

# I. INTRODUCTION

## BENEFITS AT A GLANCE

This is only a summary of your benefits. Although a service may be covered, there may be limitations. You are responsible for reading this booklet and knowing your benefits. Please call Customer Services at **1-800-422-4658** if you have any questions.

The Plan's website is: **statehealthplan.state.nc.us (do not use www.)**

**Benefits for the North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan are based upon legislation enacted by the North Carolina General Assembly, as well as comprehensive medical policies approved by the Executive Administrator and Board of Trustees.**

Unless noted, all benefits are subject to the Plan year deductible and coinsurance maximums.

## BENEFITS AT A GLANCE

BENEFIT	COVERAGE
<b>Maximum Benefit</b> <i>see page 24</i>	\$5 million lifetime
<b>Plan Year</b> <i>see page 7</i>	July 1 through June 30 (fiscal year)
<b>Deductible</b> <i>see pages 11, 24</i>	Currently \$350 per Plan year with \$1,050 limit for each Employee and Child(ren) or Employee and Family contract per Plan year
<b>Coinsurance</b> <i>see pages 4, 25</i>	Member pays 20% up to \$1,500 maximum each Plan year; up to \$4,500 maximum for each Employee and Child(ren) or Employee and Family contract per Plan year
<b>Prescription Drugs</b> <i>see pages 8, 25-27</i>	Not subject to deductible and coinsurance Copayments for each 34-day supply <ul style="list-style-type: none"> <li>• \$10 Generic</li> <li>• \$25 Preferred Brand without Generic</li> <li>• \$35 Preferred Brand with Generic</li> <li>• \$40 Non-Preferred Brand</li> </ul> Copayment limit of \$2,500 per person per Plan year <u>For prescription drug benefit questions call the Pharmacy Benefit Manager (PBM) at 1-888-693-7750.</u>
<b>Medical Supplies</b> <i>see page 27</i>	Colostomy bags, catheters, dressings, oxygen, syringes and needles, and other similar supplies are covered.
<b>Physician Services</b> * office visits <i>see pages 4, 28, 33, 37-39, 53, 60</i>	\$15 copayment per visit per provider
<b>Surgery</b> <i>see pages 29, 38, 39, 42, 43</i>	Covered, when determined medically necessary by the CPC. Some surgeries require prior approval
<b>Inpatient Physician Services</b> <i>see page 29, 30</i>	Covered under most circumstances
<b>X-ray, lab, radiation therapy</b> <i>see pages 29, 30, 37, 37, 53, 55</i>	Covered, when determined medically necessary by the CPC
<b>Maternity Care</b> <i>see pages 7, 14, 36, 47</i>	Covered if the mother is enrolled as either the employee or spouse

BENEFIT	COVERAGE
<b>Emergency Room</b> <i>see page 28</i>	\$100 copayment for each visit unless patient is admitted, or if patient is in an observation unit (not to exceed 23 hours)
<b>Wellness Benefits</b> <ul style="list-style-type: none"> <li>• routine examinations</li> <li>• procedures</li> <li>• pap smears <i>see page 37</i></li> </ul>	\$150 each Plan year is not subject to deductible or coinsurance. Charges beyond the \$150 are subject to deductible and coinsurance. \$15 copayment is required for routine examination. For screening procedures: <ul style="list-style-type: none"> <li>• no limit for well visits for children younger than age 1</li> <li>• three well visits between the ages 1 and 2</li> <li>• one well visit a year for ages 2 through 6</li> <li>• once every three years for ages 7 through 39</li> <li>• once every 2 years between ages 40 and 49</li> <li>• once every year over age 50</li> </ul> Pap smears are allowed each year for female members of any age as part of the wellness benefits.
<b>Immunizations</b> <i>see page 38</i>	Immunizations for prevention of contagious diseases are not subject to deductible and coinsurance.
<b>Chiropractic Services</b> <i>see page 55</i>	\$15 copayment per visit. Covered up to \$2,000 each Plan year with limitations
<b>Diabetes Self-Care Program</b> <i>see page 55</i>	Covered up to \$300 each Plan year with limitations
<b>Therapy Services</b> <i>see pages 28, 29, 43</i>	\$15 copayment per visit. Physical, occupational and inhalation therapies are covered and require prior approval if rendered at home. Speech therapy is covered and requires prior approval.
<b>Home Care</b> <i>see pages 43, 44</i>	Requires prior approval - with limitations
<b>Private Duty Nursing</b> <i>see page 44</i>	Requires prior approval - with limitations
<b>Skilled Nursing Facility</b> <i>see page 45</i>	Requires prior approval - with limitations
<b>Outpatient Hospital and Ambulatory Surgical Facility</b> <i>see pages 28, 29</i>	\$50 copayment for outpatient hospital and ambulatory surgical facility services over \$500 per episode of care. Readmission within 30 days after discharge for same reason is considered the same episode of care.
<b>Inpatient Hospital Care</b> <ul style="list-style-type: none"> <li>• room and board</li> <li>• other hospital services - intensive care</li> </ul> <i>see pages 28, 29-32</i>	\$100 inpatient admission copayment. All admissions require pre-admission certification. Semi-private room rate covered <u>For Pre-admission Certification and Length-of Stay call 1-800-672-7897</u>
<b>Out of State Network</b> <i>See pages 31, 33</i>	Out of State participating providers, call PHCS at 1-866-680-7427 or visit their website at <a href="http://www.phcs.com">www.phcs.com</a>
<b>Organ Transplants</b> <i>see pages 43, 56</i>	Require prior approval - with limitations
<b>Durable Medical Equipment, Prosthetic &amp; Orthopedic Appliances</b> <i>see pages 48-50</i>	Most rental and purchases over \$1000 require prior approval
<b>Ambulance Services</b> <i>see pages 42, 55, 56</i>	Any land transport over 50 miles and all air ambulance transport require prior approval
<b>Cardiac Rehabilitation</b> <i>see page 55</i>	Covered with limitations
<b>Dental Services</b> <i>see pages 52-54</i>	\$15 copayment per visit for accident related services. Routine dental care is not covered.
<b>Vision Care</b> <i>see pages 47</i>	\$15 copayment per medical eye exam. Routine eye exams, lenses, frames and contact lenses are not covered.

## BENEFITS AT A GLANCE

BENEFIT	COVERAGE
<p><b>Mental Health/Chemical Dependency</b></p> <ul style="list-style-type: none"> <li>• <b>outpatient treatment</b></li> <li>• <b>inpatient care</b></li> <li>• <b>23 hour crisis evaluation and stabilization</b></li> <li>• <b>partial hospitalization</b></li> <li>• <b>intensive outpatient treatment</b></li> <li>• <b>residential treatment center</b></li> </ul> <p><i>see pages 58-64</i></p>	<p>No benefits are provided, except as noted below, for outpatient treatment unless services are certified and approved in advance (precertification) by the Mental Health Case Manager. An eligible provider must render all services.</p> <p><b>\$15 copayment per visit</b>  <b>NOTE: First 26 combined mental health and chemical dependency visits each Plan Year do not require precertification by the Mental Health Case Manager. Visits 27 and beyond each Plan Year DO require approval in advance (precertification) by the Mental Health Case Manager. Certain documentation by your outpatient provider MUST be submitted to the Mental Health Case Manager prior to the 27<sup>th</sup> visit.</b></p> <p><b>\$100 inpatient admission copayment; requires approval in advance (precertification) by the Mental Health Case Manager.</b></p> <p><b>Requires approval in advance (precertification) by the Mental Health Case Manager.</b></p> <p><b>Requires approval in advance (precertification) by the Mental Health Case Manager.</b></p> <p><b>Requires approval in advance (precertification) by the Mental Health Case Manager.</b></p> <p><b>\$100 inpatient admission copayment; requires approval in advance (precertification) by the Mental Health Case Manager.</b>  <b>NOTE: Call the Mental Health Case Manager before selecting a residential treatment center. Certain age and program stipulations apply.</b></p> <p style="text-align: center;"><u>To request precertification from the Mental Health Case Manager, call 1-800-367-6143</u></p>

## COMMONLY USED TERMS

Please read this booklet for more detailed information about your benefits.

---

### **Allowable Charge (Amount)**

The maximum amount the Plan allows for covered services. (see Usual, Customary and Reasonable)

### **Benefit**

Coverage that is available for eligible services and is the same as allowable charge.

### **Claims Processing Contractor (CPC)**

The company with which the State Health Plan contracts to process claims and to provide related administrative services. Currently the CPC is Blue Cross and Blue Shield of North Carolina.

### **Coinsurance**

The amount the member must contribute toward the cost of covered medical expenses. Once the Plan year deductible is met, the Plan pays 80% of allowable charges while the member pays 20%. Coinsurance is limited to \$1,500 each Plan year; up to \$4,500 maximum for each Employee/Child(ren) or Employee/Family contract. This is in addition to any copayments, deductibles and cost of charges not covered by the Plan.

### **Copayment**

Specified portion of a charge for which the member is responsible. Copayments are required for services such as prescription drugs, professional services, emergency room visits, outpatient hospital, ambulatory surgical facility and inpatient hospital benefits.

### **CostWise®**

An agreement between Blue Cross and Blue Shield of North Carolina and participating North Carolina doctors which limits the member responsibility to the Plan year deductible, coinsurance and copayment amounts, and charges for services not covered by the Plan.

### **Covered Services**

Medical and mental health treatment and care that is eligible for payment of benefits under the Plan. (see Non-covered Services)

**Deductible**

See **Plan Year Deductible**

**Dependent**

A member of an employee's or retiree's family who is eligible for coverage such as a spouse or unmarried dependent child(ren) to age 19 or if enrolled as a full-time student to age 26. (see **Dependent Child and Spouse**)

**Dependent Child**

An unmarried natural child, stepchild, legally adopted or foster child. (see **Student and Dependent**)

**Diagnosis Related Groups (DRG)**

Method by which the Plan pays inpatient hospital charges. Payment is based on seriousness of the admission, including the patient's medical condition, gender, any surgical procedures performed, and length-of-stay in the hospital rather than the actual amount charged by the hospital.

**Durable Medical Equipment (DME)**

Standard equipment which normally is used in an institutional setting, can withstand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of an illness or injury, and is appropriate for use in the home.

**Deluxe or Luxury DME**

DME add-ons or upgrades that do not significantly enhance DME functionality.

**Employee**

Any permanent full-time or permanent part-time regular employee (designated as half-time or more) of an employing unit. (see **Member**)

**Employing Unit**

A North Carolina school system, community college, university, charter school, state department, agency, institution, Administrative Office of the Courts, or association or examining board whose employees are eligible for membership in a retirement system supported by the State of North Carolina. An employing unit shall also mean bona fide fire departments, rescue or emergency medical service squads and National Guard units.

**Episode of Care**

Episode of care is a term used to describe and measure the various health care services rendered in connection with an identified injury or period of illness.

### **Experimental/Investigational**

Services, procedures or supplies that are not recognized by the Plan as standard medical care for the condition, disease, illness or injury being treated. (A service, procedure or supply includes, but is not limited to, diagnostic service, treatment, facility, equipment, drug or device.) These services do not meet the criteria for “medically necessary services” because these services are not standard medical practice. Services are considered investigational when there is insufficient or inconclusive scientific evidence provided in appropriate peer review medical literature that would enable the CPC to make a conclusive evaluation. Benefits are not provided for services when the beneficial effect and health outcomes have not been proven.

### **Health Benefits Representative (HBR)**

An employee designated by the employing unit who is responsible for administering the Plan for its employees. 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**

To receive services in the home, a member is considered homebound when:

- The patient requires physical assistance and significant supervision by another person in order to leave his/her residence and travel to a physician’s office or outpatient treatment facility.
- A physician has ordered treatments of such frequency or duration that it is unreasonable to expect the patient to receive this treatment in an outpatient facility or a physician’s office.
- Lack of transportation is not a medical criterion to be considered homebound.
- Children from birth through 5 years old and children with special needs may be considered homebound when home care services are medically necessary.

### **Letter of Medical Necessity**

A statement or medical records submitted and signed by a physician to support the need for the requested service, equipment or supply.

**Maternity**

Any service, care or treatment related to an eligible enrolled employee's or enrolled spouse's pregnancy, such as miscarriage, prenatal care, delivery, post-partum care, inpatient routine nursery services and inpatient well-baby care. Mother must be enrolled in the Plan as either the employee or spouse to be eligible for maternity benefits.

**Medical Necessity**

A service or supply provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease. The service or supply must not be experimental, investigational, or cosmetic in purpose. It must be necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms. It must be within generally accepted standards of medical care in the community. It must not be solely for the convenience of the insured, the insured's family, or the provider.

**Member**

Any eligible employee, retiree or dependent enrolled in the Plan. (see Employee)

**Mental Health Case Manager (MHCM)**

The company with which the Claims Processing Contractor contracts to manage the mental health and chemical dependency benefits.

**Non-covered Services**

Services, care, treatment or items that are not eligible for payment of benefits under the Plan.

**Orthotic device**

An orthopedic appliance or apparatus used to support, align, prevent or correct deformities, or to improve the function of movable parts of the body.

**Pharmacy Benefit Manager (PBM)**

The company with which the State of North Carolina contracts to manage the prescription drug benefit. The PBM is currently AdvancePCS.

**Plan**

North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan, which is a self-funded health benefits plan for eligible employees, retirees and their dependents.

**Plan Year**

Based on the State of North Carolina's fiscal year (July 1 to June 30).

**Plan Year Deductible**

The amount of allowable charges that members must pay each Plan year before benefits are payable.

**Pre-admission Certification and Length-of-Stay Approval for Medical Services**

Process that ensures inpatient admissions and the time spent in the hospital for medical services are appropriate to treat the patient's condition. (This requirement is different from Prior Approval.)

**Precertification and Length-of-Stay Approval for Mental Health and Chemical Dependency**

Process of calling the Mental Health Case Manager prior to receiving services and obtaining approval for all continuing care, except the first 26 combined outpatient psychotherapy and chemical dependency visits allowed each Plan year. (This requirement is different from **Prior Approval**, and is not a guarantee of payment.)

**Prescription Drug**

A drug approved by the Food and Drug Administration (FDA) that only can be purchased with a doctor's written prescription.

**Prior Approval**

Review of request for coverage of services prior to services being rendered that ensures certain covered services are deemed medically necessary and appropriate in order to treat the patient's condition.

**Prosthesis**

The replacement of an absent body part by an artificial substitute, such as an eye or a leg.

**Protected Health Information (PHI)**

Individually identifiable health information in whatever form it exists. PHI includes:

- enrollment information (name, address, member ID, telephone number, etc.)
- premium payment
- claims information
- explanation of Benefits
- any information relating to past, present, or future physical or mental health of an individual.

The CPC and the Mental Health Case Manager are permitted to use and disclose PHI as needed in the normal course of business. Patients are given specific rights to see their own health information, ask for correction and amendment, see who has accessed it, and other rights.

**Provider**

A licensed professional, hospital, clinic or pharmacy that is eligible to provide services under the terms of the Plan. Must be certified / licensed in the state in which covered services are provided. The term Provider may also be used for a supplier of durable medical equipment.

**Provider, Out of State Network**

The company with which the State Health Plan contracts to provide a nationwide network of physicians, hospitals, labs, healthcare professionals, and other ancillary services. Private Healthcare Systems (PHCS) is the current out of state network provider. Mental Health and Chemical Dependency Benefits/Visits do not apply to the PHCS Network.

**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.

**Retrospective Review**

If the member has received all of the requested health care services, the medical necessity review is considered 'retrospective.'

**Student**

An unmarried dependent child, between the ages of 19 and 26, who is enrolled as a full-time student in an accredited school.

**Spouse**

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

**Usual, Customary and Reasonable (UCR)**

The maximum amount allowed for covered services as determined by the Claims Processing Contractor. (see Allowable Charge)

**Wellness Benefits**

Routine physical or screening services which assess a patient's health in the absence of symptoms or illness.

