCP selection tool, available via eBenefits, the Plan’s enrollment system you will be able to identify CPP PCPs within the North Carolina State Health Plan Network. Always confirm that the provider is in-network before receiving care.

If your PCP or specialist leaves the North Carolina State Health Plan Network and is currently treating you for an ongoing special condition that meets the continuity of care criteria, Blue Cross NC will notify you 30 days before the provider’s termination, as long as Blue Cross NC receives timely notification from the provider. You may be eligible to elect continuing coverage for a period of time if, at the time of the provider’s termination, you meet the eligibility requirements. See Continuity of Care in "Utilization Management." Please contact the State Health Plan Customer Service at the number in "Who to Contact" for additional information.

In-Network Benefits

By receiving care from an in-network provider, you receive a higher level of benefit coverage. In-network providers will file claims for you and request prior 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 North Carolina State Health Plan Network hospital where they practice, unless that hospital cannot provide the services you need. The Plan contracts with a broad network of North Carolina providers to deliver covered services to Plan members. Please note that dentists and orthodontists do not participate in the North Carolina State Health Plan Network, but there are a limited number of oral maxillofacial surgeon’s available in-network. However, if the condition is an emergency or if an in-network provider is not reasonably available or that provider type does not participate in the network, benefits will be paid at the in-network level. For more information on Blue Cross NC’s access to care standards, see the State Health Plan website at www.shpnc.org or call Customer Service at the number given in “Who to Contact.” In-network providers include:

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

You do not need a referral to see a North Carolina State Health Plan Network provider. To see which providers are available in-network, please refer to, the “Find a Doctor” section of this Benefits Booklet, on our website at www.shpnc.org, or call State Health Plan Customer Service at the number given in "Who to Contact."
The list of in-network providers may change from time to time, so please verify that the provider is still in the North Carolina State Health Plan Network before receiving care, even if referred by an in-network provider.

If you see a 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 out-of-pocket limits.

Out-of-Network Benefits
With the PPO Plan, you may choose to receive covered services from an out-of-network provider and benefits will be subject to out-of-network benefits and/or reimbursements level.

However, if the condition is an emergency, or if in-network providers are not reasonably available to the member as determined by Blue Cross NC’s access to care standards, benefits will be paid at the in-network benefit level. For more information on Blue Cross NC’s access to care standards, see the State Health Plan website at www.shpnc.org or call Customer Service at the number given in “Who to Contact.” If you believe an in-network provider is not reasonably available, you can help assure that benefits are paid at the correct benefit level by calling State Health Plan Customer Service before receiving care from an out-of-network provider. See the number for "Prior Review (Certification)" in "Who to Contact."

When you see an out-of-network provider, you may be responsible for more of the cost. Out-of-network benefits are generally lower than in-network benefits. In addition, you may be required to pay the difference between the provider’s actual charge and the allowed amount. You eliminate this additional cost by receiving care from in-network providers.

The State Health Plan encourages you to discuss the cost of services with out-of-network providers before receiving care, so you will be aware of your total financial responsibility. Out-of-network providers may or may not bill the State Health Plan directly for services. If the provider does not bill the State Health Plan, you will need to submit a claim form to the State Health Plan.

Out-of-network providers, unlike in-network providers, are not obligated by contract to request prior 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 will result in a full denial of benefits. Before receiving the service, you may want to verify with the State Health Plan or its representative, that certification has been obtained. See “Prospective Review/Prior Review” in “Utilization Management” for additional information.

Note: Some services may not be covered out-of-network. See "Summary of Benefits" and "Covered Services." See "Out-of-Network Benefits Exceptions" and "Emergency and Urgent Care Services." Also see "Behavioral Health 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 behavioral health services:  
State Health Plan  
c/o Blue Cross NC  
PO Box 30087  
Durham, NC 27702

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

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

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

**Identification Card**

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

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

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

If any information on your ID card is incorrect or for *ID card* requests, please visit “Blue Connect” which can be accessed from eBenefits. For information about how to access eBenefits, visit the *Plan’s* website at [www.shpnc.org](http://www.shpnc.org) or call Customer Service at the number listed in “Who to Contact” or on the back of your *ID card*.
UNDERSTANDING YOUR SHARE OF THE COST

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

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

<table>
<thead>
<tr>
<th>Type of Provider</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-network providers are health care professionals and facilities that have contracted with the Plan and/or Blue Cross NC, or a provider participating in the BlueCard program, Blue Cross NC’s national network. Ancillary providers outside of North Carolina are considered in-network only if they contract directly with Blue Cross NC, even if they participate in the BlueCard program. In-network providers agree to limit charges for covered services to the allowed amount. Please note that dentists and orthodontists do not participate in the North Carolina State Health Plan Network but there are a limited number of oral maxillofacial surgeon’s available in-network. The list of in-network providers may change from time to time. In-network providers are listed on the Plan’s website at <a href="http://www.shpnc.org">www.shpnc.org</a> or call Customer Service at the number listed in “Who to Contact.”</td>
<td>Out-of-network providers are not designated as North Carolina State Health Plan Network providers or Blue Card providers. Also see “Out-of-Network Benefit Exceptions.”</td>
</tr>
<tr>
<td><strong>Allowed Amount vs. Billed Amount</strong></td>
<td>If the billed amount for a covered service is greater than the allowed amount, you are not responsible for the difference. You will be responsible for any applicable copays, deductible, coinsurance, and non-covered expenses based on the allowed amount. It is important to note, that there are some instances, due to the provider contract, that the allowed amount may be greater than the billed amount.</td>
<td>You may be responsible for paying any charges over the allowed amount in addition to any applicable deductible, coinsurance, non-covered expenses and certification amounts, if any, except for emergency services in the case of an emergency.</td>
</tr>
<tr>
<td>Referrals</td>
<td>The Plan does not require you to obtain any referrals.</td>
<td>The Plan does not require you to obtain any referrals.</td>
</tr>
<tr>
<td>After-hours Care</td>
<td>If you need non-emergency services after your provider’s office has closed, please call your provider’s office for their recorded instructions.</td>
<td></td>
</tr>
<tr>
<td>Care Outside of North Carolina</td>
<td>Your ID card gives you access to participating providers outside the state of North Carolina through the BlueCard program, and benefits are provided at the in-network benefit level.</td>
<td>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 benefit. Also see “Out-of-Network Benefit Exceptions.”</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Prior Review</td>
<td>In-network providers in North Carolina and in-network inpatient facilities outside North Carolina are responsible for requesting prior review when necessary. If you receive other, non-inpatient services outside of North Carolina (even if you see an in-network provider), you are responsible for ensuring that you or your provider requests prior review. For inpatient or certain outpatient behavioral health services, either in or outside of North Carolina, see the Behavioral Health number in “Who To Contact.” Prior review is not required for an emergency or for an inpatient hospital stay for 48 hours after a vaginal delivery or 96 hours after a cesarean section.</td>
<td>You are responsible for ensuring that you or your out-of-network provider requests prior review by Blue Cross NC. Failure to request prior review and obtain certification will result in full denial of benefits. Prior review is not required for an emergency or for an inpatient hospital stay for 48 hours after a vaginal delivery or 96 hours after a cesarean section.</td>
</tr>
<tr>
<td>Filing Claims</td>
<td>In-network providers in North Carolina are responsible for filing claims directly with Blue Cross NC.</td>
<td>You may have to pay the out-of-network provider in full and submit your own claim to Blue Cross NC. 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.</td>
</tr>
</tbody>
</table>

**Out-of-Network Benefit Exceptions**

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

If you believe an in-network provider is not reasonably available, you can help assure that benefits are paid at the correct benefit level by calling Customer Service before receiving care from an out-of-network provider.
80/20 PLAN (PPO) SUMMARY OF BENEFITS

The following is a summary of your 80/20 Plan (PPO) benefits. A more complete description of your benefits is found in "Covered Services." General exclusions may also apply. Please see "What Is Not Covered?" As you review the Summary of Benefits chart, keep in mind:

- The copayment amounts are fixed dollar amounts the member must pay for some covered services depending on the provider network selection made at the time of service.
- Multiple office visits or emergency room visits on the same day may result in multiple copayments.
- Coinsurance percentages shown in this section are the portion of the allowed amount that you pay.
- Deductible and coinsurance are based on the allowed amount.
- Services applied to the deductible also count toward any visit or day maximums.
- If your benefit level for services includes deductibles and coinsurance, your provider may collect an estimated amount of these at the time you receive services.

To receive in-network benefits, you must receive care from a North Carolina State Health Plan Network in-network provider. However, in an emergency, or when in-network providers are not reasonably available as determined by Blue Cross NC’s access to care standards, you may also receive in-network benefits for care from an out-of-network provider. Please see “Out-of-Network Benefits” and "Emergency and Urgent Care Services" for additional information on emergency care. Access to care standards are available on our website at www.shpnc.org, then click “Find a Doctor” or by calling the State Health Plan Customer Service number given in “Who to Contact.”

- If you see an out-of-network provider, you will receive out-of-network benefits unless otherwise approved by the State Health Plan or its representative.

Out-of-Network Labs: If your provider sends your lab work to an out-of-network lab for processing, your claims will no longer be paid at the in-network coinsurance. Your claims for these services will be paid at the appropriate out-of-network deductible coinsurance level. This may result in you having to pay more for out-of-network lab work. Talk to your provider to ensure they are using the North Carolina State Health Plan Network in-network labs.

- For some services that are not covered benefits, discounts may be available as “value-added benefits.” Please see the section called “Value-Added Programs” in the back of this booklet.

This plan offers Wellness Premium Credits and Wellness Incentives to encourage decisions that are good for your health.

To receive the Wellness Premium Credit, you must attest to being a non-tobacco user or agree to participate in a tobacco cessation program within 30 days of becoming first eligible to enroll and annually during Open Enrollment. Members who agree to participate in the tobacco cessation program must commit to visit their PCP or a CVS MinuteClinic for at least one tobacco cessation counseling session within 90 days from their initial hire date. Those who agree to participate in tobacco cessation during the 2022 Open Enrollment must complete at least one session by November 30, 2021.

- To receive Wellness Incentive discounts, you must use the Primary Care Provider (PCP) on your member ID card.
- Preventive Care as described under the Affordable Care Act (ACA) is covered at 100% with an in-network provider so long as any applicable medical management requirements are met.
- Preventive medications listed under the Affordable Care Act (ACA) with a prescription written by a provider and filled at a participating pharmacy, are covered at 100%.

In the formulary, prescription medications are divided into six categories or tiers: (Tier 1), the most cost-effective non-specialty medications, which would include mostly generic medications; (Tier 2), preferred brand non-specialty medications, including some high-cost generic medications; (Tier 3), non-preferred brand non-specialty medications and compounds; (Tier 4), the most cost-effective specialty medications, including generics and some biosimilars; (Tier 5), preferred brand specialty medications; and (Tier 6), non-preferred brand specialty medications. Refer to the State Health Plan website for a list of specialty medications. There is also a special tier for Preferred Blood Glucose Monitoring Meters (BGM) and Supplies and a $0 copay for all insulins. The formulary, or drug list of covered medications, changes quarterly, so changes in drug coverage are possible, which may affect your out-of-pocket costs. Refer to the State Health Plan website for a list of medications.

- The Plan may use reasonable medical management procedures to determine any coverage limitations or restrictions that may apply.
Please note the list of *in-network providers* may change from time to time, so please verify that the *provider* is still in the North Carolina State Health Plan Network before receiving care. A *provider* locator is available through our website at [www.shpnc.org](http://www.shpnc.org) or by calling *State Health Plan* Customer Service at the number given in "Who to Contact."
**Lifetime Maximum, Deductible, and Out-of-Pocket Limit**

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

<table>
<thead>
<tr>
<th></th>
<th>In-Network</th>
<th>Out-of-Network*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lifetime Maximum</strong></td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
</tbody>
</table>

Unlimited for all covered services except where otherwise specifically indicated or excluded. If you exceed any lifetime maximum, additional services of that type are not covered. In this case, you may be responsible for the entire amount of the Provider’s billed charge.

**Deductible**

<table>
<thead>
<tr>
<th></th>
<th>In-Network</th>
<th>Out-of-Network*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual, per benefit period</td>
<td>$1,250</td>
<td>$2,500</td>
</tr>
<tr>
<td>Family, per benefit period</td>
<td>$3,750</td>
<td>$7,500</td>
</tr>
</tbody>
</table>

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

- Preventive Care as defined by the Affordable Care Act.
- Copayments.
- In-Network services do not apply to the Out-of-Network deductible.
- Inpatient newborn care for well-baby.

**Out-of-Pocket Limit**

<table>
<thead>
<tr>
<th></th>
<th>In-Network</th>
<th>Out-of-Network*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual, per benefit period</td>
<td>$4,890</td>
<td>$9,780</td>
</tr>
<tr>
<td>Family, per benefit period</td>
<td>$14,670</td>
<td>$29,340</td>
</tr>
</tbody>
</table>

Charges over allowed amounts and charges for non-covered services do not apply to the out-of-pocket limit. The out-of-pocket limit, which is the deductible plus any copays and coinsurance you pay, is the total amount you will pay for covered services.

**Preventive Care**

<table>
<thead>
<tr>
<th></th>
<th>In-Network</th>
<th>Out-of-Network*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Provider</td>
<td>No Charge</td>
<td>Benefits not available¹</td>
</tr>
<tr>
<td>Specialist</td>
<td>No Charge</td>
<td>Benefits not available¹</td>
</tr>
</tbody>
</table>

Nutrition Counseling

<table>
<thead>
<tr>
<th></th>
<th>In-Network</th>
<th>Out-of-Network*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No Charge</td>
<td>40% after deductible</td>
</tr>
</tbody>
</table>

Available in an office-based, outpatient, or ambulatory surgical setting, or urgent care center. Services include among others: routine physical exams and screenings, well-baby care, well-child care, well-woman care, immunizations, nutritional counseling, gynecological exams, cervical cancer screening, ovarian cancer screening, screening mammograms, colorectal screening, bone mass measurement, prostate-specific antigen tests, and newborn hearing screening.

This benefit is only for services that indicate a primary diagnosis of preventive or wellness. Please visit the Plan’s website at [www.shpnc.org](http://www.shpnc.org) for the most up-to-date information on preventive care covered under federal law.

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

**Provider’s Office**

See Outpatient Service for outpatient clinic or hospital-based services. Office visits for the evaluation and treatment of obesity are limited to a combined in- and out-of-network maximum of four visits per benefit period. Any visits in excess of these benefit period maximum are not covered services.

<table>
<thead>
<tr>
<th></th>
<th>In-Network</th>
<th>Out-of-Network*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Provider</td>
<td>$0 copay</td>
<td>40% after deductible</td>
</tr>
<tr>
<td></td>
<td>when using CPP PCP listed on ID card</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$10 copay</td>
<td></td>
</tr>
<tr>
<td></td>
<td>when using Other In-Network PCP on ID card</td>
<td></td>
</tr>
</tbody>
</table>
### Specialist (includes Ambulatory Infusion Suite)

- **$25 copay** – when using in-network PCP not listed on the ID card
- **$40 copay** when using CPP Specialist
- **$80 copay** when using other In-Network Specialist

40% after deductible

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

### CT Scans, MRIs, MRAs, and PET Scans

- **20% after deductible**

40% after deductible

### Short-Term Therapy Services (Includes Evaluation and Management)

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

<table>
<thead>
<tr>
<th>In-Network</th>
<th>Out-of-Network*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Short-Term Rehabilitative Therapies</strong></td>
<td></td>
</tr>
<tr>
<td>$26 copay when using CCP provider</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>$52 copay when using other In-Network provider</td>
<td></td>
</tr>
</tbody>
</table>

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

**Other Therapies**

| | No Charge | 40% after deductible |

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

### Infertility and Sexual Dysfunction Services

| Primary Care Provider | | |
|-----------------------|-----------------| |
| **$0 copay** when using CPP PCP listed on ID card | | |
| **$10 copay** when using Other In-Network PCP on ID card | | |
| **$25** – when using in-network PCP not listed on the ID card | | |

| Specialist | | |
|------------|-----------------| |
| **$40 copay** when using CPP Specialist | | |
| **$80 copay** when using other In-Network Specialist | | |

Combined in- and out-of-network lifetime limit of 3 ovulation induction cycles and associated services without insemination. Any services in excess of this lifetime limit are not covered services.

### Routine Hearing Evaluation Tests

<p>| Primary Care Provider | | |
|-----------------------|-----------------| |
| <strong>$0 copay</strong> when using CPP PCP listed on ID card | | |
| <strong>$10 copay</strong> when using Other In-Network PCP on ID card | | |
| <strong>$25</strong> – when using in-network PCP not listed on the ID card | Benefits not available |</p>
<table>
<thead>
<tr>
<th>Specialist</th>
<th>In-Network</th>
<th>Out-of-Network*</th>
</tr>
</thead>
<tbody>
<tr>
<td>$40 copay when using CPP Specialist</td>
<td>$80 copay when using other In-Network Specialist</td>
<td>Benefits not available</td>
</tr>
</tbody>
</table>

### Urgent Care Centers, Emergency Rooms, and Ambulance Services

<table>
<thead>
<tr>
<th>Service Type</th>
<th>In-Network</th>
<th>Out-of-Network*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent Care Centers</td>
<td>$70 copayment</td>
<td>$70 copayment</td>
</tr>
<tr>
<td>Emergency Room Visit</td>
<td>$300 copayment, then 20% after deductible</td>
<td>$300 copayment, then 20% after deductible</td>
</tr>
</tbody>
</table>

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

| Ambulance Services         | 20% after deductible       | 20% after deductible     |

### Ambulatory Surgical Centers

<table>
<thead>
<tr>
<th>Service Type</th>
<th>In-Network</th>
<th>Out-of-Network*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulatory Surgical Services</td>
<td>20% after deductible</td>
<td>40% after deductible</td>
</tr>
</tbody>
</table>

### Outpatient Services

<table>
<thead>
<tr>
<th>Service Type</th>
<th>In-Network</th>
<th>Out-of-Network*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Services</td>
<td>20% after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>Hospital and Hospital Based Services</td>
<td>20% after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>Outpatient Clinical Services</td>
<td>20% after deductible</td>
<td>40% after deductible</td>
</tr>
</tbody>
</table>

#### Outpatient Diagnostic Services

<table>
<thead>
<tr>
<th>Service Type</th>
<th>In-Network</th>
<th>Out-of-Network*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient lab tests, when performed alone (physician and hospital-based services)</td>
<td>No Charge</td>
<td>40% after deductible</td>
</tr>
</tbody>
</table>

#### Outpatient lab tests, when performed with another service

<table>
<thead>
<tr>
<th>Service Type</th>
<th>In-Network</th>
<th>Out-of-Network*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Services</td>
<td>No Charge</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>Hospital and Hospital-based Services</td>
<td>20% after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>Outpatient x-rays, ultrasounds, and other diagnostic test, such as EEGs, EKGs and pulmonary function tests</td>
<td>20% after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>CT scans, MRIs, MRAs, and PET scans</td>
<td>20% after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>Outpatient diagnostic mammography (physician and hospital-based services)</td>
<td>No Charge</td>
<td>40% after deductible</td>
</tr>
</tbody>
</table>
See “Preventive Care” for coverage of screening mammograms.

**Therapy Services**
Includes short-term rehabilitative therapies and other therapies.

<table>
<thead>
<tr>
<th></th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>20% after deductible</td>
<td>40% after deductible</td>
</tr>
</tbody>
</table>

**Inpatient Hospital Services**

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network</th>
<th>Out-of-Network*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Services</td>
<td>20% after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>Hospital and Hospital Based Services</td>
<td>$300 copayment, then 20% after deductible/coinsurance</td>
<td>$300 copayment, then 40% after deductible</td>
</tr>
</tbody>
</table>

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

**Nursing**

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network</th>
<th>Out-of-Network*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled Nursing Facility</td>
<td>20% after deductible</td>
<td>40% after deductible</td>
</tr>
</tbody>
</table>

Combined in- and out-of-network maximum of 100 days per benefit period. Services applied to the deductible count towards the day maximum. Any services in excess of this benefit period maximum are not covered services.

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network</th>
<th>Out-of-Network*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private Duty Nursing</td>
<td>20% after deductible</td>
<td>40% after deductible</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network</th>
<th>Out-of-Network*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Services</td>
<td>20% after deductible</td>
<td>40% after deductible</td>
</tr>
</tbody>
</table>

Includes durable medical equipment, hospice services, medical supplies, orthotic devices, private duty nursing, prosthetic appliances, and home health care. Hearing aids are limited to one per hearing-impaired ear every 36 months for members under the age of 22. Members over of the age of 22 are not covered for any hearing aid related services. Any services in excess of these benefit period or lifetime maximums are not covered services.