## II. ELIGIBILITY AND ENROLLMENT

Please review the information in this section for a general understanding of eligibility and enrollment guidelines. The term “employee” refers to teachers, state employees, members of the General Assembly and retirees.

### ELIGIBILITY

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

- All permanent full-time teachers and state employees who are either (1) paid from general or special state funds or (2) paid from non-state funds and the employing unit has agreed to provide coverage.
- Employees of state agencies, departments, institutions, boards and commissions, not otherwise covered by the 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.
- Employees of the General Assembly, not otherwise covered by this section, as determined by the Legislative Services Commission, except pages and interns.
- Retired North Carolina public school teachers and state employees.
- Former employees who are receiving disability retirement benefits are eligible for the benefit provisions of the 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.
- Members of the General Assembly.
- 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 of coverage is limited to 12 months following separation from service because of job elimination.
- Employees on approved leave of absence with pay, or receiving worker’s compensation.

- Employees on approved leave under the Family and Medical Leave Act of 1993 (FMLA).
- Surviving spouses of deceased active or retired (1) teachers, (2) state employees and (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 Plan member occurred prior to October 1, 1986.

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

- Spouses and eligible dependent children of enrolled employees, retirees, members of the General Assembly and former members of the General Assembly.
- Former members of the General Assembly who are enrolled in the Plan at termination of membership in the General Assembly.
- Employees of the General Assembly, not otherwise covered by this section, as determined by the Legislative Services Commission, except pages and interns.
- All permanent part-time employees (designated as half-time or more) who are paid from general or state funds.
- Employees on official leave of absence without pay.
- Former employees whose jobs were eliminated because of reduction in funds must pay 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 (1) retirees, (2) teachers and state employees, (3) members of the General Assembly and (4) former members of the General Assembly, provided the surviving spouse was covered by the Plan at the time of the employee's death.

- A surviving dependent child who was covered by the Plan at the time of the employee's death is entitled to coverage as a surviving dependent. In the absence of an eligible surviving parent, each child is eligible for member only (individual) coverage until attaining one of the usual dependent children ineligibility events. If a surviving child was certified and covered as an incapacitated dependent, the dependent is eligible for life, or until the dependent marries or ceases to be incapacitated. When coverage ceases for a surviving dependent child, he or she may be eligible for continuation coverage. (see page 18)

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 and their dependents.

## **DEPENDENTS**

Family members must be enrolled when first eligible in order to receive benefits without a waiting period for preexisting conditions or to avoid unnecessary delays with claims processing. Newborns are covered at birth without a waiting period for preexisting conditions if the employee currently has Employee/Child(ren) or Employee/Family coverage. Newborns should be enrolled as soon as possible. Children born to employees having Employee Only coverage shall be covered at the time of birth without a waiting period for preexisting conditions as long as the newborn is enrolled within 30 days of the date of birth, and the employee changes from Employee Only to Employee/Child(ren) or Employee/Family coverage. The employee must also pay any additional premiums required for the selected coverage type retroactive to the first of the month in which the child is born.

### **Eligible dependents are:**

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

Dependent child coverage may be extended beyond the 19<sup>th</sup> birthday under the following conditions:

- The dependent is covered to age 26 if unmarried and a full-time student at an accredited school.
- The dependent is physically or mentally incapacitated to the extent that he or she is incapable of earning a living and such handicap developed or began to develop before the dependent's 19<sup>th</sup> birthday or 26<sup>th</sup> birthday if the dependent was covered by the Plan as a full-time student. When requesting extension of coverage, a **Coverage Request for a Mentally or Physically Incapacitated Child** Form (form P17s) should be submitted to the Health Benefits Representative (HBR). For further information, employees should contact their HBRs.

## ENROLLMENT

New employees must enroll themselves and their dependents within 30 days of employment to prevent a waiting period for preexisting conditions. The **Enrollment Application** Form (form C9s) must be completed and returned to the HBR within the first 30 days of employment. The employee should retain one copy of the **Enrollment Application** Form (form C9s) for his or her records.

## 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. In addition, no person shall be eligible for coverage as a dependent of more than one employee or retired employee at the same time.

**Plan members who are retired should refer to the special retiree section, which begins on page 20.**

## IDENTIFICATION CARDS

Two identification (ID) cards are issued. You should present your ID card to your provider when you receive services to ensure claims are filed with the correct identification number. Your ID card serves as your medical **and** prescription drug card. If you lose your ID card or need additional ID cards for family members, you may call **1-800-422-4658** to request a replacement card.

<b>STATE OF NORTH CAROLINA</b> TEACHERS' AND STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN	
NAME	
<input type="text" value="PRINT POSITION"/>	
I.D. NUMBER	CONTRACT TYPE
<input type="text" value="PRINT POSITION"/>	<input type="text" value="PRINT POSITION"/>
DATE PRINTED	
<input type="text" value="PRINT POSITION"/>	
For further information refer to Your Health Benefits Booklet or call Customer Services at 1-800-422-4658 or visit the website at <a href="http://statehealthplan.state.nc.us">statehealthplan.state.nc.us</a> .	

<ul style="list-style-type: none"><li>• Mental Health and Chemical Dependency Services must be precertified by calling 1-800-367-6143, 24 hours a day, 7 days a week.</li><li>• Hospital Admissions other than for mental health or chemical dependency must be precertified by calling 1-800-672-7897, M - F, 8 a.m. to 5 p.m.</li><li>• Pharmacy Customer Service: 1-888-693-7750</li><li>• Pharmacy Help Desk: 1-800-364-6331</li></ul>	
<b>Send claims for medical services rendered in NC to:</b>  Claims Processing Contractor PO Box 30025 Durham, NC 27702-3025	<b>Send claims for medical services rendered outside NC to:</b>   PRIVATE HEALTHCARE SYSTEMS MD Plan Claims Processing Contractor PO Box 3823 Durham, NC 27702-3823 Call 1-800-355-7810 to locate a participating PHCS provider outside NC.

## TYPES OF CONTRACTS

The Plan offers the following contracts:

1. **Employee Only** - covers only the employee or retiree.
2. **Employee and Child(ren)** - covers the employee or retiree and all eligible dependent children.
3. **Employee and Family** - covers the employee or retiree, legal spouse and all eligible dependent children.

**The mother must be enrolled as either the employee or spouse in order to receive maternity and newborn inpatient well-baby benefits. (see page 36)**

## EFFECTIVE DATES OF COVERAGE

Coverage does not begin on the date of employment; rather, the effective date is determined based on one of the following:

- **New employee**

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. Dependents must be enrolled with the same effective date as the employee to avoid a waiting period for preexisting conditions.

- **Newly-eligible dependent, except newborn**

The effective date of coverage is the first day of the month following an eligibility event, such as marriage, or the first day of the second month.

- **Newborn**

The mother must be an enrolled employee or enrolled spouse to receive newborn benefits. The effective date of coverage is the date of birth; however, a member must have Employee/Child(ren) or Employee/Family coverage effective the first of the month in which the child is born. If you wish to add a newborn and you are currently enrolled on Employee Only coverage, you must submit a **Change Form** (form C48s) to the HBR within 30 days of the child's birth.

- **Adoption**

The effective date of coverage is the date of adoption or placement in the adoptive parent's home; however, a member must have Employee/Child(ren) or Employee/Family coverage effective the first of the month in which the child is adopted or placed in the home. Adopted children may also be covered the first of the month following adoption or placement in the adoptive parent's home. If you wish to add an adopted child and you are currently enrolled on Employee Only coverage, you must submit a **Change Form** (form C48s) to the HBR within 30 days of the date of adoption or placement in the adoptive parent's home.

## WAITING PERIOD FOR PREEXISTING CONDITIONS

Employees or dependents not enrolling when first eligible may have a 12-month waiting period for preexisting conditions. A preexisting condition is defined as a condition, disease, illness or injury diagnosed and treated within six months prior to the effective date of coverage. Health care services determined to be related to a preexisting condition are not covered during the waiting period.

You must complete and return the **Enrollment Application** (form C9s) or **Change Form** (form C48s) to the HBR within 30 days of a family status change in order to avoid a 12-month waiting period for preexisting conditions.

(see page 17)

## CREDIT FOR PRIOR HEALTH COVERAGE

Credit toward the 12-month waiting period for preexisting conditions may be given for the time enrolled in previous health coverage if no more than 63 days have elapsed between the termination date of the prior health coverage and the enrollment date in the Plan.

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

If health coverage was withheld under a previous employer because of a probationary period, the Plan will not count this time period toward the 63-day time limit. The Plan, however, will apply the probationary time period toward the 12-month waiting period for preexisting conditions.

Credit will be given for prior coverage even if the other coverage is still in effect.

## SPECIAL ENROLLMENT

The Plan provides an enrollment period during which eligible individuals who initially declined coverage because they had other coverage may enroll at a later date without a waiting period for preexisting conditions.

An employee, retiree or eligible dependent is eligible to enroll in the Plan without a 12-month waiting period for preexisting conditions if he or she:

- loses other health insurance coverage
- submits an **Enrollment Application** (form C9s) or **Change Form** (form C48s) to the HBR within 30 days of losing coverage and
- submits proof of prior coverage

An employee or retiree who gains eligible dependents as the result of a legal marriage, birth, adoption or placement for adoption is eligible to enroll other dependents in the Plan without a 12-month waiting period for preexisting conditions by submitting a **Change Form** (form C48s) to the HBR within 30 days of acquiring the dependents.

If an employee or retiree has dependents prior to acquiring the new dependents, the existing dependents are also eligible to enroll without a waiting period for preexisting conditions when the new dependents enroll.

## **FLEXIBLE BENEFIT PLAN (INTERNAL REVENUE CODE SECTION 125)**

The Flexible Benefit Plan allows active employees to pay premiums on a pre-tax basis. The Flexible Benefit Plan year begins October 1, and is a 12-month election. This only applies to active state employees who have elected to pay premiums on a pre-tax basis. Retirees and COBRA members are not eligible to participate in the Flexible Benefit Plan in accordance with Internal Revenue Code Section 125.

If an employee is participating in the Flexible Benefit Plan, coverage may be changed only if the employee has one of the following family status changes occur:

- A change in legal marital status, which includes marriage, death of spouse, divorce, legal separation or annulment.
- Dependent change due to birth, adoption, placement for adoption, or death of the dependent.
- The employee, spouse or dependent(s) terminate or commence employment.
- The employee, spouse or dependent(s) reduce or increase their hours of employment.
- Dependent(s) cease or commence to satisfy the requirements for coverage due to attainment of age or student status.
- The employee, spouse or dependent(s) change place of residence or work.
- The employee, spouse, or dependent(s) are entitled to coverage under Part A or Part B of Medicare or entitled to coverage under Medicaid.
- The employee, spouse or dependent(s) commence or return from an unpaid leave of absence such as Family and Medical Leave or military leave.
- The employee receives a court order to provide coverage for his or her child.
- The employee stops the withholding of premiums from his/her pay.
- There is a substantial change in premiums and/or benefits in the plan covering dependents.

**Changes in coverage type can be processed only when a status change occurs.**

**Requests to change coverage because of a qualifying family status change must be made by completing a Change Form (form C48s) and submitting it to your HBR. Failure to do so within 30 days may result in a waiting period or penalty.**

## WHEN COVERAGE ENDS

You must notify your HBR when there is a change in eligibility. Coverage for you, or your dependents ends the last day of the month in which an ineligibility event occurs. Some examples of ineligibility events are divorce, marriage, no longer a full-time student, termination of employment, etc.

You or your dependents may be eligible for continuation coverage under COBRA or to convert to a non-employer sponsored plan (see page 19) the first day of the month following an ineligibility event.

## CONTINUATION COVERAGE (COBRA)

Federal law (COBRA) allows the option of continuing group health coverage under certain **qualifying events** as noted below. Under COBRA, you or your eligible dependents continue to have the same health coverage as before the qualifying event. The rates for COBRA coverage are 2% higher than normal group rates. You must pay the entire cost of coverage.

Qualifying Event	Length of Continuation Period
<b>Termination of employment</b>	18 months
<b>Reduction of hours worked</b>	18 months
<b>Employee enters military service</b>	18 months
<b>Disability under Social Security</b>	29 Months
<b>Divorce</b>	36 months
<b>Legal separation (if employee removes spouse)</b>	36 months
<b>Dependent child marries</b>	36 months
<b>Dependent child reaches age 19 (unless a full-time student enrolled in an accredited school)</b>	36 months
<b>Dependent child ceases to be a full-time student or reaches maximum student age of 26</b>	36 months
<b>Dependent child ceases to be physically or mentally incapacitated</b>	36 months
<b>Dependent of active employee loses coverage when employee chooses Medicare as primary</b>	36 months
<b>DEPENDENT ENTERS MILITARY SERVICE</b>	36 months
<b>Death of COBRA member</b>	36 months

You may also choose to bypass COBRA and convert directly to a non-employer sponsored plan. (see page 19)

## COBRA ENROLLMENT STEPS

1. Within 30 days of experiencing one of the qualifying events listed above, you must submit a **Change Form** (form **C48s**) to your HBR or the State Retirement System.
2. Your HBR or the State Retirement System will notify the CPC.
3. Within 14 days of notification from the HBR or the State Retirement System, the CPC will send the ineligible individual(s) an **Enrollment Application Form** (form **C9s**) and letter explaining continuation coverage.
4. You or your dependent(s) must complete and return the COBRA election form within 60 days from the date of the notification letter. At this time, appropriate payment should be made. COBRA is retroactive to the date group coverage under the Plan ended.
5. The Plan will bill you or your dependent(s) directly each month thereafter for the cost of COBRA.

## COBRA TERMINATION

**COBRA ends when any of the following occur:**

- monthly payments are not made.
- other group health coverage is obtained without waiting periods for preexisting conditions or limitations.
- Medicare eligibility is reached (employees or dependents not eligible for Medicare may remain covered for the duration of COBRA coverage).
- COBRA period ends.
- the State of North Carolina no longer offers its employees group health benefits.
- member is no longer disabled.

## CONVERSION TO A NON-EMPLOYER SPONSORED PLAN

You and your dependents are eligible to convert to a non-employer sponsored plan at the end of COBRA regardless of insurability. You may also choose to bypass COBRA and convert directly to a non-employer sponsored plan.

For those who selected COBRA, the CPC sends COBRA expiration notices approximately 45 days prior to the coverage expiration date.

**You and your dependents must apply for conversion coverage within 30 days after termination of group eligibility.**

To obtain additional information, you may call **1-800-222-4816**. Benefits offered under conversion coverage are not the same as those under the Plan.

## MEDICARE

The Plan coordinates benefits with Medicare.

Medicare consists of two parts:

**PART A** - pays hospital bills, and is normally provided at no charge to those eligible for Medicare, and

**PART B** - pays doctor, and other professional bills, and requires a monthly payment from the person eligible for Medicare.

If you or your covered dependent are 65 years old, and are not eligible for either part of Medicare, the Plan requires written documentation from the Social Security Administration explaining the reason for ineligibility. **Benefits cannot be paid unless this documentation is received.**

### WHEN YOU REACH AGE 65

The Plan mails a Medicare eligibility letter approximately 60 days prior to your 65<sup>th</sup> birthday, which asks that you confirm your eligibility for Medicare benefits.

If you are **actively employed**, your HBR will receive and forward to you the Medicare eligibility election form.

**If you are actively employed and eligible for Medicare, the Plan is primary and Medicare is secondary.**

If you are a **retired** employee, the Medicare eligibility election form is sent to your home address.

**Once a retiree is eligible for Medicare, the Plan becomes the secondary coverage.**

### WHEN MEDICARE IS YOUR PRIMARY COVERAGE

All covered charges not paid by Medicare are subject to the terms and conditions of the Plan, including the Plan year deductible, coinsurance and copayment requirements.

If you or your spouse have Medicare because of being age 65 or over and are also enrolled in COBRA, Medicare is the primary payer.