**Behavioral Health Services**

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network</th>
<th>Out-of-Network*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health Services Office Services</td>
<td>$0 copay for CPP Provider; $25 copay for other Behavioral Health Specialists</td>
<td>40%</td>
</tr>
<tr>
<td>Behavioral Health Services Outpatient Services</td>
<td>20% after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>Behavioral Health Services Inpatient Services**</td>
<td>$300 copayment, then 20% after deductible</td>
<td>$300 copayment, then 40% after deductible</td>
</tr>
<tr>
<td>Residential Treatment Centers***</td>
<td>$300 copayment, then 20% after deductible</td>
<td>$300 copayment, then 40% after deductible</td>
</tr>
</tbody>
</table>

No age limit for Substance Abuse.
**Requires certification** within two business days of admission.
***Requires certification and prior review in advance and must be an approved residential treatment center.
Failure to request prior review and receive certification will result in full denial of benefits. Certification is not a guarantee of payment. See “Covered Services” and “Prospective Review/Prior Review” in “Utilization Management.”
Certification Requirements

In-network providers outside of North Carolina, except for Veterans Affairs (VA) and military providers, are responsible for requesting prior review for inpatient facility services. For all other covered services received outside of North Carolina, you are responsible for ensuring that you or your provider requests prior review by the State Health Plan even if you see an in-network provider.

Certain services, regardless of the location, require prior review and certification in order to receive benefits. If you go to an in-network provider in North Carolina, your provider will request prior review when necessary. If you go to an out-of-network provider in North Carolina or to any provider outside of North Carolina, you are responsible for requesting or ensuring that your provider requests prior review. Failure to request prior review and receive certification will result in full denial of benefits. See “Covered Services” and “Prior review (pre-service)” in “Utilization Management.”

For certification for certain prescription medications, your physician may call CVS Caremark at 800-294-5979 to initiate a certification request.

NOTICE: Your actual expenses for covered services may exceed the stated coinsurance amount because actual provider charges may not be used to determine the Plan’s and member’s payment obligations. For out-of-network benefits, you may be required to pay for charges over the allowed amount in addition to any deductible and coinsurance amount.

Prescription Medications

Prescription medication benefits are administered by CVS Caremark (the Pharmacy Benefits Manager – PBM). See “Prescription Medication Copayment and Benefits” in “Covered Services” for more information.

<table>
<thead>
<tr>
<th></th>
<th>0-30 Day Supply</th>
<th>31-60 Day Supply</th>
<th>61-90 Day Supply</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1</td>
<td>$5</td>
<td>$10</td>
<td>$15</td>
</tr>
<tr>
<td>Tier 2</td>
<td>$30</td>
<td>$60</td>
<td>$90</td>
</tr>
<tr>
<td>Tier 3</td>
<td>20% coinsurance after deductible</td>
<td>20% coinsurance after deductible</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Tier 4</td>
<td>$100</td>
<td>$200</td>
<td>$300</td>
</tr>
<tr>
<td>Tier 5</td>
<td>$250</td>
<td>$500</td>
<td>$750</td>
</tr>
<tr>
<td>Tier 6</td>
<td>20% coinsurance after deductible</td>
<td>20% coinsurance after deductible</td>
<td>20% coinsurance after deductible</td>
</tr>
</tbody>
</table>

Affordable Care Act Preventive Medications

Covered at 100%

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

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

Insulin

Both preferred and non-preferred insulin is available at a $0 copay.

Blood Glucose Monitoring (BGM) and - Supplies

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

<table>
<thead>
<tr>
<th></th>
<th>0-30 Day Supply</th>
<th>31-60 Day Supply</th>
<th>61-90 Day Supply</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preferred Blood Glucose Meters (BGM) and Supplies*</td>
<td>$5</td>
<td>$10</td>
<td>$15</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>-------------</td>
<td>-------------</td>
<td>-------------</td>
</tr>
<tr>
<td>Non-Preferred BGMs &amp; Supplies</td>
<td>20% coinsurance after deductible</td>
<td>20% coinsurance after deductible</td>
<td>20% coinsurance after deductible</td>
</tr>
</tbody>
</table>

* This does not include Continuous Glucose Monitoring Systems or associated supplies. Preferred Continuous Glucose Monitoring Systems and associated supplies are considered a Tier 2 member copay.

For certification for certain prescription medications, your physician may call CVS Caremark at 800-294-5979 to initiate a certification request.
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 benefit service is covered, and you cannot find the information in "Covered Services," see “Summary of Benefits" or call State Health Plan Customer Service at the number listed in "Who to Contact."

Also keep in mind as you read this section:

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

- Exclusions and limitations may apply to your coverage. Exclusions that apply to many services are listed in “What Is Not Covered?” To understand the exclusions and limitations that apply to each service, read “Covered Services,” “Summary of Benefits” and “What Is Not Covered?”

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

Office Services

Care you receive from a doctor, physician’s assistant, nurse practitioner or nurse midwife as part of an office visit or house call is covered with a copayment, except as otherwise noted in this benefits booklet. Some providers may get ancillary services, such as laboratory services, medical equipment, supplies, or specialty medications from third parties. In these cases, you may be billed directly by the ancillary provider. Benefit payments for these services will be based on the type of ancillary provider, its network status, and how the services are billed. The Plan also covers infusion services received at an ambulatory infusion suite. Certain infusion services require prior review and certification, or services will not be covered. If you select a PCP during enrollment, and you use the PCP printed on the front of your ID card, you will pay the lower copay amount each time you see that PCP.

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

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

Preventive Services

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

Under federal law, you can receive certain covered preventive care services from an in-network provider in an office-based, outpatient, or ambulatory surgical setting, or urgent care center, at no cost to you. The specific services covered change from time to time. The Plan follows federal and Blue Cross NC guidelines that are based on the most current scientific evidence and are adapted from standards published by nationally recognized authorities. The specific guidelines can be found on Blue Connect. Please note, this benefit is only for services that indicate a primary diagnosis of preventive or wellness and which are identified by recent federal legislation as being eligible.
Services that do not include a primary diagnosis of preventive or wellness will be subject to your in-network benefit level for the location where services are received.

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

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

- Adult and Child Obesity Services
  - Obesity screening
  - Behavioral intervention
  - Nutritional counseling

- Adult Preventive Care (Routine Exams)

- Adult Screening Tests
  - Cholesterol (lipid) screening
  - Colorectal screening
  - Depression screening
  - Diabetes screening
  - High blood pressure screening
  - Pap test
  - Osteoporosis screening
  - Ovarian Cancer Screening
  - Prostate Screening
  - Screening mammograms

- Women’s Health Services include
  - Breastfeeding Support and Counseling
  - Contraceptive methods and counseling - Contraceptive methods and procedures requiring a prescription and approved by the U.S. Food and Drug Administration are covered for each member with reproductive capacity through age 50. In addition, over-the-counter contraceptives are covered when a provider’s prescription is presented at the pharmacy. See “What Is Not Covered” for list of contraceptive methods that are not covered.
  - Gestational diabetes screening (pregnant women)
  - HIV screening and counseling
  - HPV testing
  - Well-woman visits
  - Mammograms
Immunizations
- Diphtheria, Pertussis, Tetanus Toxoid
- Inactivated Poliovirus
- Measles, Mumps, Rubella (MMR)
- Influenza
- Pneumococcal
- Hepatitis A and B
- Human Papillomavirus (HPV)
- Meningococcal
- Varicella
- Tetanus, Diphtheria, Pertussis
- Rotavirus
- Herpes Zoster

Well-Baby/Well-Child Care
- Physical examinations
- Sensory screening (vision and hearing)
- Developmental/behavioral assessments
- Oral health

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

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

Out-of-Network Labs: If your provider sends your lab work to an out-of-network lab for processing, your claims will no longer be paid at the in-network coinsurance. Your claims for these services will be paid at the appropriate out-of-network coinsurance. This may result in you having to pay more for out-of-network lab work. Talk to your provider to ensure they are using Blue Cross NC in-network labs.

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

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

Urgent Care Centers, Emergency Rooms, and Ambulance Services

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

Transport to and from a dialysis center:

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

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

Ambulance transportation services will be reviewed for medical necessity in the case of:

- Ambulance services from a hospital or skilled nursing facility to a member’s home.
- Non-emergency air ambulance services.

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

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

  See “What Is Not Covered” for information about ambulance services exclusions.

- **Emergency Care**
  The Plan provides benefits for emergency services.

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

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

Heart attacks, strokes, uncontrolled bleeding, poisonings, major burns, prolonged loss of consciousness, spinal injuries, shock and other severe, acute conditions are examples of emergencies.
What to do in an Emergency

In an emergency, you should seek care from an emergency room or other similar facility. If necessary and available, call 911 or use other community emergency resources to obtain assistance in handling life-threatening emergencies. Prior 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.

Benefits for services in the emergency room.

<table>
<thead>
<tr>
<th>Situation</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>You go to an in-network emergency room for a non-emergency condition.</td>
<td>Applicable copay, deductible and coinsurance. Prior review and certification are not required.</td>
</tr>
<tr>
<td>You go to an out-of-network emergency room for a non-emergency condition.</td>
<td>Applicable copay, out-of-network deductible and coinsurance. You may be required to pay the provider and submit a claim for out-of-network reimbursement.</td>
</tr>
<tr>
<td>You go to an in-network hospital emergency room for an emergency condition.</td>
<td>Applicable copay, deductible and coinsurance. Prior review and certification are not required.</td>
</tr>
<tr>
<td>You go to an out-of-network hospital emergency room for an emergency condition.</td>
<td>Benefits are paid as in-network. Because it is an out-of-network provider, you may be required to pay the entire bill at the time of service and file a claim. Prior review and certification are not required.</td>
</tr>
<tr>
<td>You are held for observation.</td>
<td>Outpatient benefits may apply to all covered services received in the emergency room and during observation. Emergency room copayment is waived.</td>
</tr>
<tr>
<td>You are admitted to the hospital from the ER following emergency services.</td>
<td>Inpatient hospital benefits apply for all covered services received in the emergency room and during hospitalization. Prior review and certification are required for inpatient hospitalization and other selected services following emergency services (including screening and stabilization) or coverage will be denied. You may need to transfer to an in-network hospital once your condition is stabilized in order to continue receiving in-network benefits.</td>
</tr>
<tr>
<td>You get follow-up care (such as office visits or therapy) after you leave the ER or are discharged.</td>
<td>Use in-network providers to receive in-network benefits. Follow-up care related to the emergency condition is not considered an emergency.</td>
</tr>
</tbody>
</table>

Urgent Care

The Plan also provides benefits for urgent care services.

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

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

- Maternity Care

Maternity care includes prenatal care, labor and delivery, and post-delivery care, and are available to all subscribers and enrolled spouses of subscribers. However, maternity benefits for dependent children cover only the treatment for complications of pregnancy.

Coverage for breastfeeding counseling and certain breast pumps for pregnant or postpartum members are covered under your preventive care benefit. Coverage includes:

- Breastfeeding counseling covered at 100% through in-network providers.
- Certain breast pumps for pregnant and post-partum women:
  - One manual or electric breast pump purchase per delivery is covered.
  -Benefit available during third trimester or after member has delivered the baby.
  - Breast pumps come with certain supplies, such as tubing, shields and bottles; therefore, replacement breast pump supplies will not be separately reimbursable on the same date as the breast pump, as the supplies are included in the initial purchase.
  - Breast pump supplies will be limited to two units per code, per year.

  - Breast pumps must be purchased from participating Durable Medical Equipment (DME) vendors.
    - Not all participating DME vendors carry all items. Please check with your local participating vendor of choice to see if they carry breast pumps. Edgepark carries breast pumps (1-800-321-0591) or go to the Find a Doctor or Facility page to find a vendor close to you. If you need help finding a DME vendor that carries breast pumps, call the Customer Service number on the back of your member ID card.
    - See “What Is Not Covered” for information about breast pump exclusions.

Please visit the Plan’s website at www.shpnc.org for the most up-to-date information on preventive care covered under federal law.

Post-delivery care is all care for the mother after the baby's birth that is related to the pregnancy.

<table>
<thead>
<tr>
<th>Mom</th>
<th>Newborn</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prenatal care</td>
<td>Care related to the pregnancy before birth.</td>
<td>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.</td>
</tr>
<tr>
<td>Labor &amp; delivery services</td>
<td>No prior review required for inpatient hospital stay for 48 hours after a vaginal delivery or 96 hours after a cesarean section. Mothers choosing a shorter stay are eligible for a home health visit for post-delivery follow-up care if received within 72 hours of discharge.</td>
<td>No prior review required for inpatient well baby care for 48 hours after a vaginal delivery or 96 hours after a cesarean section. Benefits include newborn hearing screening ordered by a doctor to determine the presence of permanent hearing loss. (Please see preventive care in “Summary of Benefits.”)</td>
</tr>
<tr>
<td>Post-delivery services</td>
<td>All care for the mother after baby’s birth that is related to the pregnancy. Prior review and certification are required for inpatient stays extending beyond 48/96 hours or coverage will be denied.</td>
<td>After the first 48/96 hours, whether inpatient (sick baby) or outpatient (well-baby), the newborn must be enrolled for coverage as a dependent child, according to the rules in “When Coverage Begins Ends.” For inpatient services following the first 48/96 hours, prior review and certification are required or coverage will be denied.</td>
</tr>
</tbody>
</table>

**Statement of Rights under the Newborns’ and Mothers’ Health Protection Act**

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

Also, under federal law, group health plans and health insurance issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.
In addition, a plan or issuer may not, under federal law, require that a doctor or other health care provider obtain certification for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain certification. For information on certification, contact State Health Plan Customer Service at the number given in “Who to Contact.”

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

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

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

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

- **Infertility Services**
  Benefits are provided for certain services related to the diagnosis, treatment and correction of any underlying causes of *infertility* for all members except *dependent children*. See “Summary of Benefits” for limitations that may apply.

- **Sexual Dysfunction Services**
  The Plan provides benefits for certain services related to the diagnosis, treatment and correction of any underlying causes of *sexual dysfunction* for all members.

  See “What Is Not Covered” for information about sexual dysfunction services exclusions.

- **Sterilization**
  This benefit is available for all members. Sterilization includes female tubal occlusion and male vasectomy.

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

  See “What Is Not Covered” section for information on family planning exclusions.

**Facility Services**

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

  The following are covered services:
  - *Medical care* provided by a doctor or other professional provider.
  - Observation.
  - General nursing care.
  - Medications administered by the facility.
  - Diagnostic services.
  - *Medical supplies.*
• Use of appliances and equipment ordinarily provided by the facility for the care and treatment of *outpatients*.
• Operating room, recovery room and related services (*outpatient surgery*).
• *Short-term rehabilitative and habilitative 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**

_Inpatient_ services received in a *hospital* or non-hospital facility. You are considered an _inpatient_ if you are admitted to the *hospital* or non-hospital facility as a registered bed patient for whom a room and board charge is made. Your _in-network provider_ is required to use the North Carolina State Health Plan Network _hospital_ where they practice, unless that _hospital_ cannot provide the services you need. If you are admitted before the _effective date_, benefits will not be available for services received prior to the _effective date_. Take home medications are covered as part of your pharmacy benefit. If you are in the _hospital_ as an _inpatient_ at the time you begin a new _benefit period_, you may have to meet a new _deductible_ for _covered services_ from _doctors or other professional providers_.

The following are examples of _covered services_:
• _Medical care_ provided by a _doctor or other professional provider_.
• A semi-private room; or a private room if _medically necessary_ or the _hospital_ has only private rooms.
• Operating room, delivery room, recovery room, nursery and related services.
• General nursing care.
• Intensive care.
• Critical care.
• Medications administered by the _hospital_.
• Diagnostic services and _medical supplies_.
• Use of appliances and equipment ordinarily provided by the _hospital_.
• _Short-term rehabilitative and habilitative therapies and other therapies*.
• _Medical supplies._

_Prior review_ must be requested, and _certification_ must be obtained, in advance for _inpatient_ admissions or coverage will be denied, except for maternity deliveries and _emergencies_. See “Maternity Care,” if applicable and “Emergency Care.”

➢ **Ambulatory Surgical Centers**

Benefits are provided for surgical services received in an _ambulatory surgical center_.

The following are _covered services_:
• _Medical care_ provided by a _doctor or other professional provider_.
• General nursing care.
• Medications administered by the facility.
• Diagnostic services.
• _Medical supplies_.
• Use of appliances and equipment ordinarily provided by the facility for the care and treatment of _surgical procedures_.
• Operating, recovery room and related services.

➢ **Skilled Nursing Facilities**

Benefits are provided for _covered services_ received in a _skilled nursing facility_. _Skilled nursing facility services_ are limited to a combined _in-network_ and _out-of-network_ day maximum per _benefit period_. See “Summary of Benefits.”

_Prior review_ must be requested, and _certification_ must be obtained, in advance for payment of claims. Service for which _prior review_ is not obtained will not be covered. See “Summary of Benefits.”
Other Services

 Blood
The Plan covers the cost of transfusions of blood, plasma, blood plasma expanders and other fluids injected into the bloodstream. Benefits are provided for the cost of storing a member's own blood only when it is stored and used for a previously scheduled procedure.
See “What Is Not Covered” section for information on Blood Exclusions.

 Clinical Trials
The Plan provides benefits for participation in clinical trials phases I, II, III, and IV. Coverage is also provided for Centers of Medicare & Medicaid Services (CMS) Investigational Device Exemption (IDE) Category B device trials. Coverage is provided only for medically necessary costs of health care services associated with the trials, and only to the extent such costs have not been or are not funded by other resources. The member must meet all protocol requirements and provide informed consent in order to participate. The trial must involve the treatment of cancer or a life-threatening medical condition with services that are medically indicated and preferable for that member compared to non-investigational alternatives. In addition, the trial must:

• Involve determinations by treating physicians, relevant scientific data and opinions of relevant medical specialists;
• Be approved or funded 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, CMS, and the Department of Energy; and
• Be conducted in a setting and by personnel of high expertise based on training, experience and patient volume.
See “What Is Not Covered for information on Clinical Trials exclusions.

 Dental Treatments Covered Under Your Medical Benefit
The Plan provides limited benefits for services provided by a duly licensed doctor, doctor of dental surgery or doctor of dental medicine for diagnostic, therapeutic or surgical procedures, including oral surgery involving bones or joints of the jaw, when the procedure or dental treatment is related to one of the following conditions:

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

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

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

When any of the conditions listed above require surgical correction, benefits for surgery will be subject to medical necessity review to examine whether the condition resulted in functional impairment. Examples of functional impairment include an impairment that affects speech or the ability to eat, or injury to soft tissue of the mouth.

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

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

Reconstructive dental services following accidental injury are only covered when the accident occurred while the member is covered by the State Health Plan. Unless reconstructive dental services following accidental injury are related to the bones or joints of the jaw, face, or head, reconstructive dental services are covered only when provided within two years of the accident.

Prior review and certification are required for certain surgical procedures or services will not be covered, unless treatment is for an emergency. Other dental services, including the charge for surgery, are not covered.

See “What Is Not Covered” for information about dental treatments excluded under your Medical Benefit.

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

- Meters
- Supplies including needles, test strips and lancets
- Medications
- Laboratory testing
- Self-management training
- Orthotics
- Insulin
- Educational services
- Eye exams for diabetic retinopathy

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

See “What Is Not Covered” for information on diabetes related service exclusions.

Durable Medical Equipment
Benefits are provided for medically necessary durable medical equipment and supplies required for operation of equipment when prescribed by a doctor. Equipment may be purchased or rented at the discretion of the State Health Plan or its representative. The State Health Plan provides benefits for repair or replacement of the covered equipment. Benefits will end when it is determined that the equipment is no longer medically necessary.

In order to receive the in-network benefit, durable medical equipment must be provided by an in-network supplier. It is important that you or provider verify that the durable medical equipment supplier is an in-network provider. Most out-of-state suppliers are out-of-network providers. Certain durable medical equipment requires prior review and certification, or services will not be covered.

The following are examples of covered durable medical equipment:

- Wheelchairs
- Traction equipment
- Hospital beds
- Mattress accessories
- Respiratory (inhalation) or suction machines

See “What Is Not Covered” for information on Durable Medical Equipment exclusions.
Hearing Aids

Coverage for all hearing aid devices and related services is only available for members under the age of 22 years. Members under the age of 22 are limited to one hearing aid per hearing-impaired ear every 36 months. Members over the age of 22 are not covered for any hearing aid devices or related services.

Coverage includes all medically necessary hearing aids, including implantable bone-anchored hearing aids (BAHA) and services ordered by a provider or an audiologist. BAHA devices and all related services are considered hearing aids and, therefore, not considered a prosthetic appliance or durable medical equipment.

The following are covered:
- Initial hearing aids and replacement hearing aids.
- New hearing aids with alterations to the existing hearing aid that does not adequately meet the member’s need.
- Services, including the initial hearing aid evaluation, fitting, and adjustments and supplies including ear molds.

All hearing aid related coverage is limited to eligible members under the age of 22. Reimbursement will be limited to the contracted amount and you may be billed by the provider for charges greater than the allowed amount. Members over the age of 22 are not covered for any hearing aid devices or related services.

Home Health Care

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

Home health care requires prior review and certification, or services will not be covered.

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

See “What Is Not Covered” for information on Home Health Care exclusions.

Home Infusion Therapy Services

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

The following are examples of covered services:
- Specimen collection, laboratory testing and analysis.
- Patient and family education.
- Management of emergencies arising from home infusion therapy.
- Prescribed medications related to infusion services, and delivery of medications and supplies.
Hospice Services
Your coverage provides benefits for hospice services for care of a terminally ill member with a life expectancy of six months or less. Services are covered only as part of a licensed health care program centrally coordinated through an interdisciplinary team directed by a doctor that provides an integrated set of services and supplies designed to give comfort, pain relief and support to terminally ill patients and their families.