If you or a family member has Medicare because of a disability and are also enrolled in COBRA, Medicare is the primary payer.

If you or a family member has end stage renal disease (ESRD) and is eligible for Medicare on that basis, Medicare is the primary payor.

**NOTICE**  
**IMPORTANCE OF**  
**ENROLLING IN**  
**MEDICARE!**

**If you are not an active employee, OR if you have end stage renal disease (ESRD), and are eligible for Medicare Part B, it is recommended that you enroll.**

**If you choose not to enroll in Medicare Part B, the Plan estimates the amount that Medicare would have paid for covered services, and considers for Plan payment only the remaining balance just as if Medicare had paid.**

## MEMBERSHIP REMINDERS

This is only a summary of helpful information to assist you with membership requirements.

Please contact your Health Benefits Representative if you have any questions, or call 1-800-422-4658 if you need further assistance.

**NOTE: IF YOU DO NOT NOTIFY THE PLAN OF CHANGES WITHIN THE REQUIRED TIME PERIOD, YOUR PREMIUMS WILL NOT BE REFUNDED.**

EVENT	TIME LIMIT/YOU MUST
Change name or address	Within 30 days of event, contact your HBR. Complete Change Form, form C48s.
Add newborn, adopted, or foster child	Within 30 days of event, contact your HBR. Complete Change Form, form C48s. Mother must be enrolled to receive maternity benefits.
Dependent child reaches age 19 and <u>is not</u> a full-time student in an accredited school	Within 60 days of 19 <sup>th</sup> birthday complete and return the letter the CPC mails to your home.
Dependent child reaches age 19 and <u>is</u> a full-time student in an accredited school	Within 60 days of 19 <sup>th</sup> birthday complete and return the letter the CPC mails to your home.
Dependent student ceases to be a full-time student	Within 30 days of event, contact your HBR. Complete Change Form, form C48s.
Dependent child reaches age 26	Within 60 days of 26 <sup>th</sup> birthday complete and return the letter the CPC mails to your home.
Incapacitated dependent child over the age of 19	Within 30 days of the 19 <sup>th</sup> birthday, contact your HBR and have your dependent child's doctor complete a Coverage Request for Mentally or Physically Incapacitated Child, form P17s.
Employment terminates	Within 30 days of event, contact your HBR. A COBRA offer will be mailed to your home within 14 days after the CPC is notified of coverage loss.
Become a former member of the General Assembly if covered under the Plan at termination of membership in the General Assembly	Within 30 days of the end of the term in office, complete and return the letter the CPC mails to your home.

<b>EVENT</b>	<b>TIME LIMIT/YOU MUST</b>
<b>Retirement</b>	<b>60 days before retirement, contact your HBR. Complete and sign an Enrollment/Change Application form RET.HM. (see page 20)</b>
<b>Active employee becomes eligible for Medicare</b>	<b>Notify your HBR or the CPC. If the reason for Medicare eligibility is end-stage renal disease (ESRD), provide onset date and date dialysis began. (see page 20)</b>
<b>Retired employee reaches 65 and becomes eligible for Medicare</b>	<b>By your 65<sup>th</sup> birthday, complete and return the Medicare Eligibility and Election form the CPC mails to your home.</b>
<b>Retired employee under 65 becomes eligible for Medicare</b>	<b>As soon as you receive information from Medicare, notify the CPC or State Retirement System with a copy of your Medicare card.</b>
<b>Former employees whose jobs are eliminated because of a reduction in work force</b>	<b>Within 90 days after termination of the initial 12-month continuation period, former employee must elect to pay for coverage.</b>

### III. MEDICAL AND SURGICAL BENEFITS

#### **LIFETIME MAXIMUM BENEFIT**

The Plan provides a lifetime maximum of \$5 million in benefits for covered services to each enrolled eligible state employee, retiree and dependent.

#### **DEDUCTIBLE, COINSURANCE AND COPAYMENTS**

The Plan requires that you share in the cost of your health care by satisfying a Plan year deductible, coinsurance and copayments before benefits are payable.

#### **PLAN YEAR DEDUCTIBLE**

With the Plan year beginning every July 1, you must meet a \$350 deductible each Plan year (July 1 through June 30) before the Plan pays benefits for covered services. The deductible may be increased each Plan year by the Medical Consumer Price Index.

Only allowable charges that qualify for benefits are used to meet your Plan year deductible.

The combined family deductible is \$1,050 (with a maximum of \$350 per family member) for each Employee and Child(ren) or Employee and Family contract each Plan year, for families of 4 or more covered by The Plan.

If one or more family members are injured in the same accident, only one deductible of \$350 is necessary for claims directly related to the accident.

#### **Examples of how Plan year deductibles may be accumulated are:**

<u>Ms. Brown</u> (employee only contract)		<u>Williams Family</u> (employee/family contract)		<u>Smith Family</u> (employee/children contract)		<u>Jones Family</u> (employee/family contract)	
Ms. Brown	\$350	Employee	\$350	Employee	\$350	Employee	\$200
		Spouse	\$350	Child	\$275	Spouse	\$350
		Child	<u>\$350</u>	Child	\$ 50	Child	\$350
			\$1050	Child	\$200	Child	\$100
				Child	<u>\$175</u>	Child	<u>\$ 50</u>
					\$1050		\$1050

## PLAN YEAR COINSURANCE

After you have met the Plan year deductible, the Plan pays 80% of allowable charges, after applicable copayment. You pay 20% coinsurance up to a maximum of \$1,500 each Plan year; up to \$4,500 maximum for each Employee/Child(ren) or Employee/Family contract per Plan year. The Plan then pays 100% of allowable charges for covered services.

## PRESCRIPTION DRUG COPAYMENT AND BENEFITS

A Pharmacy Benefit Manager (PBM), AdvancePCS, manages the prescription drug benefit.

Covered prescription drugs are all drugs that are FDA approved, except the following drugs, which are covered as described below. The list is subject to revision. When prior authorization is required, your prescribing physician must obtain it. Also some prescription drugs may be subject to quantity limits based on the criteria developed by the Plan. Prior authorization approval is required before additional quantities of the drug will be covered. **This list is subject to change.**

<u>Coverage</u>	<u>Drug Class</u>
Requires Prior Authorization	Antifungal Drugs Botox (botulinum toxin) Cox II inhibitors- Bextra, Celebrex, Vioxx Other - Enbrel, Humira, Kineret, Remicade, Xolair
Requires Prior Authorization*	Growth Hormones Weight Loss
Requires Prior Authorization for exceeding quantity limits	Migraine Medication- Amerge, Axert, Imitrex, Maxalt, Zomig Proton Pump Inhibitors - Prilosec, Protonix, Prevacid, Aciphex, Nexium, omeprazole
Treated as a prescription	Insulin
Not Covered	Anti-Wrinkle Compounded Drugs that do not contain at least one drug that requires a prescription Erectile Dysfunction Hair Growth Medical Supplies (under prescription drug benefit page 27) Over the Counter Drugs

**\*Coverage for growth hormones and weight loss drugs are not covered unless medically necessary “to the health of the member”, as determined by the CPC**

**For prior authorization of prescription medication please contact AdvancePCS at 1-800-294-5979.**

Your identification card serves as both a medical and prescription drug card.

### **Using a Contracting Pharmacy**

When you use a pharmacy that contracts with the PBM and present your ID card to the pharmacist, you will not be required to pay more than the appropriate copayment for each 34-day supply. Most chain and independent pharmacies contract with the PBM. You may obtain information about which pharmacies are contracting by:

- searching on the Plan’s website **statehealthplan.state.nc.us** (**do not use www.**) by pharmacy name, county, city and/or zip code, or
- calling the PBM at **1-888-693-7750**.

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

The convenience of mail order pharmacy is available for your maintenance medications by completing a Mail Service Order Form and returning it with your original prescription and appropriate copayment to the PBM. You may get a Mail Service Order Form on the website or by calling the PBM.

Instructions on how to obtain refills will be sent to you. Refills may be requested by mail, using the Internet at **www.AdvanceRx.com** or by telephoning **1-800-241-3212**. You may use a credit card for copayments for telephone or Internet refills.

### **Preferred Drug List**

The Preferred Drug List is a list of prescription drugs selected by a committee of North Carolina physicians and pharmacists organized by the Plan. The committee chooses the preferred drugs using strict criteria such as safety and efficacy. When there is more than one brand name drug available for your

medical condition, it is suggested that you ask your physician to prescribe a drug on the preferred list.

Generic drugs are often an effective alternative to brand drugs. All generic drugs are preferred drugs. Ask your physician to authorize generic substitution whenever a generic equivalent is available and your copayment will be only \$10 per 34-day supply.

The Preferred Drug List can be obtained from the Plan’s website or by calling the PBM.

When you use a drug on the preferred list, your copayment will be \$10 for generic, \$25 for a brand without generic, or \$35 for a brand with generic for each 34-day supply. If you choose to use a drug not on the preferred list, your copayment will be \$40 for each 34-day supply.

The Preferred Drug List will be updated periodically. All updates will be communicated on the Plan’s website and to your HBR.

The following copayments apply:

<b>DAYS SUPPLY</b>	<b>0-34</b>	<b>35-68</b>	<b>69-102</b>
<b>GENERIC</b>	<b>\$10</b>	<b>\$20</b>	<b>\$30</b>
<b>Preferred Brand Without Generic Available</b>	<b>\$25</b>	<b>\$50</b>	<b>\$75</b>
<b>Preferred Brand With Generic Available</b>	<b>\$35</b>	<b>\$70</b>	<b>\$105</b>
<b>NON-PREFERRED BRAND</b>	<b>\$40</b>	<b>\$80</b>	<b>\$120</b>

**Prescription drug copayments are limited to \$2,500 per person per Plan year. After the \$2,500 maximum is reached The Plan pays 100% of allowed prescription drug charges.**

**Prescription drugs are not subject to the Plan year deductible or coinsurance amounts.**

**A prescription cannot be refilled until three fourths (3/4) of the medication has been used as prescribed by your physician.**

### **MEDICAL SUPPLIES**

Medical supplies are not covered under the prescription drug benefit. Covered medical supplies such as diabetic syringes and needles, test strips, colostomy bags, oxygen and other similar supplies are subject to the general Plan provisions. Claims for medical supplies should be filed using a medical claim form and sent to the CPC. Medical supplies that are an integral part of the primary medical or surgical service are not covered.

**Insulin benefits are covered under the prescription drug benefit.**

## PROFESSIONAL SERVICES COPAYMENT

A \$15 professional services copayment is applied for professional services rendered in the home, office or outpatient clinic and rest home. This includes doctor services, inhalation, physical, speech and occupational therapies; chiropractic visits, accidental dental, medical eye exams, mental health and chemical dependency visits. The copayment will apply only once per person per provider per day. The copayment does not apply to injected medications including IV therapy, cardiac rehabilitation, laboratory, pathology, and radiology services.

**The professional services copayment is applied before, is in addition to and does not count toward the Plan year deductible and coinsurance maximum.**

## EMERGENCY ROOM COPAYMENT

Emergency room visits are subject to a \$100 copayment for each visit unless:

- the patient is admitted to the hospital, or
- the patient is in an observation unit and the length of stay does not exceed 23 hours.

**The emergency room copayment is applied before, is in addition to and does not count toward the Plan year deductible and coinsurance maximum.**

## OUTPATIENT HOSPITAL AND AMBULATORY SURGICAL FACILITY COPAYMENT

A \$50 copayment will apply to outpatient hospital and ambulatory surgical facility services exceeding \$500 per episode of care. Readmission within 30 days after discharge for the same reason is considered the same episode of care.

**The outpatient hospital and ambulatory surgical facility center copayment is applied before, is in addition to, and does not count toward, the Plan year deductible and coinsurance maximum.**

## INPATIENT HOSPITAL COPAYMENT

If you are admitted to the hospital, you must pay a \$100 inpatient copayment per admission.

This copayment is waived on subsequent admissions when you are readmitted to the hospital within 60 days with the same diagnosis or medical problem.

**The inpatient hospital copayment is applied before, is in addition to and does not count toward the Plan year deductible and coinsurance maximum.**

## OUTPATIENT HOSPITAL AND AMBULATORY SURGICAL FACILITY

The Plan provides benefits for **covered** diagnostic services, therapies, laboratory, radiology, and previously approved elective surgical procedures provided in an **outpatient hospital** setting or in an **ambulatory surgical facility (ASF)**.

The Plan has a preferred provider program, which includes hospitals that provide favorable prices for their outpatient services. When a preferred provider is available but not used, you must pay an additional copayment of 20% up to a maximum of \$5,000. The coinsurance for use of a non-preferred hospital is limited to \$15,000 per Plan year per Employee and Child(ren) or Employee and Family contract.

Contracting providers agree to file all claims for covered services and limit the member's out-of-pocket expenses to the Plan year deductible, coinsurance amount, \$50 outpatient and ambulatory surgical facility copayment, and charges for services not covered by the Plan. The contracting providers also agree not to bill the patient for charges that exceed the Plan's contracted amount.

Contact Customer Services at **1-800-422-4658** to determine the contracting status of an outpatient hospital facility or ambulatory surgical facility.

The Plan will consider the medical necessity of an alternate setting and professional anesthesia for treatment that is normally provided in an office setting, if specific medical criteria are met.

## INPATIENT HOSPITAL BENEFITS

### HOSPITAL PRE-ADMISSION DIAGNOSTIC TESTING

The Plan pays for covered pre-admission diagnostic tests prior to your hospital admission. Hospital pre-admission diagnostic testing services are not subject to the Plan year deductible or coinsurance when performed:

- on an outpatient basis, and
- within 14 days of a scheduled hospital admission.

If the testing is performed after the admission to the hospital, the charges will be part of the hospital admission charges and subject to the Plan year deductible and coinsurance amounts.

## INPATIENT HOSPITAL SERVICES

Inpatient hospital services include the following:

- room and board (semi-private accommodations, unless the hospital has only private rooms)
- medically necessary supplies
- medications
- laboratory tests
- radiological services
- operating/recovery rooms
- hospital staff (doctor and nursing care) (see page 32)

Inpatient hospital services are reimbursed based on Diagnosis Related Groups (DRG).

### DIAGNOSIS RELATED GROUPS (DRG)

Most inpatient hospital benefits are based on **diagnosis related groups (DRG)**. Rather than paying benefits based on the hospital charges (which vary widely), the Plan makes payment based on the diagnoses and procedures related to the hospitalization. As a result, the hospital better manages the resources needed to treat the patient's condition. Contracting hospitals agree to accept the DRG payment and will not hold you responsible for the difference in cost if the hospital charge is higher than the DRG allowance.

**Non-contracting hospitals will hold you responsible for the difference** in cost if the hospital charge is higher than the DRG allowance. You will also be responsible for an additional 20% coinsurance up to a maximum of \$5,000 not to exceed \$15,000 per fiscal year per Employee and Child(ren) or Employee and Family contract if services are received in a non-contracting hospital.

Mental health and chemical dependency admissions are not reimbursed based on the DRG method. These claims are reimbursed based on allowable charges.

All hospitals hold you responsible for the Plan year deductible, coinsurance amounts, \$100 inpatient hospital admission copayment and charges for services not covered by the Plan.

For hospital admissions reimbursed by DRG, the coinsurance is based upon the lesser of the total hospital charge or the DRG allowed amount.

## EMERGENCY TREATMENT

In the event of an out of state emergency, and you are unable to seek care from a participating provider, the CPC will review the services to determine if additional payment can be authorized.

## OUT OF STATE NETWORK

The State Health Plan has contracted with Private Healthcare Systems (PHCS) a nationwide network of physicians, hospitals, labs, healthcare professionals, and other ancillary services. If you choose to receive care from a participating provider in the PHCS network, you will not be held responsible for amounts above the allowance for covered services. To obtain a list of participating providers please contact PHCS toll free at 1-866-680-7427 or [www.phcs.com](http://www.phcs.com).

Plan members will be responsible for any deductibles, co-payments, co-insurance and non-covered charges.

Mental Health and Chemical Dependency Benefits/Visits do not apply to the PHCS Network.

## PRE-ADMISSION CERTIFICATION (PAC) AND LENGTH-OF-STAY (LOS) APPROVAL

All inpatient hospital admissions require PAC and LOS approval. If you are admitted because of a medical emergency after normal business hours, weekends or holidays, you must make sure the length-of-stay certification is obtained within 48 hours of admission or the next business day.

Pre-admission certification and length-of-stay approval for each hospital admission must be obtained by calling 1-800-672-7897. Although your doctor or the hospital staff should call for certification, you are responsible for making sure that PAC and LOS is obtained.

**If you do not obtain pre-admission certification and length-of-stay approval, you will be responsible for 50% of eligible charges up to a maximum of \$500. In addition, you will be responsible for services determined not medically necessary in an inpatient hospital setting.**

Pre-admission certification and length-of-stay approval ensure that a hospital admission is appropriate for your medical condition. **It is not a guarantee of payment.**

**Even if you have Medicare coverage, you must obtain pre-admission certification and length-of-stay approval for your hospital admission.**

Mental health and chemical dependency inpatient admissions must be precertified by contacting the Mental Health Case Manager at  
**1-800-367-6143**

24 hours a day, 365 days a year.

All other care must be precertified with the Mental Health Case Manager Monday through Friday during business hours: 8 AM - 6 PM, Eastern time.  
(see pages 62 - 63)

**Hospitals contract with individual physicians and physician groups to provide certain professional services within their facilities. These services include anesthesiology, emergency department, pathology and radiology. Not all of these physicians or physician groups are CostWise® participants. Therefore, even though the hospital is a preferred provider, the member may be responsible for certain professional charges which are in excess of the Plan's usual, customary and reasonable (UCR) allowance.**

### **USUAL, CUSTOMARY AND REASONABLE**

The Plan determines fair allowances for covered medical care provided by doctors using **usual, customary and reasonable (UCR)** allowances.

**Usual** - is based on a doctor's average fee that he or she charges patients.

**Customary** - is based on the average fees that doctors with similar specialties and years of practice and expertise charge patients.

✓ **The Plan takes the lower of *usual* and *customary* in determining the allowed amount.**

**Reasonable** - is based on a review of medical records when there are extenuating circumstances or when a covered medical procedure requires additional skill or experience.

### **COSTWISE®**

CostWise® is an agreement between Blue Cross Blue Shield of North Carolina (an independent licensee of the Blue Cross and Blue Shield Association) and participating doctors in North Carolina. CostWise® participating doctors agree to accept the Plan's UCR allowance for covered services. Your insurance coverage is provided by the State Health Plan, not Blue Cross Blue Shield.

Doctors participating in CostWise® agree to:

- file all claims for covered services;
- limit the out-of-pocket expenses to the Plan year deductible, coinsurance amount, \$15 professional services copayment and charges for services not covered by the Plan; and
- not bill the patient for charges that exceed the Plan's UCR allowance.

If you visit a provider who is not a CostWise® participant, you will be responsible for paying any amount above the Plan's UCR allowance and you may have to file the claim, (see pages 66 through 69) even if this is the only provider for the type of service rendered.

**Note: All claims must be filed within 18 months from the date of service. CostWise® providers who fail to submit charges within the 18 months are not eligible to receive reimbursement from the Plan or its members.**

To determine which physicians are participating in the CostWise® program contact Customer Services at **1-800-422-4658**. Participating doctors will often display CostWise® signs and decals in their offices. Please note that participation is subject to change without notice.

### **OUT OF STATE NETWORK**

The State Health Plan has contracted with Private Healthcare Systems (PHCS) a nationwide network of physicians, hospitals, labs, healthcare professionals, and other ancillary services. If you choose to receive care from a participating provider in the PHCS network, you will not be held responsible for amounts above the allowance for covered services. To obtain a list of participating providers please contact PHCS toll free at 1-866-680-7427 or [www.phcs.com](http://www.phcs.com).

You will always be responsible for the Plan year deductible, coinsurance amount, any professional services copayment and charges for services not covered by the Plan.

The PHCS Network does not apply to Mental Health and Chemical Dependency Benefits.

## Examples of Determination of Member Responsibility

**Notice:** Your actual expenses for covered services may exceed the stated coinsurance percentage because actual provider charges may not be used to determine Plan and member payment obligations.

The following examples illustrate member responsibility when a CostWise or Non-CostWise provider is used:

DEDUCTIBLE NOT MET	Using CostWise Provider		Using Non-CostWise Provider	
	Office Visit	\$120	Office Visit	\$120
UCR	\$100	UCR	\$100	
Amount over UCR	\$ 20	Amount over UCR *	\$ 20	
Copayment *	\$ 15	Copayment *	\$ 15	
Deductible *	\$ 85	Deductible *	\$ 85	
Plan Payment	Zero	Plan Payment	Zero	
	<b>* Member Responsibility</b>		<b>* Member Responsibility</b>	
	\$85 + \$15 = \$100		\$20 + \$15 + \$85 = \$120	

DEDUCTIBLE MET	Using CostWise Provider		Using Non-CostWise Provider	
	Office Visit	\$120	Office Visit	\$120
UCR	\$100	UCR	\$100	
Amount over UCR	\$ 20	Amount over UCR *	\$ 20	
Copayment *	\$ 15	Copayment *	\$ 15	
20% Coinsurance *	\$ 17	20% Coinsurance *	\$ 17	
Plan Payment	\$ 68	Plan Payment	\$ 68	
	<b>* Member Responsibility</b>		<b>* Member Responsibility</b>	
	\$15 + \$17 = \$32		\$20 + \$15 + \$17 = \$52	

DEDUCTIBLE AND COINSURANCE MET	Using CostWise Provider		Using Non-CostWise Provider	
	Office Visit	\$120	Office Visit	\$120
UCR	\$100	UCR	\$100	
Amount over UCR	\$ 20	Amount over UCR *	\$ 20	
Copayment *	\$ 15	Copayment *	\$ 15	
Plan Payment	\$ 85	Plan Payment	\$ 85	
	<b>* Member Responsibility</b>		<b>* Member Responsibility</b>	
	Copayment \$15		\$20 + \$15 = \$35	

## ELIGIBLE MEDICAL PROVIDERS

The following is a list of licensed medical professionals whose services are eligible for Plan benefits.

Although a medical professional may be eligible, the type of care and treatment provided must also be covered and within the scope of his or her license in order to be considered for benefits.

- Doctor of **medicine** (M.D.)
- Doctor of **osteopathy** (D.O.)
- Doctor of **podiatry** (D.P.M.)
- Doctor of **chiropractic** (D.C.)
- Doctor of **dental surgery** (D.D.S.) (D.M.D.) Limited to covered oral/dental procedures.
- **Physician assistant** (P.A.) must be employed by a doctor, clinic, agency or institution
- Licensed **physical, speech, respiratory and occupational therapists**
- **Nurses** (advance practice registered nurses, registered nurses and licensed practical nurses, includes Nurse Midwives)
- **Home care aides** (under the direct supervision of a registered nurse and employed by a licensed home care agency)

A list of eligible **mental health** and **chemical dependency** providers is located on pages 61 through 62.

## INELIGIBLE MEDICAL PROVIDERS

The following is a list of some ineligible medical providers.

- Individual who is not licensed and/or credentialed by the Board of Medical Examiners of the state in which he or she practices
- Doctor of holistic/naturopathic medicine
- Doctor of Chinese/Oriental medicine
- Acupuncturist
- Massage therapist
- Certified Rolfer/Hakomi Therapist
- Licensed Dietary Nutritionist (LDN)
- Registered Dietician (RD)
- Homeopath
- Certified Registered Nurse Anesthetist (CRNA) unless Medicare has paid as primary

Call Customer Services at **1-800-422-4658** if you have questions about a professional you do not see listed.

## MATERNITY AND NEWBORN INPATIENT BENEFITS

Maternity benefits are provided to **enrolled female employees and enrolled female spouses**. The mother **must be enrolled** in the Plan in order to receive newborn well-baby benefits. (see pages 1, 7, and 15)

**There are no benefits for maternity care or complications from pregnancy for enrolled dependent children.**

Coverage for newborn care **in the hospital** (including well-baby pediatrician, well-baby nursery charges and circumcision) is a maternity benefit. **The mother must be enrolled to receive routine newborn inpatient benefits.**

When a newborn requires special care as a sick baby, the care is no longer considered a maternity benefit. For benefits to be provided, the newborn must be enrolled in the Plan effective the first day of the birth month. (see page 15) When enrollment requirements are met, benefits are provided for treatment of special care.

Pre-admission certification is required if the mother's hospital stay is longer than forty-eight (48) hours for vaginal delivery or longer than ninety-six (96) hours for a Cesarean Section. It is also required when the newborn requires special care. (see page 31)

## WELLNESS AND PREVENTIVE CARE

Wellness and preventive care benefits include routine physical and screening procedures performed for periodic health assessments in the absence of illness or symptoms.

### ROUTINE PHYSICAL AND SCREENING PROCEDURES

The Plan will pay 100% of allowable charges for routine physicals, pap smears, breast, colon, rectal and prostate exams, blood pressure checks, mammograms, electrocardiograms, hearing tests, routine blood and urine tests, occult blood tests, chest x-rays, thyroid studies, tuberculosis tests, and general health checkups that are medically necessary for the maintenance and improvement of an individual's health. The maximum amount payable at 100% of allowable charges is \$150 per Plan year.

The \$150 maximum amount payable each Plan year is not subject to the Plan year deductible and coinsurance amounts. Any charges over \$150 are subject to the deductible and coinsurance requirements. You are, however, responsible for a \$15 professional services copayment.

Each screening procedure, including mammograms, is limited as follows:  
(A year is defined as 365 days)

- unlimited well visits from birth up to 1 year
- 3 well visits between the ages of 1 and 2
- 1 visit per year between the ages of 2 and 7 (365 days must pass between visits.)
- once every 3 years (1,095 days) between 7 and 39 years of age
- once every 2 years (730 days) between 40 and 49 years of age
- once every year (365 days) for 50 years old and older

**Examinations and laboratory tests for screening for the early detection of cervical cancer are allowed each year (365 days) for female members of any age and are part of the \$150 wellness maximum.**

The Plan does not pay benefits for physical examinations, tests and reports performed as part of employment, insurance, legal, school, camp, travel, athletic, or governmental requirements.

## IMMUNIZATIONS

The Plan provides benefits for immunizations for the prevention of certain contagious diseases. These benefits are not subject to the Plan year deductible and coinsurance requirements and are paid at 100% of UCR. You are, however, responsible for a \$15 professional services copayment if charged for an office visit.

If an immunization is dispensed as a prescription drug it will be considered a prescription benefit and subject to the appropriate prescription co-payment. The full series of standard immunizations recommended by the Centers for Disease Control and Prevention (CDC) is covered.

- Diphtheria-Pertussis-Tetanus Toxoid (DPT)
- Polio
- Measles-Mumps-Rubella (MMR)
- Influenza
- Pneumococcal vaccine
- HiB
- Hepatitis B
- Chicken Pox
- Meningococcal vaccine

## SURGICAL BENEFITS

The Plan offers benefits for medically necessary standard surgical procedures determined not to be investigational or experimental. These services are subject to the Plan year deductible, coinsurance and current UCR allowances. Benefits are excluded for elective, cosmetic surgical procedures and complications of any non-covered procedures.

### MULTIPLE SURGICAL PROCEDURES

The Plan pays a surgeon's services differently when two or more surgical procedures are performed at the same time.

Multiple surgical procedures performed through **separate** incisions or approaches are paid at 100% of UCR for the surgical procedure that has the higher UCR allowance and 50% of UCR for the remaining procedure(s).

Multiple surgical procedures performed through the **same** incision or approach, are paid based on the one procedure that has the higher UCR.

## **ASSISTANT SURGEONS**

Benefits for assistant surgeons are covered for certain surgical procedures, as determined by the CPC, and when no hospital-employed surgeon or resident in training is available. Contact the CPC to determine if a particular surgery provides coverage for an assistant surgeon.

## **SECOND SURGICAL OPINIONS**

Second surgical opinions are not required. However, should you elect to obtain a second opinion, benefits are subject to the Plan year deductible, coinsurance and \$15 professional services copayment.

## **ANESTHESIA**

Medical coverage is provided for professional anesthesia services for the administration of general, spinal block or local anesthesia administered by a professional anesthesiologist. Pre- and post-operative visits, fluids and/or blood, and necessary drugs and materials, are an integral part of anesthesia services and are not allowed separately. Benefits are excluded for administration of anesthesia (general, local, analgesic or IV sedation) when administered by the operating surgeon or surgical assistant or when the place of service is an office setting. The allowances for office surgical procedures include anesthesia and post operative care provided within the follow-up period. Services provided by a Certified Registered Nurse Anesthetist (CRNA) are not covered when billed separately from the professional anesthesiologist charge, unless Medicare has paid as primary. (see pages 32, 35)

## **BREAST RECONSTRUCTION**

Benefits are available for breast reconstruction surgery following a covered mastectomy even if performed in stages or different sessions. Benefits include all stages and revisions of reconstructive breast surgery performed on a non-diseased breast that will establish symmetry when reconstructive surgery on a diseased breast is performed.

Reconstruction of the nipple/areola area following a mastectomy is covered without regard to lapse of time between the mastectomy and the reconstruction.

## UTILIZATION MANAGEMENT/MEDICAL REVIEW

To make sure you have access to timely, appropriate, and cost effective health care, the Claims Processing Contractor (CPC) has a Utilization Management/Medical Review (UM/MR) program. The UM/MR program requires that certain health care services you receive be approved by the CPC in order to receive benefit coverage. As part of this process, the CPC looks at whether health care services are medically necessary, provided in the proper setting and for a reasonable length of time.

### **Your member rights**

- A right to a timely UM decision
- Have a Medical Director from the CPC make a final determination on all denials of service that were based on medical necessity
- Request a review of a denial of benefit coverage through our appeal and grievance process.

### **The CPC's Responsibilities**

- Provide you and your provider with a toll-free telephone number to call UM/MR staff whenever certification (approval) of a health care service is needed.
- Limit what we request from you or your provider to information that is needed to review the requested service.
- Obtain all information necessary to make the UM/MR decision, including pertinent clinical information.
- Provide you and your provider with prompt notification of the UM/MR decision consistent with North Carolina law and health care benefits.

In the event the CPC does not receive sufficient information to approve coverage for a health care service, the CPC will send you a letter stating denial of benefit coverage. If, after receiving the letter, you or your provider thinks additional information might change the outcome of the decision, you have the right to submit the information. Follow the instructions in the letter for submitting the additional information.

Note: The Mental Health Case Manager provides Utilization Management of Mental Health and Chemical Dependency Benefits. Approval in advance (precertification) is required prior to admission or start of treatment for inpatient care, residential treatment, partial hospitalization, treatment in an intensive outpatient program, and for crisis evaluation/stabilization. In addition, certain documentation by your provider must be submitted for approval to the Mental Health Case Manager prior to visit 27 each Plan Year. Contact the Mental Health Case Manager by calling 1-800-367-6143.

## PRIOR APPROVAL FOR MEDICAL SERVICES

The Plan requires that you obtain prior approval for certain services, equipment and supplies before services are rendered. The fact that a doctor orders services, equipment or supplies does not in itself constitute justification. Prior approval determinations are based on appropriateness and medical necessity determinations (see page 6-8 for definitions).

The medical policies used for medical necessity determinations are available on the State Health Plan Information Site at [statehealthplan.state.nc.us](http://statehealthplan.state.nc.us) (do not use www.)

Of course, prior approval is not valid if, at the time the services are received, your benefits have been exhausted or there is no coverage.

You are always responsible for the Plan year deductible, coinsurance amounts, co-payment, and charges for non-covered services.