The following are covered services:
- Professional services of an RN or LPN.
- Medical services, equipment and supplies.
- Prescribed medications.
- In-home laboratory services.
- Medical social service consultations.
- Inpatient hospice room, board and general nursing services (requires prior review and certification to avoid a denial of services).
- Inpatient respite care, which is short-term care provided to the member only when necessary to relieve the family member or other persons caring for the individual.
- Family counseling related to the member's terminal condition.
- Dietitian services.
- Pastoral services.
- Bereavement services.
- Educational services.
- Home health aide services, provided by someone other than a professional nurse, which are medical or therapeutic in nature and furnished to a member who is receiving covered nursing or therapy services.

See “What Is Not Covered” for information on Hospice Services exclusions.

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

See “What Is Not Covered” for information on Lymphedema-related service exclusions.

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

To obtain medical supplies and equipment, please find a provider on our website at www.shpnc.org or call State Health Plan Customer Service.

See “What Is Not Covered” for information on Medical Supplies exclusions.

Obesity Treatment / Weight Management
The Plan provides coverage for office visits for the evaluation and treatment of obesity; see “Summary of Benefits” for visit maximums. Members must go to a Blue Distinction Center for bariatric surgery. The Plan covers bariatric surgery when performed at a Blue Distinction Center (BDC). Surgeries performed at non-BDCs will not be a covered benefit and prior approval will not be granted to non-BDC facilities. Complications arising from surgeries performed at a non-BDC will be covered under emergency services criteria. Bariatric surgeries for which prior approval is not obtained will not be covered regardless of the facility’s BDC status. For a listing of Blue Distinction Centers (BDC),
visit the State Health Plan website at www.shpnc.org, click “Find a Doctor” and select “Obesity Surgery Blue Distinction Center”. The Plan also provides benefits for nutritional counseling visits to an out-of-network provider as part of your preventive care benefits. The nutritional counseling visits may include counseling specific to achieving or maintaining a healthy weight. Nutritional counseling visits are separate from the obesity-related office visits noted above.

See “What Is Not Covered” for a list of obesity Treatment/Weight Management exclusions.

- **Orthotic Devices**
  Orthotic devices, which are rigid or semi-rigid supportive devices that restrict or eliminate motion of a body part, are covered if medically necessary and prescribed by a provider. Foot orthotics may be covered only when custom molded to the patient and are subject to the following limits:
  - Unlimited pairs for members up to age 18
  - 4 units per calendar year for members 18 or older

  Orthotic devices for positional plagiocephaly – One device (includes dynamic orthotic cranioplasty [DOC] bands and soft helmets).

  See “What Is Not Covered” for a list of items not covered as orthotic devices.

- **Private Duty Nursing**
  Your health benefit plan provides benefits for private duty services of an RN or LPN. Coverage is limited to 4 hours per day for non-vented members and 12 hours per day for vented members. These services must be ordered by your doctor and be medically necessary. You should work with your doctor to make sure prior 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.

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

  Private duty nursing requires prior review and certification, or services will not be covered.

  See “What Is Not Covered” for information on what is not considered private duty nursing.

- **Prosthetic Appliances**
  The Plan 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. The type of prosthetic appliance will be based on the functional level of the member. Therapeutic contact lenses may be covered when used as a corneal bandage for a medical condition. Benefits include a one-time replacement of eyeglass or contact lenses due to a prescription change after cataract surgery. Bone-anchored hearing aid (BAHA) devices and all related services are considered hearing aids and, therefore, not considered a prosthetic appliance or durable medical equipment.

  Certain prosthetic appliances require prior review and certification, or services will not be covered.

  See “What Is Not Covered” for a list of prosthetic appliance exclusions.

- **Varicose Veins**
  The treatment of varicose veins is covered when medically necessary and with the following limitations:
  - Endovenous Procedures – one procedure per limb per lifetime.
  - Sclerotherapy Procedures – three per limb per lifetime.

**Surgical Benefits**
Surgical benefits by a professional or facility provider on an inpatient or outpatient basis, including pre-operative and post-operative care and care of complications, are covered. These benefits include the services of the surgeon or medical specialist, assistant, and anesthetist or anesthesiologist, together with pre-operative and post-operative care.
Surgical benefits include diagnostic surgery, such as biopsies, and reconstructive surgery performed to correct congenital defects that result in functional impairment of newborn, adoptive, and foster children.

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

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

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

- **Anesthesia**
  Your anesthesia benefit includes coverage for general, spinal block anesthetics or monitored regional anesthesia ordered by the attending doctor and administered by or under the supervision of a doctor other than the attending surgeon or assistant at surgery.

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

- **Mastectomy Benefits**
  Under the Women's Health and Cancer Rights Act of 1998, your health benefit plan provides for the following services related to mastectomy surgery:
  - Reconstruction of the breast on which the mastectomy has been performed.
  - Surgery and reconstruction of the non-diseased breast to produce a symmetrical appearance without regard to the lapse of time between the mastectomy and the reconstructive surgery.
  - Prostheses and physical complications of all stages of the mastectomy, including lymphedemas.

  See prosthetic appliances in Other Services in the “Summary of Benefits.”

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

  The benefits described above are subject to the same applicable deductibles, copayment, or coinsurance and limitations as applied to other medical and surgical benefits provided under the State Health Plan.

**Temporomandibular Joint (TMJ) Services**

The Plan provides benefits for services provided by a duly licensed doctor, doctor of dental surgery, or doctor of dental medicine for diagnostic, therapeutic or surgical procedures, including oral surgery involving bones or joints of the jaw, face or head when the procedure is related to TMJ disease. Therapeutic benefits for TMJ disease include splinting and use of intra-oral prosthetic appliances to reposition the bones. Surgical benefits for TMJ disease are limited to surgery performed on the temporomandibular joint. If TMJ is caused by malocclusion, benefits are provided for surgical correction of the malocclusion when surgical management of the TMJ is medically necessary. Please have your provider contact the State Health Plan before receiving surgical treatment for TMJ.

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

See “What Is Not Covered” for a list of TMJ services Exclusions.

**Therapies**

The Plan provides coverage for the following therapy services to promote the recovery of a member from an illness, disease or injury when ordered by a doctor or other professional provider
Short-Term Rehabilitative & Habilitative Therapies
The following therapies are covered only for treatment of conditions that are expected to result in significant clinical improvement in a member's condition:

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

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

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

Other Therapies
The Plan covers:

- Cardiac rehabilitation therapy.
- Pulmonary and respiratory therapy.
- Dialysis treatment.
- Radiation therapy, including accelerated partial breast radiotherapy (breast brachytherapy).
- Breast brachytherapy.
- Chemotherapy, including intravenous chemotherapy.

Chemotherapy benefits are based on where services are received. For chemotherapy received in conjunction with bone marrow or peripheral blood stem cell transplants, follow transplant guidelines described in “Transplants.” Also see “Pharmacy Benefits” regarding related covered prescription medications.

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

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

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

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

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

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

The Plan provides benefits for the treatment of mental illness and substance use disorder by a hospital, residential treatment facility, doctor or other provider without a referral, and includes, but is not limited to:

➢ Office Visit Services

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

• Evaluation and diagnosis.
• Preventive office visits.
• Medically necessary biofeedback and neuropsychological testing.
• Individual and family counseling.
• Group therapy.

➢ Outpatient Services

Covered outpatient treatment services when provided in a behavioral health treatment facility include:

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

Certain in-network and out-of-network outpatient services require prior review and certification or services will not be covered. The time frame for receiving prior review and treatment certification are set forth in the table below. The list of services that require prior review may change from time to time.

➢ Inpatient Services

Covered inpatient treatment services also include:

• Each service listed under office visit services.
• Semi-private room and board.
• Detoxification to treat substance abuse.

Prior review must be requested, and certification must be obtained, within two (2) business days of admission or services will not be covered, except for emergencies. The time frame for receiving prior review and treatment certification is set forth in the table below. The list of services that require prior review may change from time to time.

In-network providers in North Carolina and in-network inpatient facilities outside North Carolina are responsible for requesting prior review when necessary. If you receive other, non-inpatient services outside of North Carolina (even if you see an in-network provider), you are responsible for ensuring that you or your provider requests prior review.

Residential Treatment Facility Services

Prior review must be requested, and certification must be obtained, within two (2) business days of admission for behavioral health services received in a residential treatment facility. The time frame for receiving prior review and treatment certification is set forth in the table below. The list of services that require prior review may change from time to time.

In-network providers in North Carolina and in-network inpatient facilities outside North Carolina are responsible for requesting prior review when necessary. If you receive other, non-inpatient services outside of North Carolina (even if you see an in-network provider), you are responsible for ensuring that you or your provider requests prior review.

Applied Behavior Analysis

Coverage is provided for Applied Behavior Analysis when all of the following conditions are met:

• The member is younger than age 26;
• Diagnosed with Autism Spectrum Disorder by a licensed physician (MD or DO) or a licensed doctoral level clinical psychologist (PhD or PsyD) and
• Treatment is determined to be medically necessary.

Other than those listed in the second bullet above, no other providers are eligible for reimbursement of the diagnostic evaluation. Licensure of the MD, DO, PhD or PsyD must be in the state in which the diagnostic evaluation is performed. These services are covered only when provided by an in-network provider. There are no exceptions for non-network providers.

The diagnostic evaluation does not require prior approval. However, the results of the diagnostic evaluation may be requested during the authorization process to determine medical necessity.

Clinically recognized, validated tools can be found at http://www.cdc.gov/ncbddd/autism/screening.html.

Prior review is required for the initiation of ABA treatment services. ABA therapy for which prior approval is not obtained will not be covered.

Coverage for Applied Behavior Analysis (ABA) is only available in-network, both in-state and out-of-state. Access to Care Standards do not apply to ABA therapy.

Coverage of ABA services is limited to:

• Behavioral health providers who are currently licensed in the state in which services are delivered, and for whom ABA is within their scope of practice; or
• A psychiatrist or developmental pediatrician licensed as an MD or DO in the state in which services are delivered.

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

Substance abuse providers who are licensed or certified by NC Substance Abuse Professional Practice Board, or by the state in which services are provided, and who do not also have a current behavioral health license in their state of practice, are not eligible for reimbursement of ABA services.

See “What Is Not Covered” for information on Applied Behavior Analysis Exclusions

➤ How to Access Behavioral Health Services

Prior review is not required for any office visit services or in emergency situations. However, in emergency situations, please notify Blue Cross NC of your inpatient admission as soon as reasonably possible.

Prior review and certification are required for inpatient (including residential treatment facility services) or certain outpatient services by Blue Cross NC or services will not be covered. See the prior review and certification number listed in “Who to Contact?” Information about which services require prior review as well as a list of in-network providers can be found online at https://www.BlueCrossNC.com/content/services/medical-policy/index.htm or you can call Blue Cross NC Customer Service or the mental health phone number on the back of your ID card.

Certification for Inpatient and Outpatient Services

Prior to seeking care in an inpatient hospital, a residential treatment facility, partial day/night programs or specified outpatient services, you or your provider must receive certification. In order to receive in-network benefits, you must go to a North Carolina State Health Plan 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 North Carolina State Health Plan Network hospital where they practice, unless that hospital cannot provide the services needed.

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

If you receive certification for out-of-network services, the services will be considered at the out-of-network benefit level. However, if in-network providers are not available as determined by Blue Cross NC’s access to care standards and certification is obtained, Blue Cross NC will authorize the services to be covered at the in-network benefit level.

Emergency inpatient admissions do not require certification prior to the admission. However, you or your provider should notify Blue Cross NC of your inpatient admissions. See table below for timeframes in order to meet the Plan’s requirements for prior review and continuing treatment certifications of covered services.

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

Outside of North Carolina

Although prior review is not required in an emergency, you may contact Blue Cross NC for assistance in locating a provider.

If you need urgent inpatient or outpatient behavioral health services while outside North Carolina, contact Customer Service at the number listed in “Who to Contact” for assistance in locating a provider. You must request prior review and receive certification from Blue Cross NC for behavioral health services other than office visits or in emergencies. The numbers for Behavioral Health are provided in “Who to Contact” and on the back of your ID card. For more information on these services, see “Covered Services.”
**Time Frame Requirements for Prior review and Treatment Certification of Covered Services***

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</table>

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

**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 review and certification. You are responsible for obtaining or having your provider obtain certification on your behalf if you go to an out-of-network, or out-of-state provider. Failure to obtain certification will result in a full denial of benefits.

See “What Is Not Covered” to understand behavioral health limitations and exclusions.

**Pharmacy Benefits**

- **Prescription Medication Copayment and Benefits**
  
  A Pharmacy Benefit Manager (PBM) manages administration of the pharmacy benefit.

  Your pharmacy benefit offers a custom, closed formulary, which means that certain medications are not covered. For more information on commonly used covered medications, see the information listed under the Covered Medication List section below. A complete list of covered medications can be found on the State Health Plan’s website.

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

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

  To get a list of prescription medications that require prior approval to be covered or require approval for additional quantities, you may call PBM Customer Service at the number listed in "Who to Contact" or visit the State Health Plan’s website.
Plan website. The State Health Plan or its representative may change the list of these prescription medications from time to time.

Prescription medication synchronization as follows:

If you have multiple prescriptions and need to align your refill dates, you may need a prescription for less than a 30-day supply. If your doctor or pharmacy agrees to give you a prescription for less than a 30-day supply for this purpose you will only pay a prorated daily cost-sharing amount (any dispensing fee will not be prorated). This benefit is only available for medications covered under your pharmacy benefit, received at an in-network pharmacy, and when prior authorization requirements have been met.

In addition, the medications must:

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

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

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

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

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

- Immunizations
Certain immunizations are also covered under the pharmacy benefit. A complete list of immunizations can be found on the State Health Plan’s website at www.shpnc.org.

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

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

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

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

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

Charges for prescription medications apply to the benefit period out-of-pocket limit.

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

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

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

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

  Controlled substances, specialty and biosimilar medications are excluded from this refill policy. Exceptions to this refill policy can be made under certain circumstances.

- **Specialty Pharmacy**
  
  Specialty and biosimilar medications are designated and classified by the Plan as medications that meet the below criteria and are listed on the Specialty Medication List, which is located on the State Health Plan’s website at www.shpnc.org. Specialty and biosimilar medications are classified as such if they meet the following criteria:

  - Treats complex medical conditions(s);
  - Requires frequent clinical monitoring, e.g. dosing adjustments;
  - Requires special patient education, training and/or coordination of care; and
  - Generally prescribed by a specialist provider.

  If you use specialty medications, you must use the contracted specialty vendor for all specialty medications covered under the pharmacy benefit, excluding cancer medications. If you use a pharmacy other than the contracted vendor to purchase any specialty medications, you will be responsible for paying the total amount of the prescription at the time of purchase. For more information call the specialty pharmacy at the number listed in "Who to Contact."

  See “What Is Not Covered” for a list of prescription medication exclusions.

- **Diabetic Testing Supplies**
  
  Certain diabetic testing supplies are covered under your medical and pharmacy benefit. Certain supplies are covered under your medical supply benefit and are subject to deductible and coinsurance.

- **Tobacco Cessation Coverage**
  
  Tobacco cessation support is covered as part of your preventive benefits. Tobacco cessation counseling is available at a CVS MinuteClinic or certain Primary Care Provider offices.
Using a Contracting Pharmacy
Most chain and independent pharmacies contract with the PBM. You may obtain information about which pharmacies are contracting by:

- Visiting the State Health Plan’s website; or
- Calling the PBM at the number listed in "Who to Contact."

When you use a pharmacy not contracting with the PBM, you are responsible for any amount above the allowed amount and your copayment at the time of purchase. You or the pharmacy will be required to file a paper claim with the PBM for reimbursement. You may obtain a claim form on the State Health Plan’s website or by calling the PBM.

The convenience of mail order pharmacy is available for your maintenance medications by using the PBM’s online pharmacy services, by telephone, or by completing a Mail Service Order Form and returning it with your original prescription and appropriate copayment to the PBM. You may obtain a Mail Service Order Form on the State Health Plan’s website or by calling the PBM.

How to File a Claim for Prescription Medications
When you use a pharmacy contracting with the PBM, present your ID card to the pharmacist and you will not be required to pay more than the appropriate copayment for each 30-day supply for medications covered by the State Health Plan. The pharmacist will file the claim.

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

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

If you are sending the original pharmacy receipts, a pharmacist’s signature is not required. All receipts must contain the following information in order to process the claim:

- Date prescription filled;
- Name and address of pharmacy;
- Doctor name or ID number;
- National Drug Code (NDC);
- Name of medication and strength;
- Quantity and day supply;
- Prescription number (Rx number);
- DAW (Dispense as Written); and
- Amount paid.

Complete a separate form for each family member and pharmacy.

Medication receipts from the label or bag should not be submitted. Claims will be returned if not properly completed. For information on how to properly submit a pharmacy claim, call CVS Caremark Customer Service at the number given in "Who to Contact."

Medicare Part D

IMPORTANT INFORMATION REGARDING
YOUR PRESCRIPTION MEDICATION COVERAGE AND MEDICARE
Effective January 1, 2006, Medicare began offering prescription medication coverage for all persons enrolled in Medicare. The State Health Plan will continue to provide prescription medication coverage for all members on this plan.

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

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

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

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

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

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

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

- **Acupuncture** and acupressure.
- **Administrative** charges billed by a provider, including, but not limited to charges for failure to keep a scheduled visit, completion of a claim form, obtaining medical records, late payments, shipping and handling, taxes and telephone charges.
- Costs in excess of the allowed amount for services usually provided by one doctor, when those services are provided by multiple doctors or medical care provided by more than one doctor for treatment of the same condition.
- **Ambulance services:**
  - No benefits are provided primarily for the convenience of travel or where not medically necessary.
• Transportation for the purpose of receiving services that are not considered *covered services*, even if the destination is an appropriate facility.

• **Applied Behavior Analysis** treatments for:
  - *Members* with medical conditions or impairments that would prevent beneficial utilization of services.
  - *Members* requiring 24 hour medical/nursing monitoring or procedures provided in a *hospital* setting.

• **Applied Behavior Analysis** treatments will not be certified for the following services:
  - Speech therapy.
  - Occupational therapy.
  - Vocational rehabilitation.
  - Supportive *respite care*.
  - Recreational therapy.
  - Orientation and mobility.
  - *Respite Care*.
  - Equine therapy/Hippotherapy.
  - Dolphin therapy.
  - Service Animals.
  - Other educational services.

• **Athletic** training evaluations or re-evaluations.

• **Audiometric** testing of groups, ear protector attenuation measurements.

• **Behavioral Health** exclusions and limitations:
  - Psychoanalysis.
  - *Inpatient* confinements that are primarily intended as a change of environment.
  - Marriage counseling.
  - Wilderness camps and stand-alone outdoor treatment programs are not covered as *substance abuse* or *substance abuse residential treatment center* programs.
  - Any services including but not limited to evaluations, consultations, testing or therapy for educational, sensitivity training, professional training, or for investigation purposes relating to employment, insurance, judicial or administrative proceedings.
  - Aversive Treatment.
  - Treatment programs based solely on the 12-step Model.
  - Any personal growth training including Erhard Seminar Training (EST) or similar motivational services.
  - Services that are investigational in nature or obsolete, including any service, drugs, procedure, or treatment directly related to an investigational treatment, except as specifically covered by the Plan.
  - Any therapies including but not limited to music therapy, remedial reading, recreational or activity therapy, massage therapy, cognitive rehabilitation, all forms of special education and supplies or equipment used similarly.
  - Telephonic crisis management as a separate charge.
  - Environmental ecology treatments.
• Room and Board costs for patients admitted to a partial hospital or intensive outpatient program are not covered.
• Intensive in-home services less than two hours per day.
• Therapeutic family, foster or home care.
• L-tryptophan and vitamins, except thiamine injections on admission for alcoholism when there is a diagnosed nutritional deficiency.
• Travel time necessary for service delivery.
• Behavioral health; long term care residential (non-acute care in a residential treatment program where stay is typically longer than 30 days), with room and board, per diem.
• Community or work integration training, work hardening or conditioning.
• Family psychotherapy without patient present.
• Assertive Community Treatment Team Program.
• Community Support Team.
• Psychosocial Rehabilitation.
• Day Treatment programs license for day treatment by the NC Division of Health Service Regulation but not licensed as a Partial Hospitalization Program.
• Multi-Systematic Therapy.
• Residential treatment services described as follows:
  • Level I and Level II therapeutic foster care providers licensed under the NC Division of Social Services (131-D) as family setting homes.
  • Level II program type, Level III, and Level IV residential providers/group homes licensed by the NC Division of Health Service Regulation as a Mental Health Facility under 10A NCAC 27G.
• Substance Abuse Non-Medical Community Residential Program.
• Body piercing.

Certain Blood Services:
  • Collection and storage of blood and stem cells taken from the umbilical cord and placenta for future use in fighting a disease.
  • 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.

• All Breast Pump Supplies except what is explicitly listed as covered are excluded (i.e., creams, nursing bras, milk storage bags). Hospital-grade breast pumps are excluded and not covered. Breast pump supplies are limited to two units per code, per year.

• Breast-Feeding
  o Human breast milk processing, storage and distribution.

Childbirth preparation classes, including but not limited to Lamaze classes, childbirth refresher classes, cesarean birth classes, vaginal birth after cesarean classes, and infant safety classes including CPR by a non-physician provider.

• Claims not submitted to the Plan within 18 months of the date the charge was incurred, except in the absence of legal capacity of the member.

Clinical Trials exclusions include:
  o Non-health care services, such as services provided for data collection and analysis.
  o Early feasibility, safety and pilot states of device trials.
• CMS Investigational Device Exemption (IDE) Category A devices.

• Investigational medications and devices and services that are not for the direct clinical management of the patient.

• Side effects and complications of non-covered services, except for emergency services in the case of an emergency.

• Convenience items such as, but not limited to, devices and equipment used for environmental control, urinary incontinence devices (including bed wetting devices) and equipment, ice packs and personal hygiene items. Infrared heating pads are covered.

• Cosmetic services or improvements, which include implantation of hair follicles, skin tone enhancements, the removal of excess skin from the abdomen, arms or thighs, skin tag excisions, skin tone enhancements, cryotherapy or chemical exfoliation for active acne scarring, superficial dermabrasion, injection of dermal fillers, services for hair transplants, electrolysis and surgery for psychological or emotional reasons, except as specifically covered by the Plan.

• Services received either before or after the coverage period of the Plan, regardless of when the treated condition occurred, and regardless of whether the care is a continuation of care received prior to the termination.

• Custodial care designed essentially to assist an individual with activities of daily living, with or without routine nursing care and the supervisory care of a doctor. While some skilled nursing services may be provided, the patient does not require continuing skill services 24 hours daily. The individual is not under specific medical, surgical, or psychiatric treatment to reduce a physical or mental disability to the extent necessary to enable the patient to live outside either the institution or the home setting with substantial assistance and supervision, nor is there reasonable likelihood that the disability will be reduced to that level even with treatment. Custodial care includes, but is not limited to, help in walking, bathing, dressing, feeding, preparation of special diets and supervision over medications that could otherwise be self-administered. Such services and supplies are custodial as determined by the Plan without regard to the place of service or the provider prescribing or providing the services.

• Camisoles, or other clothing, post-mastectomy.

• Communication boards which includes the evaluation for the board.

• Contraception for males.

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Dental services

• provided in a hospital, except as specifically covered by the Plan.

• Treatment for the following conditions:
  • Injury related to chewing or biting.
  • Preventive dental care, diagnosis or treatment of or related to teeth or gums.

• Periodontal disease or cavities and disease due to infection or tumor.

• And except as specifically stated as covered:
  • Dental implants or root canals.
  • Dentures.
- Dental appliances except when medically necessary for the treatment of temporomandibular joint disease or obstructive sleep apnea.
- Orthodontic braces or devices.
- Palatal expanders.
- Removal of teeth and intrabony cysts.
- Procedures performed for the preparation of the mouth for dentures.
- Crowns, bridges, dentures or in-mouth appliances.

- Evaluation and treatment of development**al dysfunction** and/or learning disability.

**Diabetes related services including:**

- Diabetic shoes, including accessories, fittings, and associated services and supplies.
- Glasses.

- The following drugs or medications:
  - Injections by a health care professional of injectable *prescription medications* which can be self-administered, unless medical supervision is required.
  - Medications associated with conception by artificial means.
  - For prescribed *sexual dysfunction* medications.
  - Take home medications furnished by a *hospital or non-hospital facility*.
  - *Experimental medication* or any medication or device not approved by the Food and Drug Administration (FDA) for the applicable diagnosis or treatment. However, this exclusion does not apply to *prescription medications* used in covered phases I, II, III and IV clinical trials, or medications approved by the FDA for treatment of cancer, if prescribed for the treatment of any type of cancer for which the medication has been approved as effective and accepted in any one of the following nationally recognized medication reference guides:
    - The American Medical Association Drug Evaluations;
    - The American Hospital Formulary Service Drug Information;
    - The United States Pharmacopoeia Drug Information;
    - The National Comprehensive Cancer Network Drugs & Biologics Compendium;
    - The Thomson Micromedex DrugDex;
    - The Elsevier Gold Standard’s Clinical Pharmacology; or
    - Any other authoritative compendia as recognized periodically by the United States Secretary of Health and Human Services.

- **Durable Medical Equipment** including:
  - Appliances or devices that serve no medical purpose or that are primarily for comfort or convenience.
  - Repair or replacement of equipment due to abuse or desire for new equipment.
  - Compression stockings and supplies unless prescribed and medically necessary. Coverage will be limited to 8 individual units per year.
  - Heel or elbow protectors.
  - Batteries, except as required for operation of *medically necessary* equipment prescribed by a *provider*.
  - Gravity assisted traction devices.
• Wheelchair accessories of any kind including trays, commode seats, narrowing devices, and roll-about chairs with castors 5 or greater, crutch and cane holders, cylinder tank carriers, arm troughs, IV hangers.
• Immersion external heater for nebulizer.
• Bed boards, bed rails, rocking beds, pediatric cribs, bed safety frames or canopies. Medically necessary mattresses and mattress accessories including positioning cushions or wedges are covered.
• Patient lifts, seat lifts, standing frame/table systems.
• Bone-anchored hearing aid (BAHA) devices and all related services are considered hearing aids and, therefore, not considered a prosthetic appliance or durable medical equipment.

E
• Services primarily for **educational** purposes including, but not limited to, evaluation, books, tapes, pamphlets, seminars, classroom, Web or computer programs, individual or group instruction, counseling, and vocational counseling, educational supplies such as books, tapes, and pamphlets for the patient’s education at cost to physician or other qualified health care professional, educational services rendered to patients in a group setting by physician or other qualified health care professional, except as specifically covered by the Plan.
• For educational or achievement testing for the sole purpose of resolving educational performance questions.

• The following **equipment**:
  ▪ Air conditioners, furnaces, vacuum cleaners, electronic air filters and similar equipment.
  ▪ Room dehumidifiers, room humidifiers. This does not apply to humidifiers and dehumidifiers that are attached to a CPAP machine.
  ▪ Devices and equipment used for environmental accommodation requiring vehicle and/or building modifications such as, but not limited to, positioning seats, chair lifts, stair lifts, home elevators, and ramps.
  ▪ Physical fitness equipment, hot tubs, Jacuzzis, heated spas, whirlpools, pools or membership to health clubs.
  ▪ Personal computers.
  ▪ Pacemaker monitors and external defibrillators with integrated electrocardiogram analysis.
  ▪ Postural drainage boards and similar equipment.
  ▪ Standing frames.

• **Experimental** services including services whose efficacy has not been established by controlled clinical trials or are not recommended as a preventive service by the U.S. Public Health Service except as specifically covered by the Plan.

F
• **Routine foot care** that is palliative or cosmetic. Foot care related to a medical diagnosis is covered.
• These services related to **Family Planning**:
  ▪ Artificial means of conception, including, but not limited to, artificial insemination, invitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), ovum or embryo placement, intracytoplasmic sperm injection (ICSI), and gamete intrafallopian tube placement (GIFT) and associated services.
  ▪ Donor eggs and sperm.
  ▪ Cryopreservation of donor eggs, sperm or embryos.
• Surrogate mothers.
• Care or treatment of the following:
  o Maternity for dependent children.
  o Infertility and sexual dysfunction services for dependent children.
  o Reversal of sterilization.
• Abortions, except for when the pregnancy is the result of rape, incest, or for subscribers and enrolled spouses of the subscribers when the life of the mother would be endangered if the unborn child was carried to term.
• Benefits for infertility or reduced fertility that result from a prior sterilization procedure or when infertility or reduced fertility is the result of a normal physiological change such as menopause.
  o Any medications associated with artificial reproductive technology.
  o Ovulation tests.
  o Blood typing for paternity testing.
• Biopsy, oocyte polar body or embryo blastomere, microtechnique.

G
• Genetic testing, except for high-risk patients when the identification of genetic abnormality correlates with the likelihood of disease or condition, and when the therapeutic or diagnostic course would be determined by the outcome of testing.

H
• Routine hearing examinations and hearing aids or examinations for the fitting of hearing aids, except as specifically covered by the Plan.
• Members over the age of 22 are not covered for any hearing aid devices or related services.
• Holistic or alternative medicine services, which are unproven preventive or treatment modalities, generally described as alternative, integrative or complementary medicine, whether performed by a physician or any other provider, except as specifically covered by your health benefit plan.
• Home Health Care including:
  ▪ Personal comfort or convenience items.
  ▪ Dietitian services or meals.
  ▪ Homemaker services, such as cooking and housekeeping.
  ▪ Custodial care.
  ▪ Services that are provided by a close relative or a member of your household.
• Certain Hospice Services:
  ▪ Homemaker services, such as cooking, housekeeping, food or meals.
  ▪ Medical services provided by a doctor other than as part of your hospice care program.
• Hypnosis except when used for control of acute or chronic pain.

I
• Immunizations that are required for occupational hazard or international travel.
• Inpatient admissions primarily for the purpose of receiving diagnostic services or a physical examination. Inpatient admissions primarily for the purpose of receiving therapy services, except when the admission is a continuation of treatment following care at an inpatient facility for an illness or accident requiring therapy.
• Services that are *investigational* in nature or obsolete, including any service, medications, procedure or treatment directly related to an *investigational* treatment, except as specifically covered by the Plan.

• **Incontinence** products (including briefs, diapers, underwear, underpads).

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**L**

• *Lenses* for keratoconus or any other eye procedure except as specifically covered under the Plan.

• *Low density lipoprotein* (LDL) apheresis using heparin-induced extracorporeal LDL precipitation.

• Over-the-counter compression or elastic knee-high or other stocking products for **Lymphedema**.

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**M**

• More than two **mastectomy bras** per year.

• Certain **Medical Supplies**
  - *Medical supplies* not ordered by a *doctor* for treatment of a specific diagnosis or procedure.
  - Thermometers.
  - Over-the-counter gauze, tape, adhesive first-aid bandages.
  - Spirometers and all related accessories.
  - Lubricants except when used in conjunction with specialized self-care procedures such as intermittent catheterization and insulin pumps.
  - Chemical or antiseptic solutions except when used in conjunction with specialized self-care procedures such as intermittent catheterization and insulin pumps.
  - Mucus traps.
  - Replacement bulbs or lamps for therapeutic light

• **Medical testimony**.

• Services or supplies deemed not **medically necessary** or ordered by a provider.

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**N**

• **Necropsies**.

• Services that would not be necessary if a **non-covered service** had not been received, except for *emergency services* in the case of an *emergency*. This includes any services, procedures or supplies associated with **cosmetic** services, *investigational services*, services deemed not **medically necessary**, or elective termination of pregnancy, if not specifically covered by the **Plan**.

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**O**

• **Obesity Treatment / Weight Management**:
  - Any treatment or regimen, medical or surgical, for the purpose of reducing or controlling the weight of a **member** or for treatment of **obesity**, except for surgical treatment of morbid obesity, or as specifically covered by the **Plan**.
  - Bariatric *surgery* that is not performed at a Blue Distinction Center (BDC).
  - Services provided at non-Blue Distinction Center facilities.
  - Removal of excess skin from the abdomen, arms or thighs.
  - Any costs associated with membership in a weight management program except as specifically described above.
• Orthotic Devices:
  • Pre-molded foot orthotics.
  • Over-the-counter supportive devices.
  • Plastazote shoes or sandals.

• Services provided by a close relative or a member of your household area not considered Private Duty Nursing.

• Care or services from a provider who:
  ▪ Cannot legally provide or legally charge for the services or services are outside the scope of the provider’s license or certification.
  ▪ Provides and bills for services from a licensed health care professional who is in training.
  ▪ Is in a member’s immediate family.
  ▪ Is not recognized by the Plan as an eligible provider.

• Any Prescription Medications that:
  ▪ Are not covered in the formulary.
  ▪ Are not FDA approved.
  ▪ Are not federal legend.
  ▪ Are not specifically covered by the State Health Plan.
  ▪ Are prescribed for sexual dysfunction.
  ▪ Are prescribed for hair growth.
  ▪ Are prescribed for cosmetic purposes.
  ▪ Are prescribed in conjunction with artificial reproductive technology.
  ▪ Are in excess of the stated quantity limits.
  ▪ Require certification if certification is not obtained.
  ▪ Can be purchased over the counter without a prescription, even though a written prescription is provided, except for insulin and other approved over-the-counter medications.
  ▪ Has a therapeutic equivalent available over-the-counter as determined by the State Health Plan.

• Any Prescription Compound Medication that:
  ▪ Contains an investigational medication.
  ▪ Has any active ingredient contained within the compound medication in which that active ingredient is not a covered prescription medication including bulk chemicals.
  ▪ Includes any active ingredients for a non-FDA approved indication as determined by the dosage of the active ingredient, combination of active ingredients or route of administration.

• Any Prescription medical foods.

• The following Prosthetic Appliances:
  ▪ Dental appliances except when medically necessary for the treatment of temporomandibular joint disease or obstructive sleep apnea.
  ▪ Lenses for keratoconus or any other eye procedure except as specifically covered under the Plan.
  ▪ Appliances and accessories that serve no medical purpose or that are primarily for the comfort or convenience or are upgrades beyond the stated medical purpose.
- Repair or replacement of equipment due to abuse or desire for new equipment.
- Bone-anchored hearing aid (BAHA) devices and all related services are considered hearing aids and, therefore, not considered a prosthetic appliance or durable medical equipment.

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

S
- Services or supplies that are:
  - Not performed by or upon the direction of a doctor or other provider.
  - Available to a member without charge.
- Sexual dysfunction unrelated to organic disease.
- Shoe lifts, other than heel pads, shoe accessories, attachment, equipment, inserts and other modifications, and shoes of any type unless part of a brace, and except as specifically covered by your health benefit plan.
- Services, supplies, medications or equipment used for the control or treatment of stammering or stuttering.
- Unless prescribed, medically necessary and custom made, safety equipment, devices or accessories, including but limited to helmets with face guards and soft interfaces and any type of restraints.
- Prescription medications related to sexual dysfunction are not covered. Also see Prescription Medication Exclusions.

T
- Telehealth services originating site facility fees.
- The following services are not covered for Temporomandibular Joint (TMJ):
  - Treatment for periodontal disease.
  - Dental implants or root canals.
  - Crowns and bridges.
  - Orthodontic braces.
  - Occlusal (bite) adjustments.
  - Extractions.
- The following types of therapy:
  - Applied Behavior Analysis (ABA) therapy except as specifically identified by the Plan.
  - Music therapy, recreational or activity therapy, and all types of animal therapy. Remedial reading and all forms of special education and
supplies or equipment used similarly, except as specifically covered by the Plan.

- Massage therapy.
- Alternative therapy.
- Hypothermia therapy.
- Cognitive therapy.
- Speech therapy for stammering, stuttering, or developmental delay.
- Pulmonary rehabilitation group sessions.
- Peripheral arterial disease rehabilitation.
- Community or work integration training, work hardening or conditioning.

- **Thermography** or **thermograph** examination.

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

- **Travel**, whether or not recommended or prescribed by a doctor or other licensed health care professional, except as specifically covered by the Plan.

- **Treatment** or studies leading to or in connection with sex changes or modifications and related care.

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**V**

- The following **vision** services:
  - Radial keratotomy and other refractive eye surgery, and related services to correct vision except for surgical correction of an eye injury. Also excluded are premium intraocular lenses or the services related to the insertion of premium lenses beyond what is required for insertion of conventional intraocular lenses, which are small, lightweight, clear disks that replace the distance-focusing power of the eye’s natural crystalline lens.
  - Routine eye examination services except as specifically covered by the Plan.
  - Eyeglasses or contact lenses, except as specifically covered in “Prosthetic appliances.”
  - Orthoptics, vision training, and low vision aids.

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

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**W**

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

To make sure you have access to high quality, cost effective health care, the State Health Plan has a Utilization Management (UM) program. The UM program requires that certain health care services be reviewed and approved by the State Health Plan or its representative in order to receive benefits. As part of this process, the State Health Plan determines whether health care services are medically necessary, provided in the proper setting and for a reasonable length of time.

The State Health Plan will honor a certification to cover medical services or supplies under your health benefit plan unless the certification:

- Was based on a material misrepresentation about your health condition;
- You were not eligible for these services under your health benefit plan due to termination of coverage; or
- Your premiums were not paid.

Rights and Responsibilities Under the UM Program

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

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

- **The State Health Plan's Responsibilities**
  - As part of all UM decisions, the State Health Plan or its representative will:
    - Provide you and your provider with a toll-free telephone number to call UM review staff when certification of a health care service is needed. See "Who to Contact."
    - Limit what the State Health Plan or its representative requests from you or your provider to information that is needed to review the service in question.
    - Request all information necessary to make the UM decision, including pertinent clinical information.
    - Provide you and your provider prompt notification of the UM decision consistent with your health benefit plan.

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

Prior Review (Pre-Service)

The State Health Plan requires that certain health care services receive prior review as noted in “Covered Services.” These types of reviews are called pre-service reviews. If neither you nor your provider requests prior review and receives certification, this will result in a complete denial of benefits. The list of services that require prior review may change from time to time.
General categories of services with this requirement are noted in “Covered Services.” You may also visit our website at www.shpnc.org or call Customer Service at the number listed in “Who to Contact” for a detailed list of services.

In-network providers outside of North Carolina, except for Veterans’ Affairs (VA) and military providers, are responsible for requesting prior review for inpatient facility services. For all other covered services received outside of North Carolina, you are responsible for ensuring that you or your provider requests prior review by the State Health Plan even if you see an in-network provider.

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

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

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

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

If the Plan needs more information to process your urgent authorization, the Plan will let you and your provider know of the information needed as soon as possible but no later than one calendar day following the receipt of your request. You will then be given a reasonable amount of time, but not less than 24 hours, to provide the requested information. The Plan will make a decision on your request within a reasonable time but no later than two calendar days after receipt of requested information or within two calendar days after the time period given to the provider to submit necessary clinical information, whichever comes first.
An urgent authorization may be requested by calling Customer Service at the number given in “Who to Contact.”

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

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

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

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

- **Urgent Concurrent Authorization**
  
  You have a right to an expedited review when the regular time frames for a decision: (i) could seriously jeopardize your or your dependent's life, health, or ability to regain maximum function; or (ii) in the opinion of your provider, would subject you or your dependent to severe pain that cannot be adequately managed without the requested care or treatment.

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

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

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

**Retrospective Authorization (Post-Service)**
The State Health Plan or its representative also reviews the coverage of health care services after you receive them (retrospective reviews). Retrospective review may include a review to determine if services received in an emergency setting qualify as an emergency. The State Health Plan or its representative will make all retrospective review decisions and notify you of its decision within a reasonable time but no later than 30 days from the date the State Health Plan or its representative received the request.
In the event of an adverse benefit determination, the Plan or its representative will notify you and your provider in writing within five business days of the decision. All decisions will be based on medical necessity and whether the service received was a benefit under the Plan. If more information is needed before the end of the initial 30-day period, the Plan or its representative will notify you of the information needed. You will then have 90 days to provide the requested information. As soon as the Plan or its representative receives the requested information, or at the end of the 90 days, whichever is earlier, the Plan or its representative will make a decision within 15 days.

Services that were approved in advance by the Plan or its representative will not be subject to denial for medical necessity once the claim is received, unless the certification was based on a material misrepresentation about your health condition or you were not eligible for these services under your health benefit plan due to termination of coverage or non-payment of premiums. All other services may be subject to retrospective review and could be denied for medical necessity or for a benefit limitation or exclusion.

**Care Management**

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

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

**Continuity of Care**

Continuity of care is a process that allows you to continue receiving care from an out-of-network provider for an ongoing special condition at the in-network benefit level when you or your employer changes health benefit plans or when your provider is no longer in the North Carolina State Health Plan Network.

If your PCP or specialist leaves the North Carolina State Health Plan Network and they are currently treating you for an ongoing special condition that meets the Plan’s continuity of care criteria, the Plan will notify you 30 days before the provider’s termination, as long as the Plan receives timely notification from the provider.

To be eligible for continuity of care, you must be actively being seen by an out-of-network provider for an ongoing special condition and the provider must agree to abide by the State Health Plan’s or its representative’s requirements for continuity of care.

An ongoing special condition means:

- In the case of an acute illness, a condition that is serious enough to require medical care or treatment to avoid a reasonable possibility of death or permanent harm.
- In the case of a chronic illness or condition, a disease or condition that is life-threatening, degenerative, or disabling, and requires medical care or treatment over a prolonged period of time.
- In the case of pregnancy, the second and third trimesters of pregnancy.
- In the case of a terminal illness, an individual has a medical prognosis that the member’s life expectancy is six months or less.
The allowed transitional period shall extend up to 90 days, as determined by the provider, except in the cases of:

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

Continuity of care requests will be reviewed by a medical professional based on the information provided about specific medical conditions. Claims for approved continuity of care services will be paid at the in-network benefit level. In these situations, benefits are based on the billed amount. However, you may be responsible for charges billed separately by the provider which are not eligible for additional reimbursement. If your continuity of care request is denied, you may request a review through our appeals process (see “What if I Disagree with a Decision”). Continuity of care will not be provided when the provider’s contract was terminated for reasons relating to quality of care or fraud. Such a decision may not be reviewed on appeal. Please call State Health Plan Customer Service at the number listed in “Who to Contact” for additional information.