If you do not obtain approval before services are rendered, you may request retrospective review (see page 9 for definition). To be considered for retrospective review, requests must be received within six months (180 days) of the end date of service. Requests for retrospective reviews that are received after 180 days of the end date of service will not be considered even if the services were provided in the appropriate setting and met medical necessity criteria.

If you do not obtain approval when required, you will be responsible for the entire cost.

The provider who will provide the service should send medical records and a letter of medical necessity from your doctor (see page 6 for definition), explaining the need for the services noted on pages 42 through 56 to:

**Medical Review**  
**PO Box 30111**  
**Durham, NC 27702-3111**  
**FAX 919-765-4890**  
**Telephone 1-800-422-1582**

Although you may receive **prior approval**, it does not guarantee that benefits will be paid. Benefits are subject to all other terms and conditions of the Plan.

**Prior approval is required for the following services:**

- Durable medical equipment purchase, rental or repair when the total allowed reimbursement for purchase or repair is over \$1000. This includes prosthetic, orthopedic and orthotic appliances. (No prior approval is required when Medicare is the primary coverage and the durable medical equipment being rented, purchased, repaired, or maintained **is covered by Medicare.**) (see pages 48-50)
- Licensed land ambulance over 50 miles
- Air ambulance
- Any service provided in the home (see page 43)
- Hospice care
- Private duty nursing (see page 44)
- Skilled nursing facility (SNF) care (see page 45)
- Speech therapy except inpatient hospital (see pages 28, 29, and 43)
- Subcutaneous injection - Filling material injected into tissue, such as silicone
- Temporomandibular joint (TMJ) dysfunction appliance/splint therapy (see page 53)

**Prior approval** is also needed for the following surgical procedures:

- **Abdominoplasty** - Abdominal plastic surgery
- **Blepharoplasty** - Corrective surgery to the eyelid
- **Cochlear implants** - Insertion of electronic aids in the ears to restore partial hearing
- **Excision of gynecomastia** - Surgical removal of abnormally large breasts in males
- **Fimbrioplasty** - Corrective surgery to the fallopian tubes
- **Gastric surgery** (for morbid obesity) - Surgical reduction or bypass of the stomach/intestinal tract to limit nutritional absorption. Some gastric surgical procedures are considered investigational and are not covered. (see page 46, Non-covered Services)
- **Hermaphroditism correction** - Congenital abnormality when both ovarian and testicular tissue occurs in the same individual
- **Keloid excision** - Surgical removal of scar tissue
- **Nasal structure revision** - Surgical reconstruction of the nasal passage (including septoplasty)
- **Oral surgery** - Treatment of jaw fractures, extraction of teeth due to radiation therapy, surgical correction and oral devices for the treatment of sleep apnea, excision of oral lesions and tumors performed as independent procedures (see pages 52-53)

- **Orthognathic surgery** - involves reconstructive procedures to correct deformities of the jaw and realign maxillofacial skeletal structures with each other and with other craniofacial structures that may be caused by congenital or developmental conditions
- **Penile prosthesis** - Surgically implanted device for the treatment of some types of impotency
- **Reduction mammoplasty** - Reduction in breast size by plastic surgery
- **Suction lipectomy** - Surgery for the removal of fatty tissue by suctioning
- **Temporomandibular joint (TMJ) dysfunction surgery** - Surgical correction of TMJ to correct deviation of jaw movement (see page 53)
- **Transplants** (must be on list of covered transplants) - Surgical implantation of tissue or organ(s) taken from a donor (see page 56)
- **Tubotubal anastomosis** - Corrective reconstruction of the fallopian tubes
- **Varicose vein surgery** - Including injection into varicose veins (sclerotherapy). Some varicose vein procedures are considered investigational and are not covered (see page 46).

### HOME HEALTH AGENCY SERVICES

Home health agency services provided in a Plan member's home are eligible expenses when medically necessary (see definition on page 7). The attending physician must certify that hospital or skilled nursing facility confinement would be required without such treatment and services cannot be readily provided by family members. Services may include medical supplies, equipment, appliances, therapy services (speech, physical, occupational or home intravenous (IV) therapy), hospice care and nursing services.

Home care services require **prior approval** and are limited to 60 days per Plan year. Additional days may be provided, on an individual basis, when approved by the CPC.

The Plan provides benefits for home care services if all the following conditions are met.

- **prior approval must be obtained;**
- must be homebound (see definition on page 6)
- must require and receive skilled medical services that can only be performed by licensed health care professionals;
- doctor must certify that the patient would otherwise be confined to a hospital or skilled nursing facility (SNF) without home care services;
- services of home care aides must be an adjunct to and support the skilled services of licensed and certified health care professionals; and
- must have rehabilitation potential.

The following home care services are **not** covered by the Plan:

- care provided by a family member
- care provided by a non-skilled or unlicensed care giver, such as a sitter
- care when the patient's condition, in the opinion of the Plan, no longer requires a skilled level of care
- care when the primary purpose of the care being rendered is to assist the individual in meeting the activities of daily living
- care when the maximum rehabilitation potential, in the opinion of the Plan, has been met

**Nursing services will be payable for:**

- a registered nurse (RN)
- a licensed practical nurse (LPN) under the supervision of a registered nurse
- home health aides- limited to four hours per day (must be under the direct supervision of a licensed health care professional and employed by a licensed home care agency.)

**Plan allowances for home health services shall be limited to licensed or Medicare certified home health agencies and shall not exceed 90% of the skilled nursing facility semiprivate rates as determined by the Plan.**

**Psychiatric in-home services may be certified by the Mental Health Case Manager; prior to starting such services, please call 1-800-367-6143.**

### **PRIVATE DUTY NURSING**

The Plan provides benefits for private duty nursing if all the following conditions are met:

- **prior approval** is obtained;
- private duty nursing does not replace normal hospital nursing care;
- the doctor orders the services;
- the CPC determines the illness requires this special care;
- services are provided by an RN or LPN;
- the nurse is not an immediate relative or member of the patient's household; and
- routine nursing care is not adequate for the condition being treated.

Reimbursement for private duty nursing will be based on the lesser of the Plan's usual, customary and reasonable (UCR) allowance **OR** 90% of the daily semiprivate rate at a skilled nursing facility as determined by the Plan and is subject to deductible and coinsurance requirements of the Plan.

## SKILLED NURSING FACILITY (SNF) BENEFITS

Skilled Nursing Facility (SNF) benefits are provided to help in the transition from hospital to home. Such care may also serve to help medically stabilize the patient. Once the patient is stable and no longer in need of acute medical care, eligibility for SNF benefits will end.

**Prior approval** is required upon admission in a SNF. Benefits are limited to a maximum of 100 days per Plan year for the same reason. Additional days may be provided for ventilated patients, on an individual consideration basis, when approved by the CPC.

All of the following requirements must be met:

- be hospitalized for at least 3 days for the same condition treated in the SNF;
- be admitted to a SNF within 14 days after discharge from a hospital;
- be referred to a SNF by a doctor;
- be under the continuous care of a doctor;
- require and receive skilled services on a continuous daily basis; and
- the medical condition must be such that an inpatient hospital stay would otherwise be required.

The following services are **not covered**:

- intermediate, custodial or domiciliary care
- care when, in the opinion of the Plan, the patient's medical condition is stable or does not require skilled medical services on a continuous daily basis
- care when the patient's rehabilitation has been met in the opinion of the Plan
- personal items (television, hair salon, etc.)

**Even though a patient may have a chronic condition requiring care, his or her needs may be adequately met in a lower level of care, such as an intermediate, custodial or domiciliary facility, which is not covered. A medically stable patient may not require skilled medical services on a continuous daily basis.**

## NON-COVERED SERVICES

The Plan does not provide benefits for certain services. You are responsible for the cost of these non-covered items or services if you choose to purchase them.

If you or your provider requests prior approval for services that are non-covered, you and the provider will each receive a letter stating that the services are non-covered benefits. To be eligible for an appeal or grievance, the equipment or service must be a covered benefit.

**DO NOT ASSUME THAT AN ITEM, SERVICE OR PROCEDURE IS COVERED IF IT IS NOT LISTED ON THE FOLLOWING PAGES.**

Contact Customer Services at **1-800-422-4658** if you have further questions.

### **Non-covered Services** (This is a partial list.)

- any services rendered prior to the effective date of coverage
- care related to preexisting conditions when the patient is subject to a waiting period for preexisting conditions
- treatment of disease or injury resulting from military service or a declared or undeclared war
- care related to conditions or treatment not covered by the Plan
- experimental/investigational procedures and any direct or indirect complications (examples include: echosclerotherapy, laser ablation to treat varicose veins, and Mini-Gastric Bypass Surgery)
- phase I clinical or research trials
- surgical/medical procedures specifically listed by the American Medical Association or the North Carolina Medical Society as having questionable or no medical value
- surgical/medical procedures received outside of the United States that are not sanctioned and approved in the United States
- services that are considered not medically necessary
- drugs that can be purchased without a doctor's written prescription (over-the-counter)
- services provided in a facility not appropriately licensed or accredited
- care provided by an ineligible provider
- drugs not given unrestricted market approval by the Federal Food and Drug Administration
- non-skilled services
- custodial care
- dental care not related to an accidental injury

**Non-covered Services continued** (This is a partial list.)

- dental implants
- telephone consultations
- charges for services related to injuries or illnesses sustained on the job when certain condition applies
- services of more than one doctor for the same condition on the same day
- assistant surgeons, for certain surgical procedures, as determined by the CPC, and when no hospital-employed surgeon or resident in training is available
- cosmetic services/surgery and complications from previous cosmetic surgery
- weight reduction programs
- diet or nutritional counseling
- health club memberships
- routine eye examinations, contact lenses and eyeglasses, orthoptics (also called vision therapy or eye exercises)
- radial keratotomy, LASIK, or other procedures to correct vision in lieu of corrective lenses
- artificial conception (including gamete intra-fallopian transfer, *in vitro* fertilization and artificial insemination)
- reversal of sterilization
- maternity benefits for a dependent child or non-enrolled female employee or non-enrolled female spouse
- newborn nursery care when the mother is not enrolled or eligible for maternity benefits
- sex transformation surgery and related services or complications
- personal services (telephone, television, laundry, hairdresser, etc.)
- administrative costs, including writing and compiling reports
- costs associated with the translation of foreign claims
- complications arising from non-covered services
- immunizations required for occupational hazard
- immunizations required only for foreign travel
- services which the member is entitled to have paid, or to obtain without cost, in accordance with any government laws or regulations except Medicare. Examples would include therapy services required to be provided as part of an individual education plan (IEP) through a school system.

## DURABLE MEDICAL EQUIPMENT (DME)

The Plan provides benefits for certain types of durable medical equipment (DME). Benefits are subject to the Plan year deductible and coinsurance requirements.

No prior approval is required for covered durable equipment rental, purchase or repair when Medicare is the primary coverage and the durable medical equipment requested, or being repaired, is approved by Medicare.

You must have **prior approval** for:

Durable medical equipment purchase, rental or repair when the total allowed reimbursement for purchase or repair is over \$1000. This includes prosthetic, orthopedic and orthotic appliances. Rental of DME may not exceed the purchase price. In most cases, equipment is rented for ten months; after ten months, the purchase price will have been met.

Certain equipment, such as oxygen concentrators and continuous positive airway pressure devices (CPAPs), may be eligible for periodic maintenance. If the equipment is eligible, the DME provider may submit claims for maintenance.

In order to be considered for benefits, the Plan requires that DME rental or purchases meet all of the requirements noted below. DME must be **standard** equipment (no deluxe or luxury items) that is:

- normally used in an institutional setting;
- able to withstand repeated use;
- primarily and customarily used to serve the medical condition for which it is prescribed;
- appropriate for use in the home (such as a standard hospital bed, standard wheelchair, nebulizer, etc.); and
- not used for the convenience of the caregiver.

Examples of deluxe or luxury items include, but are not limited to:

- Electric or powered lifts are considered deluxe models of manual or hydraulic lifts.
- Total electric beds are considered deluxe models of semi-electric beds.

**Contact Medical Review at 1-800-422-1582 to determine if a particular type of DME is considered 'standard.'**

**Even if DME rental or purchases meet all of the requirements listed above, they may not always qualify for benefits. Coverage is based on the fact that the DME is, in the opinion of the Plan, reasonable and medically necessary for the treatment of a specific illness or injury.**

The Plan limits benefits for covered DME to standard equipment. You are responsible for the costs of additional enhancements, convenience or luxury items. (see page 50, Non-covered Equipment)

## **DME PROVIDERS**

The CPC contracts with some DME providers.

Contracting DME providers agree to:

- file all claims for covered services;
- limit out-of-pocket expenses to the Plan year deductible, coinsurance amount, and charges for services not covered by the Plan; and
- not bill the patient for charges that exceed the Plan's contracted amount.

Contact Customer Services at **1-800-422-4658** to determine the contracting status of a DME provider.

## **NON-COVERED EQUIPMENT & SUPPLIES**

The Plan does not provide benefits for certain supplies and equipment. You are responsible for the cost of these non-covered items or services if you choose to purchase them.

If you or your provider requests prior approval for equipment or supplies that are non-covered, you and the provider will each receive a letter stating that the equipment or supplies are non-covered benefits. To be eligible for an appeal or grievance, the equipment or service must be a covered benefit

**DO NOT ASSUME THAT AN ITEM, SERVICE OR PROCEDURE IS COVERED IF IT IS NOT LISTED ON THE FOLLOWING PAGES.**

Contact Customer Services at **1-800-422-4658** if you have further questions.

## Non-covered Equipment And Supplies (This is a partial list.)

Bath, including Jacuzzi, sauna, sitz, whirlpool and paraffin	
Bed, residential-type (commercial), including Adjust-A-Bed, Lounge bed, oscillating (vibrating) with or without heat, Sleep Number, Tempur-Pedic	
Blood pressure cuff/kit, (stethoscope and/or sphygmomanometer)	
Chairs, including "Companion", or "Geri-" chairs, Niagara (recliner or massage pillow), recliner, "Roll-away," and Auto-tilt	
Humidifiers, dehumidifiers, and vaporizers (room-type)	
Mattress, (except with hospital bed) non medical or commercial	
Vacuum cleaners, including Rainbow Hyder Air Purification System	
Bathtub and shower accessories, including hand-held shower heads, tub rail, seat, shower bench, chair and stool	
Exercise and massage equipment, including exercise bicycle, gravity inversion equipment, muscle stimulator/massager, treadmill exerciser, weights, weight bench, swimming pool, parallel bars, massage devices, vibration unit (cyclomassage) and Vibrator	
Safety equipment, including restraints (body, ankle, wrist, and padding) and grab bars, including bathroom rails	
Sick room supplies, including bed bath, pillows (cervical or lumbar), emesis basin, heating pad (standard or Thermophor or Thermophax), ice blanket, lambs wool pad, lap tray, surgical face mask and table (over bed or other)	
Wheelchair accessories, including basket/tote bag, beverage holder, bumper wheels, curb ramp, curb ramp holder, custom handle, lap tray, lift (van) lifting handle, power seat lift, ramps and structural modifications, luggage rack and auto wheelchair carrier	
Youth equipment, including adaptive clothing, air mat, balls, beams, blocks, bolster, classroom aids, cognitive or developmental supplies, crawling aids, cylinders, feeding utensils, grooming supplies, ramps, swings, tables, toys (adaptive/educational/ other) and Tyke-Hike	
Youth seating equipment, including car seat, classroom chair, high chair (feeder chair), infant relaxers, pony seats, stools and straddle chairs	
Air conditioners, air cleaners and filters	H-Wave Muscle Stimulator
Air-Dyne bicycle	Hearing aids/ear molds
Aquamatic K-Thermia pad (Aqua pad)	Heat lamps
Bed board	Hydrocollator
Biomechanical orthotic device	Intercoms (communicators)
Breast pumps	Lenox Hill sports cover
Cast impressions	Medical alert equipment/services
Clothing, including mastectomy swimsuit	Molded shoe
Computers	Neuro aides/pads
Cranial prosthesis (wig)	Nocturnal bruxism appliance (mouth guard)
Cryo cuff/cold therapy	Orthotic stabilizers
Dentures (unless due to accident)	Postural drainage board
Diathermy machine	Pre-set Portable Oxygen Center
Electrostatic machine	Rectal dilator
Electrical continence aid	Scales (food or weight)
Electrocardiocorder	Snore Guard
Elevator	Speech teaching machines
Extend-A-Hand	Spinal-pelvic stabilizers
Eye glasses	Temporomandibular joint appliance (unless due to accident)
Fiberglass stabilizers	Telephone Alert System
Fracture cast sock	Termguard
Hand controls, automobile	TES-Trans electrical stimulator

## **DISEASE MANAGEMENT PROGRAMS**

If you have been identified as having a chronic disease, you may be invited to participate in a disease management program. The programs that are currently in progress include:

- Coronary Artery Disease
- End Stage Renal Disease
- Diabetes
- Pediatric Asthma

Each of these programs provides you with the educational materials and information to help you to better manage your health condition. Some participants will receive more intensive services including phone calls from health professionals and individualized case management. All of our disease management programs are completely confidential, voluntary and offered at no cost to our members.