Further Review of Utilization Management Decisions
If you receive a non-certification as part of the prior 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 (UM)
Blue Cross NC delegates certain UM services for particular benefits to other companies not associated with Blue Cross NC. Please see https://www.BlueCrossNC.com/content/services/medical-policy/index.htm for a detailed list of these companies and benefits. While some benefits have been identified under “COVERED SERVICES,” the list of benefits and/or companies may change from time to time; for the most up-to-date information visit www.BlueCrossNC.com and search for “PRIOR REVIEW” for additional information, including those services subject to prior review and certification.

Evaluating New Technology
In an effort to allow for continuous quality improvement, the State Health Plan or its representative has processes in place to evaluate new medical technology, procedures, and equipment. These policies allow the State Health Plan or its representative to determine the best services and products to offer members. They also help the State Health Plan or its representative to keep pace with the ever-advancing medical field. Before implementing any new or revised policies, the State Health Plan or its representative reviews professionally supported scientific literature as well as state and federal guidelines, regulations, recommendations, and requirements. The State Health Plan or its representative then seeks additional input from providers who know the needs of the patients they serve.
WHAT IF YOU DISAGREE WITH A DECISION?

In addition to the UM program, your health benefit plan offers a grievance procedure for members. Grievances include dissatisfaction with a claims denial or any decisions (including an appeal of a non-certification decision), policies or actions related to the availability, delivery or quality of health care services. If you have a grievance, you have the right to request that the State Health Plan or its representative review the decision through the grievance process.

Grievances are not allowed for benefits or services that are clearly excluded by this benefits booklet or for deductibles, coinsurance or out-of-pocket limits, medication formulary tiers, as well as other aspects of coverage excluded from appeal by law.

The grievance process is voluntary and may be requested by the member or an authorized representative acting on the member’s behalf with the member’s written consent. In the event you appoint an authorized representative, references to "you" under this section mean "you or your authorized representative" (i.e., the authorized representative may pursue your rights and shall receive all notices and benefit determinations).

For each step in this process, there are specified time frames for filing a grievance and for notifying you or your provider of the decision.

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

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

Steps To Follow In the Grievance Process
First Level Grievance Review

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

Any request for review should include:

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

Although you are not allowed to participate in a first level grievance review, the State Health Plan or its representative asks that you send all of the written material you feel is necessary to make a decision. The State Health Plan or its representative will use the material provided in the request for review, along with other available information, to reach a decision. You will be notified in clear written terms of the decision within a reasonable time but no later than 30 days from the date the State Health Plan or its representative received the request. You may then request, free of charge, all information that was relevant to the review.
Second Level Grievance Review

If you are dissatisfied with the first level grievance review decision, you have the right to a second level grievance review. Second level grievances are not allowed for benefits or services that are clearly excluded by this benefit booklet or for quality of care complaints. The request must be made in writing within 180 days of the first level grievance review decision. Within ten business days after the State Health Plan or its representative receives your request for a second level grievance review, the following information will be given to you:

- Name, address and telephone number of the grievance coordinator.
- A statement of your rights, including the right to:
  - Request and receive from the State Health Plan or its representative all information that applies to your case.
  - Participate in the second level grievance review meeting.
  - Present your case to the review panel.
  - Submit supporting material before and during the review meeting.
  - Ask questions of any member of the review panel.
  - Be assisted or represented by a person of your choosing, including a family member, an employer representative, or an attorney.

The second level review meeting, which will be conducted by a review panel coordinated by the State Health Plan or its representative using external physicians and/or benefit experts, will be held within 45 days after the State Health Plan or its representative receives a second level grievance review request. You will receive notice of the meeting date and time at least 15 days before the meeting. You have the right to a full review of your grievance even if you do not participate in the meeting. A written decision will be issued to you within seven business days of the review meeting.

Expedited Review

You have the right to a more rapid or expedited review of a denial of coverage if a delay: (i) would reasonably appear to seriously jeopardize your or your dependent's life, health or ability to regain maximum function; or (ii) in the opinion of your provider, would subject you or your dependent to severe pain that cannot be adequately managed without the requested care or treatment. You can request an expedited second level grievance review even if you did not request that the initial review be expedited.

An expedited review may be initiated by calling State Health Plan Customer Service at the number listed in "Who to Contact." An expedited review will take place in consultation with a medical doctor. All of the same conditions for a first level or second level grievance review apply to an expedited review. The State Health Plan or its representative will communicate the decision by phone to you and your provider as soon as possible, taking into account the medical circumstances, but no later than 72 hours after receiving the request. A written decision will be communicated within four days after receiving the request for the expedited appeal. Information initially given by telephone must also be given in writing.

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

External Review

North Carolina law provides for review of non-certification decisions by an external, independent review organization (IRO). The relevant statutory provision is N.C. Gen. Stat. § 58-50-80. The North Carolina Department of Insurance (NCDOI) administers this service at no charge to you, arranging for an IRO to review your case once the NCDOI establishes that your request is complete and eligible for review.

The State Health Plan will notify you of your right to request an external review each time you receive:
• A non-certification decision; or
• An appeal decision upholding a non-certification decision.

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

• Your request is about a medical necessity determination that resulted in non-certification;
• You had coverage with the State Health Plan when the non-certification was issued;
• The service for which the non-certification was issued appears to be a covered service; and
• You have exhausted the State Health Plan’s first and second level grievance process as described above.

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

Standard External Review
For all requests for a standard external review, you must file your request with the NCDOI within 120 days of receiving one of the notices listed above. If the request for an external review is related to a retrospective non-certification (a non-certification which occurs after you have already received the services in question), the 60-day time limit for receiving the State Health Plan’s second level determination does not apply. You will not be eligible to request an external review until you have exhausted the internal appeal process and have received a written second level grievance determination from the State Health Plan or its representative.

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

• Completed the State Health Plan’s first and second level grievance review and received a written second level determination from the State Health Plan or its representative.
• Filed a second level grievance and have not requested or agreed to a delay in the second level grievance process, but have not received the State Health Plan’s or its representative’s written decision within 60 days from the date that you can demonstrate that an appeal was filed with Blue Cross NC, or received written notification that the State Health Plan or its representative has agreed to waive the requirement to exhaust the internal appeal and/or second level grievance process.

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

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

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

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

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

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<th>Mail</th>
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| NC Department of Insurance  
Health Insurance Smart NC  
1201 Mail Service Center  
Raleigh, NC 27699-1201 | For the physical address, please visit www.ncdoi.com/Smart  
Toll-Free Telephone: 855-408-1212 | www.ncdoi.com/Smart  
for external review information and request form |

The Health Insurance Smart NC Program provides consumer counseling on utilization review and grievance issues. Within ten business days (or, for an expedited review, within two business days after the receipt of your request for an external review, the NCDOI will notify you and your provider of whether your request is complete and whether it has been accepted. If the NCDOI notifies you that your request is incomplete, you must provide all requested, additional information to the NCDOI within 150 days of the written notice from the State Health Plan or its representative, upholding a non-certification (generally the notice of a second level grievance review decision), which initiated your request for an external review. If the NCDOI accepts your request, the acceptance notice will include: (i) name and contact information for the IRO assigned to your case; (ii) a copy of the information about your case that the State Health Plan or its representative has provided to the NCDOI; and (iii) a notification that you may submit additional written information and supporting documentation relevant to the initial non-certification to the assigned IRO within seven days after the receipt of the notice. It is presumed that you have received written notice two days after the notice was mailed. Within seven days of the State Health Plan’s receipt of the acceptance notice (or, for an expedited review, within the same day), the State Health Plan or its representative shall provide the IRO and you, by the same or similar expeditious means of communication, the documents and any information considered in making the non-certification appeal decision or the second level grievance review decision. If you choose to provide any additional information to the IRO, you must also provide that same information to the State Health Plan at the same time and by the same means of communication (e.g., you must fax the information to Blue Cross NC if you faxed it to the IRO).

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

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

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

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

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

**Third Level Grievance Review**

If you do not agree with the second level decision, you may be able to appeal this decision by filing a Petition for Contested Case Hearing with the North Carolina Office of Administrative Hearings (OAH). This appeal must be received and filed with OAH within sixty (60) days of the date of the second level decision. Your second level decision and N.C. Gen. Stat. § 135-48.24 identify those appeals that may be filed at OAH, OAH’s address, the time period for filing an appeal, and any applicable fees. N.C. Gen. Stat. § 135-48.24, as well as all State Health Plan statutes and medical policies, can be found at [www.shpnc.org](http://www.shpnc.org). The OAH statutes are found in Chapter 150B of the North Carolina General Statutes. Information is also available on OAH’s website at [www.oah.nc.gov](http://www.oah.nc.gov).

**Appeals Correspondence**

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

**Medical & Behavioral Health Appeals**

State Health Plan  
c/o Blue Cross NC 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 Blue Cross NC Appeals Department  
P.O. Box 30055  
Durham, NC 27702-3055
ADDITIONAL TERMS OF YOUR COVERAGE

Benefits to Which Members are Entitled
The benefits described in this benefit booklet are provided only for members. These benefits and the right to receive payment under this health benefit plan and the right to enforce any claim arising under this health benefit plan cannot be transferred or assigned to any other person or entity, including providers. Under the health benefit plan, the State Health Plan’s Third Party Administrator, Blue Cross NC may pay a provider directly. For example, Blue Cross NC pays in-network providers directly under applicable contracts with those providers. However, any provider’s right to be paid directly is through such contract with Blue Cross NC, and not through the Plan. Under the Plan, Blue Cross NC has the right to determine whether payment for services is made to the provider, to the subscriber, or allocated among both. Blue Cross NC’s decision to pay a provider directly in no way reflects or creates any rights of the provider under the Plan, including but not limited to benefits, payments or procedures.

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

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

Any amounts paid by the State Health Plan for services not covered or that are in excess of the benefit provided under your health benefit plan coverage may be recovered by the State Health Plan. The State Health Plan or its representative may recover the amounts by deducting from a member's future claims payments or by collecting directly from the member. This can result in a reduction or elimination of future claims payments. In addition, under certain circumstances, if the State Health Plan pays the provider amounts that are your responsibility, such as deductible, coinsurance, the State Health Plan may collect such amounts directly from you.

Amounts paid by the State Health Plan for work related accidents, injuries, or illnesses covered under state workers' compensation laws will be recovered upon final adjudication of the claim or an order of the applicable state agency approving a settlement agreement. It is the legal obligation of the member, the employer or the workers' compensation insurer (whoever is responsible for payment of the medical expenses) to notify the State Health Plan or its representative in writing that there has been a final adjudication or settlement.

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

Disclosure of Protected Health Information (PHI)
The State Health Plan and its representatives take your privacy seriously and handle all PHI as required by state and federal laws and regulations. The State Health Plan has developed a privacy notice that explains the procedures. The State Health Plan privacy notice is included in the back of this booklet or it can be found on the website at www.shpnc.org.
**Administrative Discretion**

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

**Applicable Law and Venue**

All disputes arising from the provision of health benefits or the administration of the State Health Plan shall be determined under, governed by, and construed in accordance with the laws of the State of North Carolina, without regard to any conflict of law or choice of law principles. Any court proceeding related to the provision of benefits or administration of the State Health Plan shall be exclusively brought and exclusively maintained in the state courts located in the State of North Carolina, Wake County, the federal courts located in the Eastern District of North Carolina if jurisdiction is proper in federal court, upon appeal to the appellate courts corresponding to these jurisdictions, or, at the sole option of the State Health Plan, in another court in which the State Health Plan shall initiate legal or equitable proceedings, and which has subject matter jurisdiction over the matter in controversy. Member expressly submits and consents to the exclusive jurisdiction and exclusive venue therein, member waives any right to object to such jurisdiction or venue, and member hereby consents to the granting of such legal or equitable relief as is deemed appropriate by any such court. Furthermore, member waives, to the extent permitted under applicable law, any right member may have to assert the doctrine of “forum non conveniens” to the extent any proceeding is brought in accordance with this provision.

**Jury Trial Waiver**

Member irrevocably waives, to the extent permitted by law, any and all rights to a trial by jury in any proceeding or action against the State Health Plan arising out of or relating to any provision herein.

**Attorneys’ Fees and Costs**

Member irrevocably waives, to the extent permitted by law, any and all rights to recover attorneys’ fees and costs in any proceeding or action against the State Health Plan arising out of or relating to any provision herein.

**Arbitration and Mediation**

The State Health Plan does not consent to any binding arbitration or mediation. The State Health Plan may, in its sole discretion, elect to resolve any dispute arising from the provision of health benefits or the administration of the State Health Plan by mediation or arbitration in accordance with the laws of North Carolina.

**Services Received Outside Of North Carolina**

*Blue Cross NC* has a variety of relationships with other Blue Cross and/or Blue Shield licensees, generally referred to as “Inter-Plan Arrangements.” As a member of the Plan, you have access to providers outside the State of North Carolina. Your *ID card* tells providers that you are a member of the Plan. While the Plan maintains its contractual obligation to provide benefits to members for covered services, the Blue Cross and/or Blue Shield licensee in the state where you receive services (“Host Blue”) is responsible for contracting with and generally handling all interactions with its participating providers.

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

Whenever you obtain health care services outside the area in which the Blue Cross NC network operates, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include Negotiated National Account Arrangements available between Blue Cross NC and other Blue Cross and/or Blue Shield licensees.
Under the BlueCard Program, the amount you pay toward such covered services, such as deductibles, copayments, or coinsurance, is usually based on the lesser of:

- The billed charges for your covered services; or
- The negotiated price that the “Host Blue” passes on to Blue Cross NC.

This “negotiated price” can be:

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

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

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

As an alternative to the BlueCard Program and depending on your geographic location, your claim may be processed through a Negotiated National Account Arrangement with a Host Blue. In these situations, the amount you pay for covered services will be calculated based on the lower of the participating provider’s billed covered charges or the negotiated price made available to Blue Cross NC by the Host Blue.

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

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

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

- **Value Based Programs: Negotiated (non-BlueCard Program) Arrangements**
  If Blue Cross NC has entered into a Negotiated National Account Arrangement with a Host Blue to provide Value-Based Programs to your Employer on your behalf, Blue Cross NC will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted above for the BlueCard Program.
Blue Cross Blue Shield Global Core®

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

If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, you should call the Service Center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

Inpatient Services

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

Outpatient Services

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

Submitting a Blue Cross Blue Shield Global Core Claim

When you pay for Covered Services outside the BlueCard service area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a claim form and send the claim form with the provider’s itemized bill(s) to the Service Center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from Blue Cross NC, the Service Center or online at www.bcbsglobalcore.com. If you need assistance with your claim submission, you should call the Service Center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, 7 days a week.

North Carolina Provider Reimbursement

Blue Cross NC has contracted with the North Carolina State Health Plan Network and with certain providers for the provision of, and payment for, health care services provided to eligible members. The payment to some of these in-network providers utilizes a reference-based pricing methodology, where Traditional Medicare is the reference and a significant percentage above this reference will be paid for the vast majority of services, others are paid based upon a traditional negotiated discount from their billed charges. Blue Cross NC’s payment to providers may also be based on other methodologies, including without limitation, an amount per confinement or episode of care or agreed upon schedule of fees. Under certain circumstances, a contracting provider may receive payments from Blue Cross NC greater than the charges for services provided to an eligible member, or Blue Cross NC may pay less than charges for services, due to negotiated contracts. The member is not entitled to receive any portion of the payments made under the terms of contracts with providers.

Some out-of-network providers have other agreements with Blue Cross NC that affect their reimbursement for covered services provided to Plan members. These providers agree not to bill members for any charges higher than their agreed upon, contracted amount. In these situations, members will be responsible for the
difference between the Plan’s allowed amount and the contracted amount. Out-of-network providers may bill you directly. If you are billed, you will be responsible for paying the bill and filing a claim with Blue Cross NC.

**Right of Recovery/Subrogation Provision**

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

In addition, if a member receives any payment from any potentially responsible party as a result of an injury, illness, or condition the State Health Plan has the right to recover from, and be reimbursed by, the member for all amounts the State Health Plan has paid and will pay as a result of that injury or illness, up to and including the full amount the member receives from all potentially responsible parties.

Further, the State Health Plan will automatically have a lien, to the extent of benefits advanced, upon any recovery whether by settlement, judgment or otherwise, that a member receives from a third party, the third party's insurer or any other source as a result of the member's injuries. The lien is in the amount of benefits paid by the State Health Plan for the treatment of the illness, injury or condition for which another party is responsible.

As used throughout this provision, the term responsible party means any party possibly responsible for making any payment to a member due to a member's injuries or illness or any insurance coverage.

The member acknowledges that the State Health Plan's recovery rights are a first priority claim against all potentially responsible parties and are to be paid to the State Health Plan before any other claim for the member's damages. The State Health Plan shall be entitled to full reimbursement first from any potential responsible party payments, even if such payment to the State Health Plan will result in a recovery to the member which is insufficient to make the member whole or to compensate the member in part or in whole for the damages sustained. It is further understood that the State Health Plan will pay all fees associated with counsel it hires to represent its interests related to any recovery it may be entitled to, but it is agreed that the State Health Plan is not required to participate in or pay court costs or attorney fees to any attorney hired by the member.

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

The member acknowledges that the State Health Plan delegates authority to assert and pursue the right of subrogation and/or reimbursement on behalf of the State Health Plan. The member shall fully cooperate with the State Health Plan or its representative's efforts to recover benefits paid by the State Health Plan. It is the duty of the member to notify the State Health Plan or its representative in writing of the member's intent to pursue a claim against any potentially responsible party, within 30 days of the date when any notice is given to any party, including an attorney, of the intention to pursue or investigate a claim to recover damages or obtain compensation due to injuries or illness sustained by the member. The member shall provide all information requested by the State Health Plan or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the State Health Plan may reasonably request.
The *member* shall do nothing to prejudice the *State Health Plan*’s recovery rights as herein set forth. This includes, but is not limited to, refraining from entering into any settlement or recovery that attempts to reduce, waive, bar or exclude the full cost of all benefits provided by your health benefit plan.

In the event that any claim is made that any part of this right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the *member* and the *State Health Plan* or its representative agree that the *State Health Plan* shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

The *member* agrees that any legal action or proceeding with respect to this provision may be brought in any court of competent jurisdiction as the *State Health Plan* may elect. Upon receiving benefits under your health benefit plan, the *member* hereby submits to each such jurisdiction, waiving whatever rights may correspond to the *member* by reason of the *member*’s present or future domicile. If any information in this booklet conflicts with North Carolina state law or it conflicts with medical policies adopted under your health benefit plan, North Carolina law and such medical policies will prevail. Please see the above section titled “Administrative Discretion” for more information.

**Notice of Claim**

Your health benefit plan will not be liable for payment of benefits unless proper notice is furnished to the *State Health Plan* or its representative that covered services have been provided to a *member*. If the *member* files the claim, written notice must be given to the *State Health Plan* or its designated representative within 18 months after the *member* incurs the covered service. The notice must be on an approved claim form and include the data necessary for the *State Health Plan* or its representative as specifically set out in this benefits booklet to determine benefits.

**Notice of Benefit Determination**

Blue Cross NC will provide an explanation of benefits determination to the *member* or the *member*’s authorized representative within 30 days of receipt of a notice of claim if the *member* has financial liability on the claim other than a copayment, or if payment was made at the point of service, unless the *State Health Plan* has chosen to provide an explanation of benefits for additional claims where the *member* does not have a financial liability other than a copayment.

Blue Cross NC may take an extension of up to 15 additional days to complete the benefits determination if additional information is needed. If Blue Cross NC requires an extension, Blue Cross NC will notify the *member* or the *member*’s authorized representative of the extension and of the information needed. The *member* will then have 90 days to provide the requested information. As soon as Blue Cross NC receives the requested information, or at the end of the 90 days, whichever is earlier, Blue Cross NC will make a decision within 15 days.

Such notice will be worded in an understandable manner, and will include:

- The specific reason(s) for the denial of benefits;
- Reference to the benefit booklet section on which the denial of benefits is based;
- A description of any additional information needed for you to perfect the claim and an explanation of why such information is needed;
- A description of the review procedures and the time limits applicable to such procedures, including the *member*’s right to bring a civil action under Section 502(a) of ERISA following a denial of benefits.
• A copy of any internal rule, guideline, protocol or other similar criteria relied on, if any, in making the benefit determination or a statement that it will be provided without charge upon request;

• In the case of a denial of benefits based on *medical necessity*, *experimental* treatment, or a similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying the terms of the Plan to the *member’s* medical circumstances, or a statement that this will be provided without charge upon request; and

• In the case of a denial of benefits involving *urgent care*, a description of the expedited review process available to such claims.

Upon receipt of a denial of benefits, you have the right to file an appeal with Blue Cross NC. Please see “What If You Disagree With A Decision?” for more information.

**Limitations of Actions**

No legal action may be brought to recover benefits until you have exhausted all administrative remedies, which requires completion of the two-level *appeals* process. No legal action may be taken later than three years from the date services are *incurred*. Please see “What If You Disagree With A Decision?” for details regarding the *grievance* review process.

**Coordination of Benefits (Overlapping Coverage)**

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

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

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

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

**Other Rules**

• For proper coordination of your benefits, you are required to notify the State Health Plan of Medicare eligibility immediately.