Contact Customer Services at **1-800-422-4658** if you have further questions.

## **CARE COORDINATION PROGRAM**

Care coordination is a process that coordinates options and services to meet a participant's individual health care needs. Patients are selected for care coordination based upon catastrophic, severely chronic or high-risk conditions. If you or a covered dependent meet the guidelines for participation you may be contacted by a nurse and invited to participate in the program. There is no additional cost for care coordination services. You are responsible for your usual deductibles, coinsurance and co-payment amounts that are applied to the services that you receive while participating in the program.

Contact Customer Services at **1-800-422-4658** if you have further questions.

## **END STAGE RENAL DISEASE**

The Plan contracts with an independent coordinator to offer assistance for members with End Stage Renal Disease or Chronic Kidney Disease, who are 90 days or more from having Medicare as their primary insurer. Healthcare professionals called "care managers" work with you, your caregivers, your doctors and your other healthcare providers to improve your quality of life. The goals of care managers are to help you and your caregivers:

- understand and manage your disease better,
- identify and coordinate appropriate health plan benefits,
- communicate and work with your doctors and other healthcare providers,
- investigate different treatment options,
- create, review and update a written treatment plan for your unique needs,
- monitor your healthcare quality and service delivery, and
- find community resources.

This program is offered at no cost to you. For more information please call Customer Services at **1-800-422-4658**.

## ORAL SURGERY BENEFITS

The Plan provides benefits for covered oral surgery. **Prior approval** is required and benefits are limited to:

- **treatment of jaw fractures**
- **extraction of teeth** due to the effects of radiation therapy when radiation therapy has been performed for treatment of cancer of the head and neck region
- **excision of oral lesions, tumors and cysts** performed as **independent** procedures
- **office visits and diagnostic tests** (including a diagnostic MRI) to establish the diagnosis of temporomandibular joint dysfunction (TMJ)
- **medically indicated surgical correction** of developmental or congenital anomalies including cleft lip and palate and orthognathic surgery
- **reconstructive surgery and devices** to correct facial disfigurement resulting from trauma, evasive tumor removal, cleft lip and palate
- **medical treatment** of obstructive sleep apnea

## ORAL SURGERY EXCLUSIONS

Benefits are specifically excluded for:

- **dental implants** for replacement of lost or missing teeth
- **tooth replacement** prosthesis such as crowns, bridges and dentures
- **braces or orthodontics**, to realign teeth, in absence of an accidental injury
- **tooth extraction** including removal of wisdom teeth and extractions in preparation for another surgical procedures (even if other surgical procedure receives **prior approval** from the Plan)
- **operative restoration** of teeth (fillings)
- **bone grafting** in preparation for the placement of dental implants
- **oral revisions, reconstruction, or repairs** determined to be the result of previously received, non-covered oral surgery or non-covered dental treatment
- **TMJ splint/appliance therapy** in absence of an accident
- **apicoectomy**
- **removal of cysts** that are incidental to an apicoectomy or extraction of teeth
- **root canal therapy**
- **treatment of dental caries**

- **treatment of gingivitis** including surgical procedures of diseased gingiva or other periodontal procedures
- **vestibuloplasty, alveoloplasty, removal of exostosis and tori** preparatory for the fitting or continued use of dentures
- **charges for anesthesia** administered by the attending doctor in an office setting
- **orthognathic surgery**, when determined by the Plan to be for correction of malocclusion in the absence of documentation that the correction of the deformity is medically necessary for the maintenance of good physical health
- **any other procedures** involving the teeth and their supporting oral structures

### TEMPOROMANDIBULAR JOINT (TMJ) DYSFUNCTION

Benefits for TMJ are available on an individual consideration basis and are subject to the Plan year deductible and coinsurance requirements. In addition there is a \$15 professional services copayment per visit.

Coverage is available for office visits, x-rays and tests to **diagnose** TMJ and physical therapy provided by an eligible medical professional. All other treatment of TMJ including splint/appliance therapy and surgery **requires prior approval**.

Benefits **are not** provided for TMJ splint/appliance therapy in the absence of an accidental injury, which can be documented as the sole cause for the TMJ dysfunction. The injury must have occurred while the individual was covered under the Plan. Treatment must be initiated and completed within 18 months from the accident.

Braces and orthodontic treatment for TMJ, even in the presence of an accidental injury, are considered dental therapy and contractually excluded under the Medical Policy provisions of the Plan.

## ACCIDENT RELATED DENTAL BENEFITS

Coverage is provided for dental services determined to be necessary as the result of an accidental injury. Benefits are available on an individual consideration basis. In addition to the Plan year deductible and coinsurance, each visit is subject to a \$15 professional services copayment.

Accident related dental services are limited to injuries sustained as a result of external violent and accidental means, such as the impact of a moving body, vehicle collision, or fall. The injury must have occurred while the individual was covered under the Plan. Treatment must be initiated and completed within 18 months from the accident.

Benefits include extractions, fillings, crowns, bridges, other necessary appliances, and are limited to those services necessary to restore the affected teeth to the condition that existed immediately prior to the accident. Maintenance of the restoration is not covered.

## NON-COVERED DENTAL SERVICES

(This is a partial list.)

Dental benefits are not provided for the following:

- **routine dental care** (cleanings, checkups, periodontal scalings, fillings, crowns, etc.)
- **damage** incurred in the act of chewing or eating
- **enhancements** to the mouth and teeth that was recommended prior to the accident
- **damage** to or breakage of a denture not in normal use at the time of the accident
- **orthodontics**, to realign teeth, in the absence of an accidental injury
- **tooth extraction** in the absence of an accidental injury - this includes removal of wisdom teeth and extractions in preparation for a surgical procedure
- **appliance therapy for TMJ dysfunction** in the absence of an accidental injury
- **enhancements to the mouth structure and teeth** that did not exist prior to the accident
- **replacement or maintenance** of initial treatment or restorations
- **replacement of a dental appliance** broken during an accident that can be repaired
- **treatment of gum disease**, or rebuilding of gums in preparation for dentures or other appliances

## COVERED BENEFITS WITH LIMITATIONS

This is only a **partial** listing of covered benefits with limitations. If you have questions about these benefits, or about a benefit not listed, contact Customer Services at **1-800-422-4658** for assistance.

**Acupuncture** - Covered only when performed by a medical doctor (M.D.) or Doctor of Osteopathy (D.O.).

**Aphakic lenses** - One pair of lenses every 24 months for person over the age of 18, and one pair every 12 months for persons below the age of 18 (either contacts or eyeglasses).

**Aquatic therapy** - When performed by a licensed physical therapist as part of a physical therapy treatment program.

**Cardiac rehabilitation programs** - Limited to the lesser of \$1,800 or 90 days each Plan year provided services are received within 6 months of certain qualifying events such as heart attack, coronary artery bypass grafting valve surgery, percutaneous transluminal coronary angioplasty, including stent procedures, or heart transplant. Benefits are limited to patients with a diagnosis of chronic debilitating chest pain or congestive heart failure. Services must be provided in a medically supervised facility certified by the NC Department of Health and Human Services, or the appropriate agency in the state where the services are provided.

**Chiropractic services** - Limited to \$2,000 each Plan year for covered services. Services are limited to the alignment of the spine, release of pressure by manipulation, modalities and X-rays of the spine. Chiropractors are not eligible to provide medications, drugs, or nutritional supplements. If foot orthotics or other appliances are needed, they must be purchased from a DME appliance supplier.

**Diabetic self-care program** - Limited to \$300 each Plan year for patients with a medical history of diabetes. When determined medically necessary by an attending physician, services must be performed in a medically supervised facility and meet the standards of the National Diabetes Advisory Board.

**Licensed Land Ambulance Transportation** - Covered in the following situations:

- 50 miles or less and one of the following:
  - to or from a hospital for inpatient care or outpatient emergency care
  - from a hospital to the nearest facility which is prepared to accept the patient and is able to provide needed service(s) which is(are) not available at the hospital where the patient is presently confined
  - from a hospital to a skilled nursing facility, or from a skilled nursing facility to a hospital.

**The following is not covered:** Ambulance transport to or from home, skilled nursing facility or alternate care facility to an outpatient setting for non-emergent care (i.e. renal dialysis)

**Light Boxes** - Light boxes are covered for treatment of psoriasis (They are not covered for treatment of Seasonal Affective Disorder-SAD)

**Renal dialysis** - Benefits are paid based on Medicare status. The Plan is primary for the first 30 months after Medicare's effective date for active employees and eligible dependents. After the first 30 months, Medicare becomes primary.

**Therapeutic shoes** - Benefits are provided for covered therapeutic shoes for members with diabetes, peripheral vascular disease, or other high-risk conditions. The purchase of therapeutic shoes is limited to \$350 and to one pair every three years. You are responsible for any amount exceeding \$350.

**Transplant - Prior approval** is required for the following covered transplants: bone marrow, corneal, heart, kidney, liver, lung, heart-lung and pancreas. Benefits are determined based on non-experimental treatments, medical conditions and diagnoses. If Medicare is your primary insurer, the covered transplant must take place in a Medicare-approved facility.

## CONTINUITY OF CARE

Continuity of care is a process aimed to assist members with an acute, chronic or terminal illness, or members who are in the second or third trimester of pregnancy to continue receiving medical care, mental health treatment or treatment for chemical dependency from a provider when the member changes health plans or when the provider's contract with the Plan ends. To be eligible for continuity of care, one of the following conditions must apply:

- The member has 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.
- The member has 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.
- The member is in the second or third trimester of pregnancy or completing postpartum care.
- The member is terminally ill, a medical prognosis that the individual's life expectancy is six months or less.

A medical professional based on the information provided about specific medical conditions would review Continuity of Care requests. If a Continuity of Care request is approved and the provider agrees to continue the patient's care under the previous contractual agreement, members may continue to see their current provider for the following time periods:

- For acute or chronic illnesses/conditions, the Plan will continue to provide coverage for up to 90 days from the date the member was notified.
- For scheduled organ transplantation, surgery or inpatient care for a chronic or acute illness/condition: if it was scheduled, or, if the patient were on an established waiting list, the Plan will "continue coverage" through the date of discharge and post discharge follow-up care occurring within 90 days after the date of discharge.
- For a terminal illness, the Plan will provide coverage for the remainder of that member's life.
- For pregnancy (already in second or third trimester), the Plan will continue coverage through 60 days of postpartum care.

The Continuity of Care process also applies to Mental Health and Chemical Dependency benefits.

## IV. MENTAL HEALTH AND CHEMICAL DEPENDENCY BENEFITS

Before receiving certain mental health or chemical dependency treatment as noted on pages 58 through 64, you are responsible for obtaining precertification from the Mental Health Case Manager (MHCM) by calling **1-800-367-6143**.

Penalty for failure to obtain precertification as required by the Plan will result in your being responsible for the entire cost of care.

### OUTPATIENT TREATMENT

#### **Benefits**

The Plan allows 26 combined mental health and chemical dependency visits each Plan year from July 1 through June 30 without precertification by the MHCM. These 26 visits, which do not require approval by the MHCM, are called **unmanaged** visits. These unmanaged visits are combined for all providers; you do not receive 26 unmanaged visits with each provider each Plan year.

**You are responsible for keeping track of the 26 unmanaged visits.**

Note: Treatment in a partial hospitalization program (PHP) or an intensive outpatient program (IOP) is not considered within the outpatient benefit. These services are not covered under the 26 unmanaged visits; both PHP and IOP require precertification from the MHCM prior to beginning treatment in either of these programs. (see page 63)

#### **Steps to Request More than 26 Outpatient Visits**

- Prior to the 27<sup>th</sup> visit, you are responsible for obtaining certification from the MHCM.
- At the 18<sup>th</sup> visit, the Plan recommends that you request your provider to complete and submit an Outpatient Treatment Report (OTR) to the Mental Health Case Manager.
- Your provider should submit the completed OTR so that it is received by the MHCM prior to the 27<sup>th</sup> visit.
- If the OTR is not received prior to the 27<sup>th</sup> visit, certification will begin as of the date the OTR was received by the MHCM.

Note: You or your provider may obtain an OTR by calling the MHCM (1-800-367-6143) but this does not constitute a request for certification of additional outpatient visits. Having your provider submit a fully completed OTR is the process for requesting certification of additional outpatient visits beyond the 26 allowed each Plan year without approval of the MHCM.

### **Psychological Testing in an Outpatient Setting**

The 26 unmanaged outpatient visits may include psychological testing. Any psychological testing visits, which occur within the first 26 outpatient visits each fiscal year, do not require precertification by the MHCM. Any outpatient psychological testing, which occur after the first 26 visits each Plan year must be precertified with the MHCM. (see page 63)

### **Family/Couples/Marital Therapy in an Outpatient Setting**

Family/couples/marital therapies (billing codes 90846 or 90847) are covered. Diagnostic information is required on the claim.

### **Eligible Providers**

Providers eligible for reimbursement by the Plan for outpatient services are listed on pages 61 through 62. Only providers listed on these pages are reimbursable by the Plan.

### **Medication Management Visits**

Medication management visits do not require precertification and are not included in the first 26 combined outpatient psychotherapy visits when your doctor's office files CPT code 90862 as the billing code on the claim. Check with your doctor's office to determine what billing code is being submitted. All other psychotherapy-billing codes filed by your doctor are counted toward the 26 visits even if your visit was primarily about medication.

### **Initial Evaluation**

A psychiatric diagnostic interview is usually the first evaluation session with a provider. This type of visit is limited to one per provider per Plan year and counts toward the 26 unmanaged visits. If provided beyond the 26<sup>th</sup> visit, precertification is required by the MHCM.

### **Visit Limitation on the Same Day**

Only one type of outpatient mental health or chemical dependency service may be paid per day. The ONLY exception is the payment of a medication management visit with your doctor billed as CPT code 90862 on the same day as a psychotherapy visit with your therapist.

### **Electroconvulsive Treatment (ECT)**

All ECT, whether administered on an outpatient basis or inpatient basis, requires precertification with the MHCM prior to the treatment. (see page 58)

## Member's Financial Responsibility

Outpatient psychiatric and chemical dependency visits require a \$15 professional services copayment in addition to your Plan year deductible and coinsurance amounts.

**If you fail to obtain precertification when required, benefits will be denied. The Mental Health Case Manager cannot render a precertification decision for care and treatment, which has already been received.**

## Early Intervention

If you have concerns about your mental or emotional health and if active treatment is not currently being pursued, the Plan offers the opportunity for six (6) early intervention visits within the 26 combined unmanaged visits for assessment and/ or evaluation prior to diagnosis. Early intervention may also include counseling to reduce your risk of developing a mental illness or chemical dependency problem. **These visits are subject to the \$15 professional services copayment, the Plan year deductible and coinsurance amounts.**

- Assessment and counseling must not total more than six (6) visits each Plan year regardless of how many providers are seen.
- Providers must have the same credentials as currently required by the Plan for outpatient therapy. (see pages 61 through 62)
- Services may be delivered in a school based or school linked health center, a mental health center, a private office, or an outpatient clinic.
- Any additional visits within the 26 visits must have an established mental illness or chemical dependency diagnosis in order for claims to be paid.