• The benefits of a plan that covers the person as an active employee (neither laid off nor retired) or as a dependent of an active employee are determined before those of a plan that covers that person as a laid-off or retired employee or as that employee’s dependent. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

• The health benefit plan that has covered the person the longest will be primary if none of the rules listed above determine order of benefits payment.

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

**Benefit Coordination**

**Active Members and Non-Active Members who are not Medicare Primary**

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 Become Medicare Primary**

The State Health Plan mails a Medicare eligibility letter prior to your 65th birthday that outlines your coverage options once you become Medicare eligible and the timelines for making any changes.

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. Any member who becomes
eligible for Medicare may remain covered under the State Health Plan. For proper coordination of your benefits, you are required to notify the State Health Plan of Medicare eligibility immediately. If Medicare becomes your primary health coverage, you must elect Medicare Part B to maintain your same level of coverage.

- **State Health Plan Benefit Coordination with Medicare**
  - If you are actively employed and eligible for Medicare, the State Health Plan is primary, and Medicare is secondary for you and your dependents. The only exception is if you are Medicare primary due to End Stage Renal Disease (ESRD) or are receiving Social Security Disability Income benefits.
  - If you are retired and eligible for Medicare, the State Health Plan becomes secondary coverage.
  - Medicare is also primary, and the State Health Plan is secondary for the following Medicare-eligible individuals:
    - **Retirees**, including the last month that a retiree is still covered by the active group prior to being enrolled by the Retirement System.
    - **Dependents of retirees** who also have Medicare.
    - Disability members eligible through the Retirement Systems.
    - **Dependents** of disabled members who also have Medicare.
    - **Members** with End Stage Renal Disease (ESRD) following the 30-month State Health Plan primary period.
    - Individuals with “dual” Medicare entitlement. Dual entitlement occurs when Medicare is already paying as primary because of disability or age and the member also becomes eligible because of ESRD. In this case, the 30-month State Health Plan primary period is waived, and Medicare continues paying as primary.
    - Individuals who have Medicare because of disability and who are not actively working or those who are spouses of non-working employees who also have Medicare.
    - Former members and/or Medicare-eligible dependents covered under COBRA.
    - Former employees who are receiving the reduction in force (RIF) health benefit continuation coverage.

All covered charges not paid by Medicare are subject to the terms and conditions of your health benefit plan, including the benefit period deductible, coinsurance, and 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.

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**Important Information for Members Eligible for Medicare**

You must enroll in Medicare Parts A & B in order to receive full benefit coverage when Medicare is primary. If you are covered under the State Health Plan as a member or a dependent of a member, and you are eligible for Medicare Parts A & B, **your benefits under the State Health Plan will be paid as if you are enrolled for coverage under Medicare Parts A & B, regardless of whether you have actually enrolled for such coverage.** In other words, even if you have not enrolled in Medicare Parts A and/or B coverage, your health benefit plan will reduce your claim by the benefit that would have been available to you under Medicare Part A and/or 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 Parts A and/or B if you do not enroll in Medicare Parts A and/or B.**
Medicare as a Secondary Payer

The federal Medicare Secondary Payer (MSP) rules require that, for persons covered under both Medicare and a group health plan, Medicare must be the secondary payer in certain situations. This means that the group health plan must not take Medicare entitlement into account in determining whether these individuals are eligible to participate in the Plan, or in providing benefits under the Plan. If you or your covered dependent is eligible for Medicare, the following MSP rules apply:

If your Employer has 20 or more Employees, either Medicare or the Plan can be chosen as the primary coverage for you, if you are an Employee who is eligible for Medicare because you are age 65 or older; or your covered spouse is age 65 or older, regardless of your age.

If Medicare is elected as primary coverage, the law does not permit the Plan to provide benefits supplementing Medicare. Therefore, if you or your Dependent wishes to elect Medicare as your primary coverage, you must terminate the active coverage and have Medicare as your only coverage. You and/or your dependents should receive a letter from the Plan prior to your 65th birthday reminding you of your enrollment options and providing you with information about how and when to make changes. You can also contact the eligibility and enrollment center for additional information to complete the enrollment change. If you take no action, the Plan will remain your primary medical benefit, with Medicare providing supplemental coverage.

If your Employer has 100 or more Employees, medical benefits under the Plan will be paid before Medicare benefits for you and your covered Dependent who is under age 65; is eligible for Medicare because of disability; and is covered under the Plan because of your current employment status.

For all Employers, medical benefits under the Plan will be paid before Medicare benefits for you or any covered Dependent qualifying for Medicare due to end-stage renal disease. The Plan will remain the primary payer only during the first thirty (30) months after the earlier of: (1) the date renal dialysis treatments are begun; or (2) the date of Medicare entitlement following a kidney transplant.

If this Plan is the primary payer under the above rules, it will provide the same medical benefits that it provides for other Plan Participants who are not entitled to Medicare benefits.

If Medicare is the primary payer for you or any of your covered Dependents, medical benefits will be paid in accordance with the Coordination of Benefits provisions of the Plan.

Note: To protect your financial liability it is in your best interest to enroll in Medicare Parts A & B as soon as you become eligible.

Medicaid

If you or any of your covered Dependents qualify for coverage under Medicaid:

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

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

Eligibility

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

- All permanent full-time teachers and state employees who are either (1) paid from general or special state funds or (2) paid from non-state funds and the employing unit has agreed to provide coverage.
- Employees of state agencies, departments, institutions, boards, and commissions, not otherwise covered by the State Health Plan, who are employed in permanent job positions on a recurring basis and who work 30 or more hours per week for nine or more months per calendar year.
- Retired teachers and State employees, members of the General Assembly, and retired law enforcement officers who retired under the Law Enforcement Officers’ Retirement System prior to January 1, 1985. A retiring employee must have completed at least five years of contributory (membership) retirement service and have been hired prior to October 1, 2006. Conversely, on and after October 1, 2006, eligible retiree members must have completed at least twenty years of contributory (membership) retirement service with an employing unit prior to retirement from any State-supported retirement system in order to be eligible for non-contributory health benefits as a retired employee or retiree. If you withdraw your service from the Teachers and State Employees Retirement System, receive a refund of your contributions and, at a later date, become re-employed as an employee, this new start date will be considered your first hired date for enrollment and eligibility purposes.
- Surviving spouses of deceased active or retired (1) North Carolina teachers, (2) State employees, (3) members of the General Assembly who are receiving a survivor's alternate benefit under any of the state supported retirement programs, provided the death of the former State Health Plan member occurred prior to October 1, 1986.
- Employees of the General Assembly, not otherwise covered by this section, as determined by the Legislative Services Commission, except legislative pages and interns.
- Members of the General Assembly.
- Employees on official leave of absence while completing a full-time program in school administration in an approved program as a Principal Fellow.
- Employees formerly covered, other than retired employees, who have been employed for 12 or more months by an employing unit and whose jobs are eliminated because of a reduction in funds. Payment is limited to 12 months following separation from services because of job elimination.
- Former employees of a local school administrative unit who have completed a contract term of employment of 10 or 11 months and whose jobs are eliminated because of a reduction in funds. Payment is limited to 12 months following separation from services because of job elimination.
- Employees on approved leave of absence with pay or receiving workers' compensation. If you are receiving workers compensation, but separated from service (i.e. no longer an employee, then you are no longer eligible for State Health Plan benefits).
- Employees on approved leave under the Family and Medical Leave Act of 1993 (FMLA).
- Former employees who are receiving disability retirement benefits are eligible for the benefit provisions of the State Health Plan on the same basis as retired employees. Coverage for these
people will cease, however, as of the end of the month in which the former employee is no longer eligible for disability retirement benefits.

- Retirees (i) employed by an employing unit that elects to provide this coverage; and (ii) the retiree does not qualify for coverage as a permanent employee; and (iii) are determined to be “full-time” by their employing unit in accordance with section 4980H of the Internal Revenue Code and applicable regulations, as amended.

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

- School employees in a job-sharing position as described in N.C. Gen. Stat. § 115C-326.5.
- Employees and members of the General Assembly with 10, but less than 20 years of retirement service credit who were first hired on or after October 1, 2006, and the members first took office on or after February 1, 2007.

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

- Former members of the General Assembly who enrolled before October 1, 1986.
- Former members of the General Assembly who are enrolled in the State Health Plan at termination of membership in the General Assembly and elect to continue coverage within 30 days of the end of their term of office.
- Surviving spouses of deceased members of the General Assembly who enrolled before October 1, 1986.
- Employees of the General Assembly, not otherwise covered by this section, as determined by the Legislative Services Commission, except legislative pages and interns.
- Surviving spouses of deceased former members of the General Assembly, if covered at the time of death of the former member of the General Assembly.
- All permanent part-time employees (designated as half-time or more) who are paid from general or state funds.
- Retired employees with 5, but less than 10 years of retirement service credit who were first hired on or after October 1, 2006, or first taking office on or after February 1, 2007, for General Assembly members.
- Spouses and eligible dependent children of enrolled teachers, State employees, retirees, former members of the General Assembly, and Disability Income Plan beneficiaries.
- Former employees whose jobs were eliminated because of reduction in funds beyond the initial 12-month separation period.
- Certain blind persons licensed by the state as operators (or former operators) of vending facilities under contract with the Department of Health and Human Services.
- Surviving spouses of deceased retirees and surviving spouses of deceased teachers, State employees, and members of the General Assembly if the spouse was covered at the time of death and the death occurred after September 30, 1986.
- Certain surviving dependent children who are covered by the State Health Plan at the time of the employee’s death are entitled to coverage as a surviving dependent or who were covered under the State Health Plan on September 30, 1986. In the absence of an eligible surviving parent, each child is eligible for member only (individual) coverage until attaining one of the usual dependent children ineligibility events. If a surviving child was certified and covered as a disabled dependent, the dependent is eligible for life, or until the dependent ceases to be disabled. When coverage ceases for a surviving dependent child, they may be eligible for continuation coverage.
• The spouses and eligible dependent children of former employees whose jobs were eliminated because of reduction in funds.
• An employee on official leave of absence without pay.
• An employee with less than five years of retirement membership services, who is on leave without pay due to illness or injury for up to 12 months.

Under certain conditions the following are eligible:

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

**Dependent Eligibility**

For dependents to be covered under the State Health Plan, the employee or retiree must be covered, and their dependent must be one of the following:

• Spouse.
• A natural, legally adopted or foster child of the subscriber and/or spouse up to the end of the month of their 26th birthday. Dependent child includes a child for whom the subscriber is a court-appointed guardian, and a stepchild of the subscriber who is married to the stepchild’s natural parent.

Dependent child coverage may be continued beyond the 26th birthday if two statutory criteria are met:

• First, the dependent child is disabled.
• Second, the dependent was covered by the Plan on the dependent child’s 26th birthday.

Verification of the dependent child’s disability shall be provided to the Plan no later than 60 days after the dependent child’s 26th birthday. When requesting continuation of coverage, or for further information, employees should contact the Plan’s Eligibility and Enrollment Support Center at the number listed in “Who to Contact.”

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

No person shall be eligible for coverage as an employee or retired employee or as a dependent of an employee or retired employee upon a finding by the Executive Administrator, Treasurer, or Board of Trustees or by a court of competent jurisdiction that the employee or dependent knowingly and willfully made or caused to be made a false statement or false representation of a material fact in a claim for reimbursement.

**Enrolling in the Plan**

It is very important that you complete your, and if applicable, your eligible dependent(s)’ enrollment when you or your dependents are first eligible to enroll on the State Health Plan.

New employees who do not elect to enroll themselves or their dependents on the State Health Plan within 30 days of hire (first eligible) will not be allowed to enroll unless they experience a qualifying life event or enroll during the next scheduled Open Enrollment.

- **Dual Enrollment**
  No person shall be eligible for coverage as an employee or retired employee and as a dependent of an employee or retired employee at the same time, except when a spouse is eligible on a fully contributory basis. In addition, no person shall be eligible for coverage as a dependent of more than one employee or retired employee at the same time.
Qualifying Life Events that Allow Coverage Changes

If you have one of the following qualifying life events during the year, you will be able to make a coverage change that is on account of and corresponds with the qualifying life event. You are required to provide supporting documentation. Documentation must be uploaded in the Document Center of eBenefits, the Plan’s enrollment system, to facilitate the Health Benefits Representative verification of the qualifying life event in accordance to the State Health Plan policy.

- Your marital status changes due to marriage, death of a spouse, divorce, legal separation, or annulment.
- You obtain a dependent through marriage, birth, adoption, placement in anticipation of adoption, or foster care placement of an eligible child.
- You or your dependents experience an employment status change that results in the loss or gain of coverage under another group health benefit plan.
- You or your dependents become Medicare eligible.
- You, your spouse, or your dependents commence or return from an unpaid leave of absence such as Family and Medical Leave or military leave.
- You receive a qualified medical child support order (as determined by the Plan administrator) that requires the Plan to provide coverage for your children.
- If you or your dependents change your country of permanent residence by moving to or from the United States, you or your dependents will have 30 days from the date of entering or exiting the United States to change your health benefit plan election.
- If you, your spouse or dependents experience a cost or coverage change under another group health plan for which an election change was permitted, you may make a corresponding election change under the Flex Plan (e.g. your spouse’s employer significantly increases the cost of coverage and as a result, allows the spouse to change his/her election).
- If you change employment status such that you are no longer expected to average 30 hours of service per week but you do not lose eligibility for coverage under the State Health Plan (e.g. you are in a stability period during which you qualify as full-time), you may still prospectively revoke your election provided that you certify that you have or will enroll yourself (and any other covered family members) in other coverage providing minimum essential coverage (e.g. the Marketplace) that is effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.
- You may prospectively revoke your State Health Plan election if you certify your intent to enroll yourself and any covered dependents in the Marketplace for coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.
- You or your dependents lose coverage due to loss of eligibility under Medicaid or the Children’s Health Insurance Program (CHIP) and apply for coverage under this Plan within 60 days.
- You or your dependents become eligible for premium assistance with respect to coverage under this Plan under Medicaid or CHIP and apply for coverage under this Plan within 60 days.
- If you, your spouse or your dependent loses eligibility for coverage (as defined by HIPAA) under any group health plan or health insurance coverage (e.g., coverage in the individual market, including the marketplace), you may change your participation election.

In addition, eligible surviving spouses and any eligible surviving dependent child of a deceased retiree, teacher, State employee, member of the General Assembly, former member of the General Assembly, or Disability Income Plan beneficiary may continue coverage as long as they were enrolled at the time of the
member’s death and elect to continue coverage within 90 days after the death of the former State Health Plan member.

The coverage change request must occur within 30 days of the qualifying life event (except as specifically described above) or you will have to wait until the next Open Enrollment period. Retirees and surviving spouses are not required to experience a qualifying event if they wish to disenroll themselves or their dependents from the Plan; they may disenroll at any time.

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

**Enrollment Exceptions**

To make an enrollment exception request, active members must contact their HBR and request that the HBR file an enrollment exception request with the State Health Plan. Non-Active Members (Retirees, Disabled Members, RIF Members, COBRA Members, former Members of the General Assembly and other 100% contributory Members) must contact the State Health Plan office at 919-814-4400 to file an enrollment exception request. Enrollment exception requests must be submitted to State Health Plan within the following timeframe: Within sixty (60) days of enrollment, termination or change in benefit election or within thirty (30) days of premium deduction or premium payment due date reflecting enrollment, termination, or change in benefit election, whichever is later.

**Adding or Removing a Dependent**

If you want to add or remove a dependent due to a qualifying life event, you will need to do so through eBenefits, the Plan’s enrollment system. To access eBenefits, visit the [www.shpnc.org](http://www.shpnc.org) and click “eBenefits.” Failure to remove a dependent timely could result in loss of eligibility for continuation of coverage.

To add a dependent, the coverage change must occur within 30 days of the qualifying life event unless otherwise specified or you must wait until the next Open Enrollment period. The effective date of coverage for the dependent will be the first day of the month following the qualifying life event, except in the case of a newborn child or adopted child.

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

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

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

If you are a retired member or surviving spouse, you may remove dependents from your coverage without a qualifying life event. To add dependents, you must experience a qualifying life event or add them during Open Enrollment.

**Qualified Medical Child Support Order**
A Qualified Medical Child Support Order (QMCSON) 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 QMCSON 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, permanent employees is determined based on the following:

- The effective date of coverage is the first day of the month following the date of employment or the first day of the second month. For example, if the date of employment is October 12, coverage may begin November 1 or December 1. Eligible dependents must be enrolled with the same effective date as the employee, unless there is a qualifying event.

**Types of Coverage**
Your health benefit plan offers the following types of coverage:

- **Subscriber only coverage** - The health benefit plan covers the subscriber.
- **Subscriber/spouse coverage** - The health benefit plan covers the subscriber and his/her spouse.
- **Subscriber child(ren) coverage** - The health benefit plan covers the subscriber and his/her dependent child or children.
- **Family coverage** - The health benefit plan covers the subscriber 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, you are required to contact your HBR or follow the online process for updating your information through your enrollment system. It will help us give you better service if the State Health Plan or its representative is kept informed of these changes.

**When Coverage Ends**
Coverage for you or your dependents ends the last day of the month in which an ineligibility event occurs. Some examples of ineligibility events are divorce, entering active military service, and termination of employment. For additional ineligibility events, contact the Plan’s Eligibility and Enrollment Support Center at the number in “Who to Contact.” You must make the change request through eBenefits when there is a change of eligibility for a dependent. If notification is not made within the 30 days following the dependent’s ineligibility event, the dependent will be removed from coverage on the last day of the month in which the notification is received, and the coverage type change will be the first of the month following notification,
except in the case of death, in which case the coverage type change will be made retroactively to the first of the month following death.

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

If the premium amount due is only for dependent coverage, then only the dependent coverage will be terminated; however, if the premium is for both the subscriber and the dependents, all members of the family will have their coverage canceled.

If you are terminated due to non-payment, you will not be able to come back on the Plan until the next Open Enrollment period, even if you experience a qualifying life event.

Coverage for you or your dependents may also end on the date through which premiums have been paid. You or your dependents may be eligible for continuation coverage under COBRA or to convert to a non-employer sponsored plan the first day of the month following an eligibility event.

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

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

The State Health Plan offers telephonic coaching for disease and case management for members with the following conditions: asthma, chronic obstructive pulmonary disease (COPD), cerebrovascular disease (CVD), coronary artery disease (CAD), peripheral vascular disease (PAD), heart failure, and diabetes. Case management will also be provided for members with complex health care needs and with conditions such as chronic and end stage renal disease.

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.

Blue Cross NC offers Value Added Programs to help you take charge of your care and save you money. These innovative programs complement your health plan and are available at no additional cost. Value Added Programs include discounts, information and more on a variety of health-related products, services and topics. Now that's value-added. That's your plan for better health. To get started, go to the Plan’s website at www.shpnc.org, click on eBenefits to log in to the Plan’s enrollment system. Scroll down to find Blue Connect on the left-hand menu. Look for the Blue365 tile. Members will need to register in order to receive access to the Blue365 program.

Get Connected with Blue Connect

State Health Plan subscribers have access to Blue Connect, a protected online resource to help you manage your health plan and maximize your benefits. With Blue Connect, registered users can complete a variety of self-service tasks online, 24 hours a day, without ever picking up the phone.

- Find a provider and read provider reviews.
- View your claim status and where you are in meeting your deductible.
- View your Health Care Summary Report.
- Order new ID cards.
- View your Explanation of Benefits (EOB), which has recently been redesigned to provide more transparency, greater detail and enhanced understanding of your health care costs.
- Research health and wellness topics to help you make more informed health care decisions.
- Register for Blue365® Discount Program, which provides:
  - Gym memberships and fitness gear.
  - Vision and hearing care.
  - Weight loss and nutrition programs.
  - Travel and family activities.
  - Mind/body wellness tools and resources.
  - Financial tools and programs.

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 Blue Cross NC is liable for problems resulting from goods and services they do not provide directly, such as goods and services not being provided or being provided negligently. The State Health Plan or Blue Cross NC may stop or change these programs at any time.
DEFINITIONS

ACCESS TO CARE STANDARDS — the guidelines in place to protect a Member when an in-network provider is not reasonably available or that provider type does not participate in the network. If there is not a network provider available, a non-network provider may be paid at the in-network level. The non-network provider must be approved by Blue Cross NC prior to having the service performed. Members should contact State Health Plan Customer Service at the number in "Who to Contact" for additional information.

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

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

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

ALLOWED AMOUNT — the maximum amount that the Plan and/or Blue Cross NC determines is reasonable for covered services provided to a member. The allowed amount includes any Plan payment to the provider, plus any copayment, deductible, or coinsurance. For providers that have entered into an agreement with the Plan and/or Blue Cross NC, the allowed amount is the negotiated amount that the provider has agreed to accept as payment in full. The allowed amount may be greater than the billed amount. Except as otherwise specified in “Emergency Care,” or as defined in “Access to Care Standards,” for providers that have not entered into an agreement with the Plan and/or Blue Cross NC, the allowed amount will be the lesser of the provider’s billed charge or an amount based on an out-of-network fee schedule established by Blue Cross NC or through the BlueCard Program that is applied to comparable providers for similar services under a similar health benefit plan. Where Blue Cross NC has not established an out-of-network fee schedule amount for the billed service, the allowed amount will be the lesser of the provider’s billed charge or a charge established by Blue Cross NC using a methodology that is applied to comparable providers who may have entered into an agreement with Blue Cross NC for similar services under a similar health benefit plan. Other than described above, Blue Cross NC will not pay the out-of-network provider’s billed charge unless doing so is required by law. Calculation of the allowed amount is based on several factors including Blue Cross NC’s medical, payment and administrative guidelines. Under the guidelines, some procedures charged separately by the provider may be combined into one procedure for reimbursement purposes.