Ask your provider or counselor to call 1-800-367-6143 to ask about special claims filing requirements prior to filing a claim for these services. When you call the 800 number, request to speak with someone in Account Services for the State Health Plan.

## ELIGIBLE MENTAL HEALTH AND CHEMICAL DEPENDENCY PROVIDERS

The following providers, and no others, may provide either psychiatric/mental health (MH) or substance abuse/chemical dependency (CD) services as designated below. The type of care and treatment provided must also be a covered benefit and within the scope of the provider's license.

<u>Eligible Provider</u>	<u>Requirements</u>	<u>Type of Treatment</u>	
		<u>MH</u>	<u>CD</u>
<b>Psychiatrist</b> (MD or DO)	Licensed as an MD or DO in the state in which services are provided and has completed psychiatric residency	Yes	Yes
<b>Doctor of Psychology</b> (PhD, PsyD or EdD)	Licensed or certified at the doctoral level in psychology in the state in which services are provided	Yes	Yes
<b>Certified Clinical Social Worker</b> (CCSW)	Certified as a CCSW in the state in which services are provided	Yes	Yes
<b>Licensed Clinical Social Worker</b> (LCSW)	Licensed as a LCSW in the state in which services are provided	Yes	Yes
<b>Licensed Professional Counselor</b> (LPC)	Licensed as an LPC in the state in which services are provided	Yes	Yes
<b>Licensed Psychological Associate</b> (LPA)	Masters' level psychologist licensed as an LPA in the state in which services are provided. For services prior to 01/01/04, LPA must have been supervised <b>and</b> employed by a licensed psychiatrist or licensed psychologist.	Yes	Yes
<b>Certified Clinical Specialist in Psychiatric and Mental Health Nursing</b> (RN,APRN,BC, )	Licensed as an RN in the state in which services are provided and nationally certified by the American Nurses' Credentialing Center which now certifies a clinical specialist as an Advance Practice Registered Nurse, Board Certified.)	Yes	Yes
<b>Registered Nurse; Registered Nurse, Certified</b> (RN or RNC)	Licensed as an RN in the state in which services are provided; RNC is also nationally certified as a generalist in psychiatric mental health nursing by the American Nurses' Credentialing Committee and works under the direct employment and supervision of an eligible doctor (M.D., D.O., Ph.D., Psy.D. or Ed.D.)	Yes	Yes

<u>Eligible Provider</u>	<u>Requirements</u>	<u>Type of Treatment MH</u>	<u>CD</u>
<b>Licensed Physician's Assistant</b>	Licensed as a physician assistant in the state in which services are provided and is directly supervised by an eligible psychiatrist.	Yes	Yes
<b>Pastoral Counselor (PhD)</b>	Certified as a fee-based practicing pastoral counselor in the state in which services are provided (Pastoral counselor associates are not covered)	Yes	Yes
<b>Physician (MD or DO)</b>	Licensed as an M.D. or D.O. in the state in which services are provided, and certified by the American Society of Addiction Medicine	No	Yes
<b>Certified Substance Abuse Counselor (CSAC)</b>	Certified as a Substance Abuse Counselor for the treatment of chemical dependency in the state in which services are provided	No	Yes
<b>Certified Clinical Addictions Specialist (CCAS)</b>	Certified as a Clinical Addictions Specialist for the treatment of chemical dependency in the state in which services are provided.	No	Yes
<b>Certified Clinical Supervisor (CCS)</b>	Certified as a Clinical Supervisor for the treatment of chemical dependency in the state in which services are provided.	No	Yes
<b>Others</b>	Appropriate background and experience to render chemical dependency treatment and approved by the MHCM	No	Yes

## **INPATIENT AND OTHER HIGHER LEVELS OF CARE**

All inpatient or residential treatment services require a \$100 copayment in addition to the Plan year deductible and coinsurance amounts.

Prior to entering any treatment, for psychiatric/mental health or substance abuse/ chemical dependency, you are responsible for calling the MHCM at **1-800-367-6143** to obtain precertification for the following services. The MHCM may also need to speak with your provider or facility. Please note that emergency inpatient treatment may be precertified by the MHCM 24 hours per day, 7 days per week. All other requests for precertification must be called in to the MHCM Monday through Friday during regular business hours, 8 AM - 6 PM, Eastern Time.

## Benefits

- Inpatient mental health/psychiatric treatment: You must be confined to a licensed psychiatric bed and have an attending physician who is a psychiatrist.
- Inpatient chemical dependency treatment. You must be confined to a licensed chemical dependency bed and have an attending physician who is a psychiatrist or addictionologist.
- Chemical dependency detoxification and treatment programs.
- Psychiatric treatment in a residential treatment center. The facility must have 24-hour, on site RNs, current licensure for psychiatric residential treatment in the state in which services are provided, and current accreditation by a national accrediting organization approved by the MHCM. Psychiatric residential treatment is limited to children who are 17 years old or younger.
- Chemical dependency treatment in a residential treatment center. The facility must have 24- hour, on site RNs, current licensure for residential treatment of chemical dependency in the state in which services are provided, and current accreditation by a national accrediting organization approved by the MHCM.
- Partial hospitalization. Treatment in a partial hospitalization program is not considered an outpatient benefit and is not included in the 26 outpatient unmanaged visits.
- Treatment in an intensive outpatient program (IOP). Treatment requires at least 9 hours of care per week with different types of treatment provided by various types of professionals. Treatment in an intensive outpatient program is not considered an outpatient benefit and is not included in the 26 unmanaged outpatient visits.
- All psychological testing administered during inpatient hospitalization or during treatment in a residential treatment center, partial hospitalization or intensive outpatient program, or during crisis evaluation and stabilization, requires precertification by the MHCM. The only exception is when this testing is included in the hospital's or treatment program's daily charge.
- 23-hour crisis evaluation and stabilization (23-hour observation)
- Electroconvulsive treatment
- Hypnotherapy
- Sodium amytal interviews
- Stress, relaxation and occupational therapies except when included in the hospital's or treatment program's daily charge
- Psychosurgery

**If you fail to obtain precertification when required, benefits will be denied. The Mental Health Case Manager cannot render a precertification decision for care and treatment, which has already been received.**

## Noncontracting Facility

If you receive services in North Carolina from a noncontracting hospital or residential treatment center, you will be held responsible for an additional 20% copayment up to a maximum of \$5,000 not to exceed \$15,000 per Plan year per Employee and Child(ren) or Employee and Family contract.

Contact Customer Services for the Claims Processing Contractor at **1-800-422-4658** to determine the contracting status of a hospital or residential treatment center.

### NON-COVERED MENTAL HEALTH & CHEMICAL DEPENDENCY SERVICES

The following is a list of non-covered services/charges. This is a **partial** list.

- Any residential program which does not meet the Plan requirements of 24-hour on-site RNs, current licensure for residential treatment in the state in which services are provided and current national accreditation accepted by the Mental Health Case Manager
- Court ordered psychiatric and chemical dependency services or treatment except as precertified by the Mental Health Case Manager as medically necessary
- Educational testing for the sole purpose of evaluating learning disabilities or other learning problems
- Experimental or investigational treatment
- Group homes
- Foster care, therapeutic foster care, or therapeutic homes
- Rebirthing or holding therapy
- Report writing for psychological or other testing
- Separate charges for sessions to review results of psychological testing
- Telephone services for treatment, consultation, crisis intervention, psychotherapy or any mental health/chemical dependency service provided via telephone
- Two or more psychotherapy visits in one day except when one visit is medication management filed with billing code 90862 on the claim
- Wilderness camps and other stand-alone outdoor treatment programs unless residential treatment requirements are met (see page 63)

See **statehealthplan.state.nc.us (do not use www.)** for all mental health and chemical dependency medical policies, which outline non-covered services as limitations and exclusions.

Mental health and chemical dependency services not specified elsewhere in this booklet as covered benefits are not eligible for appeal and are considered to be non-covered services.

## V. CLAIMS PROCEDURES

### COORDINATION OF BENEFITS

When both you and your spouse are working, members of your family may be covered under more than one group health benefit plan. This could result in benefits being paid in excess of the actual charges. However, the Plan includes a Coordination of Benefits (COB) provision so that total payments from both plans do not exceed 100% of the Plan allowance.

If you or your covered dependents have coverage under another employer-sponsored group health benefit plan in addition to the Plan, the two plans will coordinate benefits.

If you or your spouse have Medicare because of being age 65 or over and are also enrolled in COBRA, Medicare is the primary payer.

If you or a family member has Medicare because of a disability and are also enrolled in COBRA, Medicare is the primary payer.

Under the COB provision, the plan that pays second is the secondary coverage. The secondary plan's payment helps to make up the difference not paid by the primary plan. However, the Plan only coordinates benefits up to its UCR allowance. When one plan does not have a COB provision, that plan is always considered primary and pays first.

Following are the rules for determining when a plan is primary or secondary:

- If the employee is the patient, the employee's coverage is primary.
- If a dependent child is the patient, the group plan of the parent whose birthday occurs earlier in the year is the primary plan. Should the parents have the same birthday, the primary plan will be the group plan that has been in effect longer. If the other plan does not use this birthday rule, and an agreement cannot be reached with the plan administrator on the order of benefits, the other plan's rule will override the birthday rule.
- If the child's parents are divorced or legally separated, the plan of the parent having custody is primary and the plan of the non-custodial parent is secondary. However, the plan of the parent who, by court order, is financially responsible for the child is primary, even though that person may not have custody.

- If none of these conditions apply, the plan that has covered the patient longer is primary.

If you are covered by Medicare and are a member of the Plan, please see pages 20 through 21.

### TIME LIMIT FOR FILING CLAIMS

You are responsible for ensuring that all claims for covered services are filed **within 18 months** from the date of service. The Plan will not pay claims for services that are not received within the 18-month time limit.

### CLAIMS FILING PROCEDURES

TYPE OF CLAIM	<u>How to File</u>
For <u>all</u> services other than prescription drugs	<p>Complete the <b>Member Submitted Claim Form (G216)</b> and attach a copy of the provider's itemized receipt. Claim forms are available by contacting your HBR, the State Retirement System, by calling the CPC at <b>1-800-422-4658</b> or by accessing the Plan's website at <b>statehealthplan.state.nc.us (do not use www.)</b></p> <p><b>Claims should be mailed to:</b>  <b>Claims Processing Contractor</b>  <b>P O Box 30025</b>  <b>Durham, NC 27702-3025</b></p>
For services from the Out of State Network (PHCS)	<p><b>Claims should be mailed to:</b>  <b>Claims Processing Contractor</b>  <b>P O Box 3823</b>  <b>Durham, NC 27702-3823</b></p>
For prescription drugs only	<p>Claim forms are available by contacting your HBR, the State Retirement System, by calling the PBM at <b>1-888-693-7750</b> or by accessing the Plan's website at <b>statehealthplan.state.nc.us (do not use www.)</b></p> <p><b>Claims should be mailed to:</b>  <b>AdvanceRX</b>  <b>P O BOX 853901</b>  <b>Richardson, TX 75085-3901</b></p>

## HOW TO FILE A CLAIM

When you receive covered medical or mental health/chemical dependency services, many hospitals and doctors will complete the claim form for you. You should show your ID card and ask that the claim be filed with the CPC. If you receive covered services from a CostWise® participating doctor, he or she will **always** file the claim for you.

If a provider is not a CostWise® participating doctor and will not file a claim for you, you should pay the charge and submit an itemized receipt for each family member. You will receive reimbursement for covered services up to the UCR allowance, less copayments, deductibles and coinsurance amounts. (see page 66)

For each member, all services other than prescription drugs complete the **Member Submitted Claim Form (G216)** and attach a copy of the provider's itemized receipt, which must include all the following information:

- provider's name and signature
- provider's Blue Cross and Blue Shield of North Carolina provider number (if applicable)
- date(s) of service
- itemized charges and detailed list of services
- diagnosis, complaint or symptoms
- Explanation of Benefits or statement from the primary insurance plan (if applicable)
- Explanation of Benefits or statement from Medicare (if applicable)

## HOW TO FILE A CLAIM FOR PRESCRIPTION DRUGS

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

If you purchased prescription drugs from a pharmacy not contracted with the PBM, you will be responsible for the total amount of the prescription at the time of the purchase. You will need to complete a Prescription Drug Claim Form, (see page 66) and submit to:

**AdvanceRX**  
**P O Box 853901**  
**Richardson, TX 75085-3901**

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

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

Complete a separate form for each family member and pharmacy.

Drug receipts from the label or bag should not be submitted. Claims will be returned if not properly completed.

### **HOW TO FILE A CLAIM WHEN ANOTHER INSURANCE IS PRIMARY**

If another group plan is primary, the claim(s) should be filed with that plan first. When determination of payment by the other plan has been received, the claim(s) should be filed with the CPC with a copy of the other plan's payment determination. If the other plan's payment information is not attached, the claim(s) will be denied until documentation regarding what the other plan paid has been received.

### **HOW TO FILE A CLAIM WHEN MEDICARE IS PRIMARY**

When You Receive Medical Care in North Carolina-If Medicare Part A or Part B is your primary carrier and you receive covered medical services in North Carolina, claims should first be submitted to Medicare for processing.

Medicare should automatically send your claim to the CPC to be processed. If the CPC does not receive a claim from Medicare, you, the hospital or your doctor must submit the claim along with the Medicare Explanation of Benefits.

When You Receive Medical Care in Another State-If Medicare Part A or Part B is your primary carrier and you receive covered medical services in another state, claims must be filed with Medicare in that state.

Once Medicare in the other state processes your claim and sends you a Medicare Explanation of Benefits, you, the hospital or your doctor must submit the claim along with the Medicare Explanation of Benefits to the CPC.

## HOW TO FILE CLAIMS FOR SERVICES OUTSIDE THE USA

If you receive medical treatment, services, prescription drugs and supplies outside the United States, the following requirements must be met:

- the service received must be a covered service
- medical care must be provided by a licensed doctor, medical professional or facility licensed and recognized by the government of the country in which services are provided
- you must pay for services received
- you must submit a claim to the CPC for payment to be made directly to you
- all claims must be translated into English before you file your claim. You must file the original claim along with the translation.

The Plan does not pay any costs for translating claims or medical records.

The Plan bases payment for foreign claims on the exchange rate for the date(s) of service.

**The services that you receive outside the United States must have full-unrestricted approval in the United States and be eligible for benefits under the Plan.**

## QUESTIONS ABOUT YOUR BENEFITS OR CLAIMS

If you have any questions about membership eligibility, your benefits or the way your claim was processed, please call or write to Customer Services for assistance.

When contacting Customer Services about your question, please provide as much information as possible about your claim or situation.

Contact Customer Services by calling toll-free in the United States:

**1-800-422-4658**

8:00 a.m. to 5:00 p.m.  
Monday through Friday

You may also write to the following address:

**Customer Services  
PO Box 30111  
Durham, NC 27702-3111**

## VI. APPEALS PROCESS

### MEDICAL APPEALS

Initial contact should be made within 60 days of the original denial or benefit decision to Customer Services as an inquiry. If you do not agree with the decision, you may then submit a formal appeal.

You may request an appeal form from Customer Services at **1-800-422-4658** or at the Plan's website: **statehealthplan.state.nc.us** (do not use **www.**).

**Appeals must be submitted within 60 days of the original denial or benefit decision letter date.**

**NOTE:** Most problems or concerns are resolved by Customer Services without going through the formal appeals process.

If you are not able to submit an appeal yourself, you may ask any one of the following individuals to submit an appeal for you:

- person holding power-of-attorney for, or legal guardianship over you
- another person who you have asked to submit an appeal for you, including an attorney, your provider, the facility where services were received, or a family member. (Note: You must submit a written, authorization form, please refer to Confidentiality pages ii.)