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

AMBULATORY INFUSION SUITE — a free-standing facility that solely provides infusion services under the supervision of a nurse or medical director.

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

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

a) Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an outpatient basis;

b) Provides nursing services and treatment by or under the supervision of doctors whenever the patient is in the facility;

c) Does not provide inpatient accommodations; and
d) Is not, other than incidentally, a facility used as an office or clinic for the private practice of a doctor or other providers.

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

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

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

**BLUE CROSS NC** — Blue Cross and Blue Shield of North Carolina.

**BEHAVIORAL HEALTH** — includes both mental illness (mental disorders, psychiatric illnesses, mental conditions and psychiatric conditions, defined more fully under “Mental Illness” below), and substance abuse (the pathological use or abuse of alcohol or other drugs in a manner or to a degree that produces impairment in personal, social, or occupational functioning, defined more fully under “Substance Abuse” below).

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

**BENEFIT PERIOD MAXIMUM** — the maximum amount of allowed charges for covered services in a benefit period that will be reimbursed on behalf of a member while covered under the health benefit plan. Services in excess of a benefit period maximum are not covered services and members may be responsible for the entire amount of the provider’s billed charge.

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

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

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

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

**COINSURANCE** — the sharing of charges by the State Health Plan and the member for covered services received by a member, usually stated as a percentage of the allowed amount.

**COMPLICATIONS OF PREGNANCY** — medical conditions whose diagnosises are distinct from pregnancy, but are adversely affected or caused by pregnancy, resulting in the mother’s life being in jeopardy or making the birth of a viable infant impossible and which require the mother to be treated prior to the full term of the pregnancy (except as
otherwise stated below), including, but not limited to: abruption of placenta; acute nephritis; cardiac decompensation; documented hydramnios; eclampsia; ectopic pregnancy; insulin dependent diabetes mellitus; missed abortion; nephrosis; placenta previa; Rh sensitization; severe preeclampsia; trophoblastic disease; toxemia; immediate postpartum hemorrhage due to uterine atony; retained placenta or uterine rupture occurring within 72 hours of delivery; or, the following conditions occurring within ten days of delivery: urinary tract infection, mastitis, thrombophlebitis, and endometritis. Emergency cesarean section will be considered eligible for benefit application only when provided in the course of treatment for those conditions listed above as a complication of pregnancy. Common side effects of an otherwise normal pregnancy, conditions not specifically included in this definition, episiotomy repair and birth injuries are not considered complications of pregnancy.

**COMPOUND MEDICATION** — is prepared by a pharmacist when mixing or altering ingredients to create a unique prescription medication that is specific for an individual patient.

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

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

**COSMETIC** — to improve appearance. This does not include restoration of physiological function resulting from accidental injury, trauma or previous treatment that would be considered a covered service. This also does not include reconstructive surgery to correct congenital or developmental anomalies that have resulted in functional impairment.

**COVERED SERVICE(S)** — a service, medication, supply or equipment specified in this benefit booklet for which members are entitled to benefits in accordance with the terms and conditions of their health benefit plan. Any services in excess of a benefit period maximum or lifetime maximum are not covered services.

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

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

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

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

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

**DEVELOPMENTAL DYSFUNCTION** — difficulty in acquiring the activities of daily living including, but not limited to, walking, talking, feeding or dressing oneself or learning in school. Developmental therapies are those to facilitate or promote the development of skills, which the member has not yet attained. Examples include, but are not limited to: speech therapy to teach a member to talk, follow directions or learn in school; physical therapy to treat a member with low muscle tone or to teach a member to roll over, sit, walk or use other large muscle skills; occupational therapy to teach a member the activities of daily living, to use small muscle skills or balance or to assist with behavior or achievement in the learning setting.
DOCTOR — includes the following: a doctor of medicine, a doctor of osteopathy, licensed to practice medicine or surgery by the Board of Medical Examiners in the state of practice, a doctor of dentistry, a doctor of podiatry, a doctor of chiropractic, a doctor of optometry, or a doctor of psychology who must be licensed or certified in the state of practice and has a doctorate degree in psychology and at least two years clinical experience in a recognized health setting or has met the standards of the National Register of Health Service Providers in Psychology. All of the above must be duly licensed to practice by the state in which any service covered by the contract is performed, regularly charge and collect fees as a personal right, subject to any licensure or regulatory limitation as to location, manner, or scope of practice. All services performed must be within the scope of license or certification to be eligible for reimbursement.

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

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

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

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

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

EMPLOYEE — the person who is eligible for coverage under the State Health Plan due to employment with the State of North Carolina, including, but not limited to teachers, state employees, retirees; certain members of boards and commissions; certain counties and municipalities; firemen and rescue workers; National Guard; and anyone else eligible pursuant to North Carolina General Statutes.

EXPERIMENTAL — see Investigational.

FACILITY SERVICES — covered services provided and billed by a hospital or non-hospital facility. All services performed must be within the scope of license or certification to be eligible for reimbursement.

FAMILY PLANNING — reproductive health services, including care for maternity, complications of pregnancy, infertility and sexual dysfunction and contraception.

FORMULARY — the list of outpatient prescription medications, insulin, and certain over-the-counter medications that may be available to members.

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

GENERIC — a medication name not protected by a trademark which has the same active ingredient, strength and dosage form, and which is determined by the Food and Drug Administration (FDA) to be therapeutically equivalent to the prescription brand name medication.
GRIEVANCE — *grievances* include dissatisfaction with a claims denial or any decisions (including an *appeal* of a *non-certification* decision), policies or actions related to the availability, delivery or quality of health care services.

HBR — *see Health Benefits Representative*.

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

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

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

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

- Provides skilled nursing and other services on a visiting basis in the *member’s* home
- Is responsible for supervising the delivery of such services under a plan prescribed by a *doctor*
- Is accredited and licensed or certified in the state where located
- Is certified for participation in the Medicare program
- Is acceptable to *Blue Cross NC*

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

- Is accredited, licensed or certified in the state where located
- Is certified for participation in the Medicare program
- Is acceptable to *Blue Cross NC*

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

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

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

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

IN-NETWORK — designated as participating in the North Carolina State Health Plan 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 North Carolina State Health Plan Network *provider* by *Blue Cross NC* or a *provider* participating in the BlueCard® program. *Ancillary providers* outside North Carolina are considered *in-network* only if they contract directly with the Blue Cross or Blue Shield plan in the state where services are received, even if they participate in the BlueCard Program.

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

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

a) Services or supplies requiring federal or other governmental body approval, such as medications and devices that do not have unrestricted market approval from the U.S. Food and Drug Administration (FDA) or final approval from any other governmental regulatory body for use in treatment of a specified condition. Any approval that is granted as an interim step in the regulatory process is not a substitute for final or unrestricted market approval.

b) There is insufficient or inconclusive scientific evidence in peer-reviewed medical literature to permit the *State Health Plan* or its representative’s evaluation of the therapeutic value of the service or supply.

c) There is inconclusive evidence that the service or supply has a beneficial effect on health outcomes.

d) The service or supply under consideration is not as beneficial as any established alternatives.

e) There is insufficient information or inconclusive scientific evidence that, when utilized in a non-
*investigational* setting, the service or supply has a beneficial effect on health outcomes and is as beneficial as any established alternatives.

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

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

**LIFETIME MAXIMUM** — the maximum amount of allowed *covered services* that will be reimbursed on behalf of a *member* while covered under this health benefit plan. Services in excess of any *lifetime maximum* are not *covered services*, and *members* may be responsible for the entire amount of the *provider’s* billed charge. See “Summary of Benefits” for any limits that may apply.

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

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

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

a) Provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease; and, except for clinical trials as described under this health benefit plan, not for *experimental, investigational, or cosmetic* purposes.

b) Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms.

c) Within generally accepted standards of *medical care* in the community.

d) Not solely for the convenience of the insured, the insured’s family, or the *provider*.

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

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

**MENTAL ILLNESS** — mental disorders, psychiatric illnesses, mental conditions and psychiatric conditions (whether organic or non-organic, whether of biological, non-biological, chemical or non-chemical 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, D.C.)
NON-CERTIFICATION — a determination by the State Health Plan or its representative that a service covered under your health benefit plan has been reviewed and does not meet requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness or the prudent layperson standard for coverage of emergency services and, as a result, the requested service is denied, reduced or terminated. The determination that a requested service is experimental, investigational or cosmetic is considered a non-certification. A non-certification is not a decision based solely on the fact that the requested service is specifically excluded under your benefits.

NON-HOSPITAL FACILITY — an institution or entity other than a hospital that is accredited and licensed or certified in the state where located to provide covered services and is acceptable to Blue Cross NC. 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 Blue Cross NC. All services performed must be within the scope of license or certification to be eligible for reimbursement. Examples may include physician assistants (PAs), nurse practitioners (NPs), or certified registered nurse anesthetics (CRNAs).

OTHER PROVIDER — an institution or entity other than a doctor or hospital, which is accredited and licensed or certified in the state where located to provide covered services and which is acceptable to Blue Cross NC.

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 North Carolina State Health Plan Network or BlueCard® networks and not certified in advance by Blue Cross NC 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 North Carolina State Health Plan Network or BlueCard® network.

OUT-OF-POCKET LIMIT — the maximum amount listed in “Summary of Benefits” that is payable by the member in a benefit period before the Plan pays 100% of covered services. It includes deductible, coinsurance and copayment, but excludes premiums.

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

OUTPATIENT CLINIC(S) — an accredited institution/facility associated with or owned by a hospital. An outpatient clinic may bill for outpatient visits, including professional services and ancillary services, such as diagnostic tests. These services may be subject to the Outpatient Services benefit. All services performed must be within the scope of the professional or facility license or certification to be eligible for reimbursement.
PHARMACY BENEFIT MANAGER (PBM) — the company with which the North Carolina State Health Plan contracts to manage the pharmacy benefit for its members.

PLAN — North Carolina State Health Plan.

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

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

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

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

PREVENTIVE CARE — medical services provided by or upon the direction of a doctor or other provider related to the prevention of disease. Certain services are identified by the Affordable Care Act as being “Preventive Care” and are covered at 100%. Examples are:
   a) Immunizations
   b) Medications
   c) Screening Services
   d) Counseling Services

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

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

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

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

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

RESIDENTIAL TREATMENT FACILITY — a residential treatment facility is a facility that either: (1) offers treatment for patients that require close monitoring of their behavioral and clinical activities related to their substance abuse or addiction to drugs or alcohol, or (2) offers treatment for patients that require psychiatric services for the diagnosis and treatment of mental illness. All services performed must be within the scope of license or certification to be eligible for reimbursement.

RESPITE CARE — services provided by an alternate caregiver or facility to allow the primary caregiver time away from those activities. Respite care is provided in-home or at an alternative location for a short stay. Services include support of activities of daily living such as feeding, dressing, bathing, routine administration of medicines, and can also include intermittent skilled nursing services that the caregiver has been trained to provide.
RETIREE — an enrolled retired employee who receives monthly retirement benefits from any retirement system supported in whole or in part by contributions of the State of North Carolina and who is eligible for benefits pursuant to North Carolina General Statutes.

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

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

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

- Occupational therapy — treatment by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those required by the person's particular occupational role after such ability has been impaired by disease, injury, or loss of a body part.
- Physical therapy — treatment by physical means, hydrotherapy, heat or similar modalities, physical agents, biomechanical and neurophysiological principles and devices to relieve pain, restore maximum function and prevent disability following disease, injury or loss of body part.
- Speech therapy — treatment for the restoration of speech impaired by disease, surgery, or injury; or certain significant physical congenital conditions such as cleft lip and palate; or swallowing disorders related to a specific illness or injury.

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

SPECIALIST — a doctor who is recognized by Blue Cross NC as specializing in an area of medical practice.

SPECIALTY MEDICATION — specialty and biosimilar medications are designated and classified by the Plan as medications that meet the following criteria. Treats complex medical conditions(s), requires frequent clinical monitoring, e.g. dosing adjustments, requires special patient education, training and/or coordination of care and generally prescribed by a specialist provider. Specialty medications are listed on the Specialty Medication List, which is located on the Plan’s website at www.shpnc.org.

SPOUSE — the husband or wife of any employee or retiree who enters into a marriage that is legally recognized under any state law.

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

STATE HEALTH PLAN — the state organization authorized pursuant to North Carolina General Statutes to make available the State Health Plan for Teachers and State Employees and optional hospital and medical benefits and programs to employees and dependents.

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

SUBSTANCE USE DISORDER — the pathological use or abuse of alcohol or other drugs in a manner or to a degree that produces impairment in personal, social, or occupational functioning and which may, but need not, include a pattern of tolerance and withdrawal.

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

- The correction of fractures and dislocations
b) Usual and related preoperative and postoperative care

c) Other procedures as reasonable and approved by the State Health Plan

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

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

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

**WELLNESS ACTIVITY** — activity that can be completed during enrollment to qualify for Wellness Premium Credit.

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

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

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.

Original Effective Date: April 14th, 2003
Revised Effective Date: June 10, 2021

Introduction

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

Your Rights

You have the right to:

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

Your Choices

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

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

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
• Address workers’ compensation, law enforcement, and other government requests
• Respond to lawsuits and legal actions

Your Rights

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

• You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
• We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
• Ask us to correct health and claims records
• You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
• We may say “no” to your request, but we’ll tell you why in writing within 60 days.
• Request confidential communications
• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
• We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.
• Ask us to limit what we use or share
• You can ask us not to use or share certain health information for treatment, payment, or our operations.
• We are not required to agree to your request, and we may say “no” if it would affect your care.
• Get a list of those with whom we’ve shared information
• You can ask for a list (accounting) of the times we’ve shared your health information (including medical records, billing records, and any other records used to make decisions regarding your health care benefits) for six years prior to the date you ask, who we shared it with, and why.
• We will include all the disclosures except: (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.
• To request an accounting, you must submit a written request to the Privacy Contact identified in this Notice. Your request must state a time period of no longer than six (6) years.

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

Choose someone to act for you

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

File a complaint if you feel your rights are violated

• You can complain if you feel we have violated your rights by contacting us using the information on page 1.
• You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
• We will not retaliate against you for filing a complaint.
Your Choices

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

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

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

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

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

- Marketing purposes, including when you provide your mobile phone number for the express purpose of enrolling in the Plan’s texting program. See “SMS Texting Terms and Conditions” for details.
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Help manage the health care treatment you receive
We can use your health information and share it with professionals who are treating you.
Example: The Plan may disclose your health information so that your doctors, pharmacies, hospitals, and other health care providers may provide you with medical treatment.

Run our organization
We can use and disclose your information to run our organization (healthcare operations), improve the quality of care we provide, reduce healthcare costs, and contact you when necessary.
Example: The Plan may use and disclose your information to determine the budget for the following year, or to set premiums.

We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.
Example: We use health information about you to develop better services for you.

Pay for your health services
We can use and disclose your health information as we pay for your health services.
Example: We share information about you with CVS Caremark to coordinate payment for your prescriptions.

Administer your plan
We may disclose your health information to your health plan sponsor for plan administration.
Example: Your employer’s Health Benefit Representative is provided information to help you understand your health benefits, and help make sure you are enrolled.

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

Help with public health and safety issues
We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone’s health or safety

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

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

Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers’ compensation, law enforcement, and other government requests
We can use or share health information about you:

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

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Other Uses and Disclosures
Some uses and disclosures of your will be made only with your written authorization. For example, your written authorization is required in the following instances: (i) any use or disclosure of psychotherapy notes, except as otherwise permitted in 45 C.F.R. 164.508(a)(2); (ii) any use or disclosure for “marketing,” except as otherwise permitted in 45 C.F.R. 164.508(a)(3); (iii) any disclosure which constitutes a sale of PHI. If you authorize the Plan to use or disclose your PHI, you may revoke the authorization at any time in writing. However, your revocation will only stop future uses and disclosures that are made after the Plan receive your revocation. It will not have any effect on the prior uses and disclosures of your PHI.

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

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

Changes to the Terms of this Notice

The Plan has the right to change this notice at any time. The Plan also has the right to make the revised or changed notice effective for medical information the Plan already has about you as well, as any information received in the future. The Plan will post a copy of the current notice at www.shpnc.org. You may request a copy by calling 919-814-4400.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the Plan or with the Secretary of the Department of Health and Human Services. You will not be penalized or retaliated against for filing a complaint.

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

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

U.S. Department of Health and Human Services
200 Independence Avenue SW.
Room 509F, HHH Building
Washington, DC 20201
1–800–368–1019, 800–537–7697 (TDD)
File complaint electronically at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

Privacy Contact

The Privacy Contact at the Plan is:

State Health Plan
Attention: HIPAA Privacy Officer
3200 Atlantic Avenue Raleigh, NC 27604
919-814-4400

Notice of HIPAA Special Enrollment Rights

If you decline enrollment for yourself or your dependents (including your spouse) because of other group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents’ other coverage). However, you must request enrollment within 30 days after your or your dependents’ other coverage ends (or after the employer stops contributing toward the other coverage).
If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children’s health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents’ coverage ends under Medicaid or a state children’s health insurance program.

If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children’s health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents’ determination of eligibility for assistance.

To request special enrollment or obtain more information, contact the Enrollment and Billing Support Center at 855-859-0966.

**Nondiscrimination and Accessibility Notice**

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

The *State Health Plan*:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides a website that is Americans with Disabilities Act (ADA) compliant for the visually impaired
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator identified below (the “Coordinator”). If you believe that the *State Health Plan* has failed to provide these services or discriminated against you, you can file a grievance with the Coordinator. You can file a grievance in person or by mail, fax, or email.

**State Health Plan Civil Rights Coordinator**

North Carolina State Health Plan
Attention: Civil Rights Coordinator
3200 Atlantic Avenue
Raleigh, NC 27604
(919) 814-4400

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, available at:

**U.S. Department of Health and Human Services**

200 Independence Avenue SW.,
Room 509F, HHH Building,
Washington, DC, 20201
1–800–368–1019, 800–537–7697 (TDD).
Notice Regarding Women’s Health and Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women’s Health and Cancer Rights Act of 1998. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.
These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under your elected plan. For more information, contact Customer Service at 888-234-2416.

Notice of Patient Protections for Non-Grandfathered Plans

The following notice applies to plans offered by the North Carolina State Health Plan for Teachers and State Employees (“Plan”) that are not considered to be a “grandfathered health plan” under the Patient Protection and Affordable Care Act. The Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the North Carolina State Health Plan Network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Customer Service at 888-234-2416.

You do not need prior review from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the North Carolina State Health Plan Network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior review for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Customer Service at 888-234-2416.
Premium Assistance Under Medicaid and the Children’s Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you’re eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren’t eligible for Medicaid or CHIP, you won’t be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren’t already enrolled. This is called a “special enrollment” opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2021. Contact your State for more information on eligibility –

<table>
<thead>
<tr>
<th>ALABAMA – Medicaid</th>
<th>COLORADO – Health First Colorado (Colorado’s Medicaid Program) &amp; Child Health Plan Plus (CHP+)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Website: <a href="http://myalhipp.com/">http://myalhipp.com/</a></td>
<td>Health First Colorado Website: <a href="https://www.healthfirstcolorado.com/">https://www.healthfirstcolorado.com/</a></td>
</tr>
<tr>
<td>Phone: 1-855-692-5447</td>
<td>Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711</td>
</tr>
<tr>
<td></td>
<td>CHP+: <a href="https://www.colorado.gov/pacific/hcpf/child-health-plan-plus">https://www.colorado.gov/pacific/hcpf/child-health-plan-plus</a></td>
</tr>
<tr>
<td></td>
<td>Health Insurance Buy-In Program (HIBI): <a href="https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program">https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program</a></td>
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<tr>
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<td>HIBI Customer Service: 1-855-692-6442</td>
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<tr>
<th>ALASKA – Medicaid</th>
<th>FLORIDA – Medicaid</th>
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<tr>
<td>The AK Health Insurance Premium Payment Program Website: <a href="http://myakhipp.com/">http://myakhipp.com/</a></td>
<td>Website: <a href="https://www.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html">https://www.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html</a></td>
</tr>
<tr>
<td>Phone: 1-866-251-4861</td>
<td>Phone: 1-877-357-3268</td>
</tr>
<tr>
<td>Email: <a href="mailto:CustomerService@MyAKHIPP.com">CustomerService@MyAKHIPP.com</a></td>
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</tbody>
</table>

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Medicaid Eligibility:  
[http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx](http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx)

<table>
<thead>
<tr>
<th>ARKANSAS – Medicaid</th>
<th>GEORGIA – Medicaid</th>
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| Website: [http://myarhipp.com/](http://myarhipp.com/)  
Phone: 1-855-MyARHIPP (855-692-7447) | Website: [https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp](https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp)  
Phone: 678-564-1162 ext 2131 |

<table>
<thead>
<tr>
<th>CALIFORNIA – Medicaid</th>
<th>INDIANA – Medicaid</th>
</tr>
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| Website:  
Health Insurance Premium Payment (HIPP) Program [http://dhcs.ca.gov/hipp](http://dhcs.ca.gov/hipp)  
Phone: 916-445-8322  
Email: [hipp@dhcs.ca.gov](mailto:hipp@dhcs.ca.gov) | Healthy Indiana Plan for low-income adults 19-64  
Website: [http://www.in.gov/fssa/hip/](http://www.in.gov/fssa/hip/)  
Phone: 1-877-438-4479  
All other Medicaid  
Website: [https://www.in.gov/medicaid/](https://www.in.gov/medicaid/)  
Phone 1-800-457-4584 |
<table>
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<tr>
<th>IOWA – Medicaid and CHIP (Hawki)</th>
<th>MONTANA – Medicaid</th>
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<tbody>
<tr>
<td>Medicaid Website:</td>
<td>Website: <a href="http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP">http://dphhs.mt.gov/MontanaHealthcarePrograms/HIP P</a></td>
</tr>
<tr>
<td><a href="https://dhs.iowa.gov/ime/members">https://dhs.iowa.gov/ime/members</a></td>
<td>Phone: 1-800-694-3084</td>
</tr>
<tr>
<td>Medicaid Phone: 1-800-338-8366</td>
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<tr>
<td>Hawki Website:</td>
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<tr>
<td><a href="http://dhs.iowa.gov/Hawki">http://dhs.iowa.gov/Hawki</a></td>
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<tr>
<td>Hawki Phone: 1-800-257-8563</td>
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<td>HIPP Website:</td>
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<tr>
<td><a href="https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp">https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp</a></td>
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<tr>
<td>HIPP Phone: 1-888-346-9562</td>
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<tr>
<th>KANSAS – Medicaid</th>
<th>NEBRASKA – Medicaid</th>
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<tr>
<td>Website: <a href="https://www.kancare.ks.gov/">https://www.kancare.ks.gov/</a></td>
<td>Website: <a href="http://www.ACCESSNebraska.ne.gov">http://www.ACCESSNebraska.ne.gov</a></td>
</tr>
<tr>
<td>Phone: 1-800-792-4884</td>
<td>Phone: 1-855-632-7633</td>
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<tr>
<th>KENTUCKY – Medicaid</th>
<th>NEVADA – Medicaid</th>
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<tr>
<td>Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: <a href="https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx">https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx</a></td>
<td>Medicaid Website: <a href="http://dhcfp.nv.gov">http://dhcfp.nv.gov</a></td>
</tr>
<tr>
<td>Phone: 1-855-459-6328</td>
<td>Medicaid Phone: 1-800-992-0900</td>
</tr>
<tr>
<td>Email: <a href="mailto:KIHIPP.PROGRAM@ky.gov">KIHIPP.PROGRAM@ky.gov</a></td>
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<tr>
<th>LOUISIANA – Medicaid</th>
<th>NEW HAMPSHIRE – Medicaid</th>
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<tbody>
<tr>
<td>Website: <a href="http://www.medicaid.la.gov">www.medicaid.la.gov</a> or <a href="http://www.ldh.la.gov/lahipp">www.ldh.la.gov/lahipp</a></td>
<td>Website: <a href="https://www.dhhs.nh.gov/oii/hipp.htm">https://www.dhhs.nh.gov/oii/hipp.htm</a></td>
</tr>
<tr>
<td>Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)</td>
<td>Phone: 603-271-5218</td>
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<tr>
<th>MAINE – Medicaid</th>
<th>NEW JERSEY – Medicaid</th>
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<tr>
<td>Enrollment Website: <a href="https://www.maine.gov/dhhs/ofi/applications-forms">https://www.maine.gov/dhhs/ofi/applications-forms</a></td>
<td>Medicaid Website: <a href="http://www.state.nj.us/humanservices/">http://www.state.nj.us/humanservices/</a></td>
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<tr>
<td>Phone: 1-800-442-6003</td>
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<tr>
<td>OKLAHOMA – Medicaid and CHIP</td>
<td>UTAH – Medicaid and CHIP</td>
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<tr>
<td>Website: <a href="http://www.insureoklahoma.org">http://www.insureoklahoma.org</a></td>
<td>Medicaid Website: <a href="https://medicaid.utah.gov/">https://medicaid.utah.gov/</a></td>
</tr>
<tr>
<td>Phone: 1-888-365-3742</td>
<td>CHIP Website: <a href="http://health.utah.gov/chip">http://health.utah.gov/chip</a></td>
</tr>
<tr>
<td>TTY: Maine relay 711</td>
<td>Phone: 1-877-543-7669</td>
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<tr>
<th>MASSACHUSETTS – Medicaid and CHIP</th>
<th>NEW YORK – Medicaid</th>
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<tr>
<td>Phone: 1-800-657-3739</td>
<td>Phone: 1-800-541-2831</td>
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<tr>
<th>MINNESOTA – Medicaid</th>
<th>NORTH CAROLINA – Medicaid</th>
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<tr>
<td>Phone: 1-800-657-3739</td>
<td>Phone: 919-855-4100</td>
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<tr>
<th>MISSOURI – Medicaid</th>
<th>NORTH DAKOTA – Medicaid</th>
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<tr>
<td>Phone: 573-751-2005</td>
<td>Phone: 1-844-854-4825</td>
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<tr>
<th>PENNSYLVANIA – Medicaid</th>
<th>VIRGINIA – Medicaid and CHIP</th>
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<tr>
<td>TTY: Maine relay 711</td>
<td>Website: <a href="http://www.greenmountaincare.org/">http://www.greenmountaincare.org/</a></td>
</tr>
<tr>
<td>Phone: -800-977-6740.</td>
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<tr>
<td>TTY: Maine relay 711</td>
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<tr>
<td>Phone: 1-800-699-9075</td>
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<tr>
<td>State</td>
<td>Medicaid and CHIP</td>
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<tr>
<td>RHODE ISLAND</td>
<td>Medicaid and CHIP</td>
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<tr>
<td>WASHINGTON</td>
<td>Medicaid</td>
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<tr>
<td>SOUTH CAROLINA</td>
<td>Medicaid</td>
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<tr>
<td>SOUTH DAKOTA</td>
<td>Medicaid</td>
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<tr>
<td>WISCONSIN</td>
<td>Medicaid and CHIP</td>
</tr>
<tr>
<td>TEXAS</td>
<td>Medicaid</td>
</tr>
</tbody>
</table>

To see if any other states have added a premium assistance program since July 31, 2021, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
[www.dol.gov/agencies/ebsa](http://www.dol.gov/agencies/ebsa)
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
[www.cms.hhs.gov](http://www.cms.hhs.gov)
1-877-267-2323, Menu Option 4, Ext. 61565

**General Notice of COBRA Rights**

*North Carolina State Health Plan (“Plan”)*
For more information on general Plan terms, contact the North Carolina State Health Plan at 855-859-0966.
For more information about COBRA, contact ITEDIUM, Inc. toll free at 877-679-6272.

**Introduction to COBRA Rights**

This notice is routinely sent to all employees and dependents covered under the State Health Plan. It is intended to inform you of your potential future options and obligations under the continuation coverage provisions of the
Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). Under COBRA, your employer is required to offer covered employees and covered family members the opportunity for a temporary extension of health coverage, called continuation coverage, at group rates when coverage under the Plan would otherwise end due to certain qualifying events. It is important that all covered individuals read this notice carefully and be familiar with its contents. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.

When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage. You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse’s plan), even if that plan generally doesn’t accept late enrollees. You can learn more about many of these options at www.healthcare.gov.

Your employer is required to offer COBRA (and this notice does apply to you) if your employer employs twenty (20) or more employees on a typical business day during the preceding calendar year. If you are not eligible for COBRA, you may be eligible for state continuation coverage. Contact the Plan for more information.

The Public Health Service Act ("PHSA") requires state and local government group health plans to provide continuation coverage. This coverage is identical to the coverage required of private group health plans under the Consolidated Budget Reconciliation Act of 1985 ("COBRA"). When used herein, the terms "COBRA or COBRA continuation coverage" also include coverage required under the PHSA.

Qualifying Events

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called 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 the Plan is lost because of the qualifying event.

If you’re an employee, you’ll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:
- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you’re the spouse of an employee, you’ll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:
- Your spouse dies;
- Your spouse’s hours of employment are reduced;
- Your spouse’s employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits; or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:
- The parent-employee dies;
- The parent-employee’s hours of employment are reduced;
- The parent-employee’s employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits;
• The parents become divorced or legally separated; or
• The child stops being eligible for coverage under the Plan as a “dependent child.”

If the Plan provides retiree health coverage, filing a proceeding for 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 employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. 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 the Plan.

If you are a reservist called to active duty and your employer does not voluntarily maintain coverage for the continuation coverage period, the employee, spouse, and covered dependents may be eligible to continue coverage under the Unformed Services Employment and Reemployment Rights Act (USERRA). Contact your employer for more information.

Availability of COBRA continuation coverage

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator, ITEDIUM, Inc., has been notified that a qualifying event has occurred. Your employer must notify ITEDIUM, Inc. of the following qualifying events:

• The end of employment or reduction of hours of employment;
• Death of the employee;
• Commencement of a proceeding in bankruptcy with respect to the employer; or
• The employee’s becoming entitled to Medicare benefits.

Under the law, the employee, spouse, or other family member has the responsibility to notify the employer of all other qualifying events, including divorce, legal separation, or a child losing dependent status under the group health plan. This notification must be made within 60 days from whichever date is later: the date of the event or the date on which health plan coverage would be lost under the terms of the insurance contract because of the event. If this notification is not completed according to the above procedures within the required notification period, then rights to continuation coverage will be forfeited.

Once ITEDIUM, Inc. learns a qualifying event has occurred, it will then notify all qualified beneficiaries of their right to elect continuation coverage. Each qualified beneficiary has independent COBRA election rights and will have 60 days to elect continuation coverage. The 60-day election period is measured from the later of the date health plan coverage is lost due to the event or from the date of COBRA notification, unless the Plan provides an extension of the election period beyond that required by law. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. If a qualified beneficiary does not elect continuation coverage within this election period, then rights to continue health insurance will end.

Qualified beneficiaries do not have to show they are insurable to elect continuation coverage; however, they must have been actually covered by the plan for at least one day prior to the qualifying event to be eligible for COBRA continuation coverage. Although a qualified beneficiary participating in COBRA continuation coverage has the same rights as an active participant to add dependents to the plan, those additional dependents may not be qualified beneficiaries. An exception to this rule is if, while on continuation coverage, a baby is born to or adopted by an employee/former employee. Procedures and deadlines for adding these individuals can be found in your benefits booklets and must be followed. The State Health Plan reserves the right to verify COBRA eligibility status and terminate continuation coverage retroactively if you are determined to be ineligible or if there has been a material misrepresentation of the facts.

Length of Continuation Coverage
COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months from the date of the qualifying event if the event causing the loss of coverage is a termination of employment (other than for reasons of gross misconduct) or a reduction in work hours. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

If you are the covered spouse or dependent child(ren) of an employee, you have the right to continuation coverage for up to 36 months from the date of the qualifying event if the original event causing the loss of coverage was the death of the employee, divorce, Medicare entitlement, or a dependent child ceasing to be a dependent child under the group health plan.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

**Disability extension of 18-month period of COBRA continuation coverage**

The 18 months of continuation coverage can be extended for an additional 11 months of coverage, to a maximum of 29 months, for all qualified beneficiaries if the qualified beneficiary is deemed disabled (as determined by Title II or XVI of the Social Security Act), at any time during the first 60 days of COBRA continuation coverage; and the qualified beneficiary notifies ITEDİUM, Inc. within 60 days after the determination of disability is made by the Social Security Administration, and within the initial 18-month period of coverage. It is the qualified beneficiary's responsibility to obtain this disability determination from the Social Security Administration and provide a copy of the determination to ITEDİUM, Inc. within 60 days after the date of determination and before the original 18 months expire. It is also the qualified beneficiary's responsibility to notify ITEDİUM, Inc. within 30 days if a final determination has been made that they are no longer disabled.

**Second qualifying event extension of 18-month period of continuation coverage**

If you are the covered spouse or dependent child(ren) of an employee, an extension of the 18-month continuation period can occur if, during the 18 months of continuation coverage, a second event takes place (divorce, death, Medicare entitlement, or a dependent child ceasing to be a dependent). If a second event occurs, then the original 18 months of continuation coverage can be extended to 36 months from the date of the original qualifying event date of the qualified beneficiary spouse and/or dependent children. If a second event occurs, it is the qualified beneficiary's responsibility to notify ITEDİUM, Inc. in writing within 60 days of the second event and within the original 18-month continuation period. In no event, however, will continuation coverage last beyond three years from the date of the event that originally made the qualified beneficiary eligible for continuation coverage.

**Cost of Continuation Coverage**

A qualified beneficiary will have to pay the entire applicable premium plus an administration charge for continuation coverage as allowed by law, currently 2% of the total premium. These premiums will be adjusted in the future if the applicable premium amount changes. In addition, if continuation coverage is extended from 18 months to 29 months due to a Social Security disability, the State Health Plan can charge up to 150% of the applicable premium during the extended coverage period. Premiums are due on the first of every month of continuation coverage. In addition, there will be a maximum grace period of 30 days for the regularly scheduled monthly premiums. Upon expiration of the continuation coverage period, a qualified beneficiary must be allowed to enroll in an individual conversion health plan provided under the State Health Plan if an individual conversion plan is available at that time.

The Trade Act of 2002 provides a federal tax credit that can be used to offset the cost of COBRA coverage. The Trade Adjustment Assistance (TAA) Extension Act of 2011 extended and increased this tax credit and extended COBRA periods for eligible individuals. This special tax credit is currently available only for workers who: (1) lose their jobs and are found eligible for trade adjustment assistance by the U.S. Department of Labor or state labor agencies, or (2) are between ages 55 and 64 and receiving monthly benefits from the Pension Benefit Guaranty Corporation. If a qualifying
event occurs, and you believe you may be entitled to this tax credit, please contact ITEDIUIM, Inc. toll free at 1-877-679-6272.

Termination of Continuation Coverage

Continuation of coverage will end prior to the maximum period if:

• Your employer ceases to provide any group health plan to any of its employees;
• Any required premium for continuation coverage is not paid in a timely manner;
• A qualified beneficiary becomes covered under another group health plan that does not contain any exclusion or limitation with respect to any preexisting condition of such beneficiary other than such exclusion or limitation which does not apply to or is satisfied by such beneficiary by reason of the Health Insurance Portability and Accountability Act of 1996.
• A qualified beneficiary becomes entitled to Medicare after the qualifying event except when the qualifying event is loss of retiree coverage due to the employer’s bankruptcy;
• A qualified beneficiary extended continuation coverage to 29 months due to a Social Security disability and a final determination has been made that the qualified beneficiary is no longer disabled;
• A qualified beneficiary notifies ITEDIUIM, Inc. that they wish to cancel COBRA continuation coverage.
• A qualified beneficiary participates in activity which would otherwise allow the Plan to terminate an active employee’s coverage (e.g. submission of a fraudulent claim).

Keep the Plan Informed

It is important that you notify the State Health Plan and ITEDIUIM, Inc. of any address change or change in marital status as soon as possible. Failure on your part to do so will result in delayed COBRA notifications or a loss of continuation coverage options. You must also notify the State Health Plan and ITEDIUIM, Inc. within 30 days of other group health coverage, Medicare entitlement or the termination of your Social Security disability status. COBRA continuation coverage which is provided improperly due to your failure to provide notice does not bind the Plan to provide further coverage.

Enrollment in the Flexible Benefit Plan (under IRS Section 125) for the State Health Plan

If you are an active employee, you are eligible for participation in the Flexible Benefit Plan to have your health benefit plan premium payments deducted on a pre-tax basis. Retirees and members with COBRA continuation coverage are not eligible for participation since they must have current earnings from which the premium payments can be deducted. The Flexible Benefit Plan allows any premiums you pay for health benefit coverage to be deducted from your paycheck before Federal, State, and FICA taxes are withheld. By participating, you will be able to lower your taxable income and lower your taxable liability, thereby in effect, lowering the net cost of your health plan coverage.

The Flexible Benefit Plan is designed so that your participation will be automatic unless you decline. If you wish to decline participation and have your contributions paid on an “after-tax” basis, you must contact your HBR. You will have the opportunity to change your participation election during each Open Enrollment period. The Flexible Benefit Plan administered by the State Health Plan is for the payment of health benefit plan premiums on a before-tax basis only and is separate and distinct from NCFlex, which is administered by the Office of State Human Resources.

Your health benefit coverage can only be changed (dependents added or dropped) during the Open Enrollment period or following a qualifying life event. These events include, but are not limited to the following:

• Your marital status changes due to marriage, death of spouse, divorce, legal separation, or annulment.
• You increase or decrease the number of your eligible dependents due to birth, adoption, placement for adoption, or death of the dependent.
• You, your spouse, or your eligible dependent experiences an employment status change that results in the loss or gain of group health coverage.
• You, your spouse, or your dependents become entitled to coverage under Medicare, or Medicaid.
• Your dependent ceases to be an eligible dependent (e.g., the dependent child reaches age 26).
• You, your spouse, or your dependents commence or return from an unpaid leave of absence such as Family and Medical Leave or military leave.
• You receive a qualified medical child support order (as determined by the plan administrator) that requires the plan to provide coverage for your children.
• If you, your spouse, or dependents experience a cost or coverage change under another group health plan for which an election change was permitted, you may make a corresponding election change under the Flex Plan (e.g., your spouse’s employer significantly increases the cost of coverage and as a result, allows the spouse to change his/her election).
• If you change employment status such that you are no longer expected to average 30 hours of service per week but you do not lose eligibility for coverage under the State Health Plan (e.g., you are in a stability period during which you qualify as full time), you may still revoke your election provided that you certify that you have or will enroll yourself (and any other covered family members) in other coverage providing minimum essential coverage (e.g., the marketplace) that is effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.
• You may prospectively revoke your State Health Plan election if you certify your intent to enroll yourself and any covered dependents in the marketplace for coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.
• You or your children lose eligibility under Medicaid or a state Children’s Health Insurance Program. In this case you must request enrollment within 60 days of losing eligibility.
• If you, your spouse, or your dependent loses eligibility for coverage (as defined by HIPAA) under any group health plan or health insurance coverage (e.g., coverage in the individual market, including the marketplace), you may change your participation election.

In addition, even if you have one of these events, your election change must be “consistent” with the event, as defined by the IRS. Consequently, the election change that you desire may not be permitted if not consistent with the event as determined by IRS rules and regulations. When one of these events occurs, you must complete your request through your online enrollment system within 30 days of the event (except as described above). If you do not process the request within 30 days, you must wait until the next Open Enrollment to make the coverage change.

Whenever you report a change due to a qualifying event, your premium deduction will be on a pre-tax basis.

Notice Regarding Availability of Health Insurance Marketplace Coverage Options (Employer Exchange Notice)

To assist you as you evaluate options for youand your family, this notice provides basic information about the Health Insurance Marketplace (“Marketplace”). The Marketplaceis designed to help you find health insurancethat meets your needs and fits your budget. The Marketplace offers “one-stop shopping” to find and compare private health insuranceoptions. You may also be eligible for a new kind of tax credit that lowers your monthly premium.

You may qualify to save money and lower yourmonthly premium, but only if your employer does not offer coverage, or offers coverage that doesn’t meet certain standards. The savings on your premium that you are eligiblefor depends on your household income. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit throughthe Marketplace and may wish to enroll in your employer’s health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards.

If the cost of a plan from your employerthat would cover you (and not any other members of your family) is more than
9.5% of your household income for the year, or if the coverage your employer provides does not meet the “minimum value” standard set by the Affordable Care Act, you may be eligible for a tax credit. An employer-sponsored health plan meets the “minimum value standard” if the plan’s share of the total allowed benefit costs covered by the plan is no less than 60% of such costs.

It is important to note, if you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution to the employer-offered coverage. Also, this employer contribution, as well as your employee contribution to employer-offered coverage, is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

For more information about your coverage offered by your employer, please review the summary plan description or contact Customer Service. The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

Notice Regarding Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is “balance billing” (sometimes called “surprise billing”)?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn’t in your health plan’s network. “Out-of-network” describes providers and facilities that haven’t signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called “balance billing.” This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit. “Surprise billing” is an unexpected balance bill. This can happen when you can’t control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan’s in-network cost-sharing amount (such as copayments and coinsurance). You can’t be balance billed for these emergency services. This includes services you may get after you’re in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan’s in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology,
assistant surgeon, hospitalist, or intensivist services. These providers **can’t** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can’t** balance bill you, unless you give written consent and give up your protections.

You’re **never** required to give up your protections from balance billing. You also aren’t required to get care out-of-network. You can choose a provider or facility in your plan’s network.

**When balance billing isn’t allowed, you also have the following protections:**

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you’ve been wrongly billed, you may contact the U.S. Department of Health and Human Services regarding enforcement of federal balance or surprise billing protection laws and the North Carolina Department of Insurance regarding enforcement of North Carolina balance or surprise billing protection laws (Phone: 855-408-1212; Address: 325 N. Salisbury Street, Raleigh, NC 27603).

Visit hhs.gov for more information about your rights under federal law.

Visit ncdoi.gov for more information about your rights under North Carolina law.