When the subject of the appeal/grievance is a dependent who is 18 years old or older or is the spouse, the member must have the dependent's written authorization to submit an appeal/grievance. The member must also have the dependent's written authorization for the CPC to disclose any information regarding the appeal or any other PHI.

**Appeals must include the following information:**

- member's name
- patient's name
- member's identification number
- member's telephone number
- date the service was provided
- name(s) of the provider(s) of service
- reason for the appeal
- copy of the Explanation of Benefits or written notification of a benefits decision
- documentation, if needed (e.g. medical records, letters from a doctor, etc.)
- name of representative in Customer Services who handled the inquiry
- member's signature and date, or authorization for the representative to act on the member's behalf, including the member's signature and date

## Benefit Exclusions

Benefits and services that are clearly stated in this benefit booklet are not eligible for grievance or appeal and are considered Benefit Exclusions. The CPC will, however, conduct a review to assure that benefits have been correctly applied. Requests should be in writing, within 60 days of the original denial or benefit decision letter date.

The CPC offers the **first** and **second** levels of appeal.

### First Level Grievance/Appeal Review

The review request should be in writing, within **60 days of the original denial or benefit decision letter date**.

Within three business days after the receipt of a review request the CPC will provide you with the name, address, and phone number of the grievance/appeal coordinator. The CPC will also give you instruction on how to submit written materials.

Although you are not allowed to attend a first level grievance/appeal review, the CPC asks that you send all written material you feel is necessary to make a decision. You will be notified in clear written terms of the decision within a reasonable amount of time. Your first level case may take 30 days from the date the CPC received the request to complete.

### Second Level Grievance/Appeal Review

If you are dissatisfied with the first level review decision, you have the right to a second level review. The request must be made in writing within **60 days of the first level review decision**. Within 10 business days after the CPC receives your request for a second level review, the following information will be given to you:

- Name, address, and telephone number of the grievance/appeal analyst
- A statement of your rights, including the right to:
  - request and receive from the CPC all information that applies to your case
  - attend the second level review meeting
  - present your case to the review panel
  - submit supporting material before and at the review meeting
  - ask questions of any member of the review panel
  - be assisted or represented by a person of your choosing, including a family member, personal representative, attorney, or physician

The second level review meeting, which will be conducted by a review panel coordinated by the CPC using external specialty matched consultants, or medical advisors, will be held, via telephone conference, within 45 days after the CPC receives a second level review request. You have the right to a full review even if you do not attend the meeting. A written decision will be issued to you within 7 business days of the review meeting.

### **Third Level Grievance/Appeal Review**

If you do not agree with the second level appeal/grievance outcome, depending on the type of case, you may submit a **third** level appeal to either the Department of Insurance for review by a separate medical consultant, or the Plan's Executive Administrator and Board of Trustees. Follow the instructions as outlined in your second level decision letter. **All requests must be submitted within 60 days of the benefit decision letter date.**

All decisions are based on the benefits noted in the North Carolina General Statutes and in the Plan's approved medical policies.

**Appeals must be submitted within 60 days of receiving the original denial or benefits decision.**

### **Expedited Review**

You have the right to request a more rapid or expedited review of a denial of coverage **if** a delay would reasonably appear to seriously jeopardize your or your dependent's life, health or ability to regain maximum function. You can request an expedited review at any level. An expedited review may be initiated by calling State Customer Services at **1-800-422-4658**, additional documentation will be required.

An expedited review will take place in consultation with a medical doctor. All the same conditions for a first or second level review apply to an expedited review. The CPC will communicate a decision within 4 business days after receiving the information justifying the expedited review.

## PHARMACY APPEALS

**Appeals must be submitted within 60 days of the non-certification letter to the State Health Benefit Office (SHBO) at:**

**State Health Benefit Office  
Attn: Pharmacy Appeals Coordinator  
4509 Creedmoor Road, Suite 102  
Raleigh, NC 27612**

If you are not able to submit an appeal yourself, you may ask any one of the following individuals to submit an appeal for you:

- person holding power-of-attorney for, or legal guardianship over you
- another person who you have asked to submit an appeal for you, including an attorney, your provider, the facility where services were received, or a family member. (Note: You must submit a written, authorization form, please refer to Confidentiality pages ii.)

When the subject of the appeal/grievance is a dependent who is 18 years old or older or is the spouse, the member must have the dependent's written authorization to submit an appeal/grievance. The member must also have dependent's written authorization for the CPC to disclose any information regarding the appeal or any other PHI.

Appeals must include the following information:

- member's name
- patient's name
- member's identification number
- member's telephone number
- date the service was provided
- name(s) of the provider(s) of service
- reason for the appeal

### **First Level Grievance/Appeal Review**

The review request should be in writing, within 60 days of the original denial or benefit decision letter date.

Within three business days after the receipt of a review request the SHBO will provide you with the name, address, and phone number of the grievance/appeal coordinator. The SHBO will also give you instructions on how to submit written materials.

Although you are not allowed to attend a first level grievance/appeal review, the SHBO asks that you send all written material you feel is necessary to make a decision. You will be notified in clear written terms of the decision within a reasonable amount of time, but no later than 30 days from the date the SHBO received the request.

### **Second Level Grievance/Appeal Review**

If you are dissatisfied with the first level review decision, you have the right to a second level review. The request must be made in writing within 60 days of the first level review decision. The SHBO will forward all information to the CPC. Within 10 business days after the CPC receives your request for a second level review, the following information will be given to you:

- Name, address, and telephone number of the grievance/appeal analyst
- A statement of your rights, including the right to:
  - request and receive from the CPC all information that applies to your case
  - attend the second level review meeting
  - present your case to the review panel
  - submit supporting material before and at the review meeting
  - ask questions of any member of the review panel
  - be assisted or represented by a person of your choosing, including a family member, personal representative, attorney, or physician

The second level review meeting, which will be conducted by a review panel coordinated by the CPC using external specialty matched consultants, or medical advisors, will be held, via telephone conference, within 45 days after the CPC receives a second level review request. You have the right to a full review even if you do not attend the meeting. A written decision will be issued to you within 7 business days of the review meeting.

### **Third Level Grievance/Appeal Review**

If you do not agree with the second level appeal/grievance outcome, depending on the type of case, you may submit a **third** level appeal (external review) within 60 days of the second level review decision to the Department of Insurance for review. Follow the instructions as outlined in your second level decision letter. All decisions are based on the benefits noted in the North Carolina General Statutes and in the Plan's approved medical policies.

## **Expedited Review**

You have the right to request a more rapid or expedited review of a denial of coverage **if** a delay would reasonably appear to seriously jeopardize your or your dependent's life, health or ability to regain maximum function. You can request an expedited review at any level. A Level 1 expedited review may be initiated by calling SHBO at **(919) 881-2300**. A Level 2 or 3 expedited review can be initiated by calling State Customer Services at **1-800-422-4658**. Additional documentation will be required.

An expedited review will take place in consultation with a medical doctor. All the same conditions for a first or second level review apply to an expedited review. The SHBO or CPC will communicate a decision within 4 business days after receiving the information justifying the expedited review.

## **MENTAL HEALTH AND CHEMICAL DEPENDENCY APPEALS PROCESS**

**Appeals must be submitted within 60 days of the date of the noncertification letter. Follow the appeal instructions enclosed with each decision letter.**

If you are not able to submit an appeal yourself, you may ask any one of the following individuals to submit an appeal for you:

- person holding power-of-attorney for, or legal guardianship over you
- another person who you have asked to submit an appeal for you, including an attorney, your provider, the facility where services were received, or a family member.

You must submit a written, authorization form allowing the designated person to appeal on your behalf.

**Note: When the subject of the appeal is a dependent who is 18 years old or older or is the spouse, the member must have the dependent's or spouse's written authorization to submit an appeal. In addition, if the dependent is under the age of 18, the dependent's authorization is required for the MHCM to disclose any information regarding the appeal (including the appeal decision) or any other confidential information considered to be Protected Health Information (PHI).**

Mental health and chemical dependency services not specified elsewhere in this booklet as covered benefits are not eligible for appeal and are considered to be non-covered services.

## **Level I and Level II Appeals**

The Mental Health Case Manager (MHCM) offers two levels of appeal. The **first** level appeal allows a review of the case by a different doctor other than the one who rendered the original noncertification decision. A **second** level appeal allows review by a doctor with an organization external to the Mental Health Case Manager.

A written request for appeal of inpatient, partial hospitalization, residential treatment center (RTC), treatment in an intensive outpatient program and 23-hour observation/evaluation stays, and periodic outpatient treatment should include:

- complete medical/treatment records;
- evaluation results or testing results completed by any professional;
- other relevant clinical information or hospital/treatment report.

A written request for appeal of services should also include any additional relevant information you wish to be considered in support of your appeal request.

### **Appeals must include the following information:**

- member's name
- patient's name
- member's identification number
- member's telephone number
- date the service was provided
- name(s) of the provider(s) of service
- reason for the appeal
- copy of Explanation of Benefits or written notification of a benefits decision
- documentation, if appropriate (e.g. medical records, letters from a doctor, etc.)
- name of representative in Customer Services who handled the inquiry, if applicable
- authorization to appeal on behalf of a dependent and/or receive information about the appeal (when the subject of the appeal is a dependent).
- member's signature and date

All decisions are based on the benefits noted in the North Carolina General Statutes and in the Plan's approved medical policies.

**Appeals must be submitted within 60 days of the date of the noncertification letter or benefits decision letter.**

### Level III Appeals

If you do not agree with the second level appeal outcome, depending on the type of case, you may submit a **third** level appeal to either the Department of Insurance for review by a separate medical consultant, or the Plan's Executive Administrator and Board of Trustees. Follow the instructions as outlined in your Level II decision letter. **All requests must be submitted within 60 days of the date of the letter advising you of the Level II decision..**

All decisions are based on the benefits noted in the North Carolina General Statutes and in the Plan's approved medical policies.

### Expedited Review

You have the right to request a more rapid or expedited review of a noncertification of care **if** a delay would reasonably appear to seriously jeopardize your or your dependent's life, health or ability to regain maximum function. You can request an expedited second level review even if you did not request that the initial review be expedited. An expedited review may be initiated by calling the Mental Health Case Manager; additional documentation will be required.

An expedited review will take place in consultation with a medical doctor. All the same conditions for a first or second level review apply to an expedited review. The Mental Health Case Manager will communicate a decision within 4 business days after receiving the information justifying the expedited review.

## MANAGED CARE PATIENT ASSISTANCE PROGRAM

Managed Care Patient Assistance (MCPA) Program is available to explain to the insured their rights as health care consumers; answer questions about managed care; provide advice about the coverage provisions of specific health care plans; and help the insured understand the utilization review process, grievance, appeal, and external review procedures. **Assistance through MCPA is not available for dental related services.**

Managed Care Patient Assistance Program  
North Carolina Department of Justice  
PO Box 629  
Raleigh, NC 27602-0629  
(866) 867-MCPA (6272) toll free in NC  
(919) 733-MCPA (6272)  
Email: MCPA@ncdoj.com

## VII. IMPORTANT TELEPHONE NUMBERS AND ADDRESSES

Customer Services PO BOX 30111 Durham, NC 27702-3111	1-800-422-4658 (in USA) 1-919-489-8389 (outside USA) 1-919-765-7080 FAX#
Medical Review ATTN: PRIOR APPROVAL PO Box 30111 Durham, NC 27702-3111	1-800-422-1582 (in USA) 1-919-765-4890 FAX#
Hospital Pre-admission Certification for MEDICAL Treatment	1-800-672-7897 (in USA) 1-919-765-4891 FAX#
Medical Appeals/Grievances PO Box 3869 Durham, NC 27702-3869	1-800-422-4658 (in USA for inquiries) 1-919-765-2923 FAX#
Pharmacy Appeals Coordinator State Health Benefit Office 4509 Creedmoor Road, Suite 102 Raleigh, NC 27612	(919) 881-2300
Mental Health Case Manager ATTN: PRECERTIFICATION PO Box 12438 Research Triangle Park, NC 27709	1-800-367-6143 (in USA)
Pharmacy Benefit Manager	1-888-693-7750
Out of State Network	1-866-680-7427 (toll free) website: <a href="http://www.phcs.com">www.phcs.com</a>
Filing Claims (Except Out of State Network and Prescription Drugs)	Claims Processing Contractor PO Box 30025 Durham, NC 27702-3025
Filing Claims (Out of State Network only)	PHCS Claims P.O. Box 3823 Durham, NC 27702-3823
Filing Claims (Prescription Drugs only)	AdvancePCS PO Box 853901 Richardson, TX 75085-3901
State Retirement System 325 North Salisbury Street Raleigh, NC 27603	1-919-733-4191
General Information	Plan's website: (do not use www.) <a href="http://statehealthplan.state.nc.us">statehealthplan.state.nc.us</a>

## VIII. INDEX

Accident-Related Dental Benefits	54	Immunizations	38
Ambulance Services	42, 55	Inpatient Hospital Benefits	29-31
Ambulatory Surgical Facility	28	Inpatient Hospital Copayment	28
Anesthesia	39	Inpatient Mental Health Benefits	62
Appeals Process	70	Limitations of Covered Benefits	55
Assistant Surgeons	39	Maternity	36
Authorization	ii	Medical Supplies	27
Benefits at a Glance	4	Medicare	20
Breast Reconstruction	39	Medication Management	59
Cardiac Rehabilitation	55	Membership Reminders	22
Care Coordination Program	51	Mental Health Benefits	58
Chemical Dependency Benefits	58	Mental Health Providers	61
Chemical Dependency Providers	59	Multiple Surgical Procedures	38
Chiropractor Visits	55	Newborn Inpatient Benefits	36
Claims Filing Procedures	66	Non-covered Equipment	50
COBRA	19	Non-covered Services	46
Coinsurance	25	Non-covered Supplies	50
Commonly Used Terms	4	Out of State Providers	31
Confidentiality	ii	Outpatient Mental Health	58
Continuation Coverage (COBRA)	18	Plan Year Coinsurance	25
Continuity of Care	57	Plan Year Deductible	24
Coordination of Benefits	65	Pre-admission Certification	31
Copayment	28	Preferred Drug List	25
CostWise®	32	Prescription Drug Benefits	25
Covered Benefits with Limitations	55	Preventive Care and Wellness	37
Deductible	24	Prior Approval	41
Dental Benefits	52	Prior Health Coverage	16
Dependents	12	Private Duty Nursing	44
Diabetes Self-Care Program	55	Professional Services Copayment	28
Diagnosis Related Groups (DRG)	30	Protected Health Information (PHI)	8
Dual Enrollment	13	Providers, Medical	35
Durable Medical Equip. Providers	49	Providers, Mental Health	61
Durable Medical Equipment	48	Providers, Out of State	31
Early Intervention Mental Health	60	Routine Physical	37
Effective Dates of Coverage	15	Second Surgical Opinions	39
Electroconvulsive Treatment (ECT)	59	Skilled Nursing Facility (SNF)	45
Eligibility	10	Special Enrollment	16
Emergency Room Copayment	28	Surgical Benefits	38
End Stage Renal Disease Program	51	Temporomandibular Joint (TMJ)	53
Enrolling in Medicare	20	Terminating Coverage	18
Enrollment	13	Time Limit for Filing Claims	66
Filing Claims Outside the USA	69	Transplants	56
Flexible Benefit Plan	17	Types of Contracts	14
Fraud	iii	Usual, Customary & Reasonable	32
Home Health Agency Services	43	Vision Care	47
Hospital Outpatient Treatment	29	Waiting Period	15
Hospital Pre-admission Testing	29	Wellness and Preventive Care	37
How to File a Claim	67	When You Reach Age 65	20
How to File a Prescription Claim	67		
Identification Cards	14		