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

State Health Plan for Teachers and State Employees

High Deductible Health Plan (HDHP)

Benefits Booklet

January 1 – December 31, 2017

September 2016

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

High Deductible Health Plan (HDHP) Benefits Booklet

January 1 – December 31, 2017

Dear Member,

Welcome to the ***State Health Plan*** **for Teachers and State** ***Employees***. To assist you in understanding your health care benefits, we have created this State Health Plan Benefits Booklet. This is your personal *member* guide with valuable information at your fingertips.

The Benefits Booklet will guide you through your plan information with ease. To help you locate what you need quickly, we have outlined the most commonly used sections below:

- Quick Reference – easy access to the information that is most frequently needed.
- Summary of Benefits – detailed information about your High Deductible Health Plan (HDHP).
- How the HDHP Works – Important information about using your plan
- *Covered Services* – information about your benefits, exclusions and limitations.
- When Coverage Begins and Ends – information about your rights to Eligibility and COBRA continuation coverage, which is a temporary extension of coverage under the Plan.
- Privacy Notice – describes how medical information about you may be used and disclosed and how you can get access to this information.

To view additional information regarding this plan, visit our website, **www.shpnc.org** and click on High Deductible Health Plan. Additionally, our prompt and knowledgeable Customer Service department is just a phone call away at **866-740-3881**.

We are happy to have you as a *member* of the State Health Plan.

Table of Contents

Quick Reference – Toll Free Phone Numbers, Websites and Addresses **1**

Tips for Getting the Most out of Your Health Care Benefits **3**

Understand your health care plan 3

Manage your out-of-pocket costs by managing the locations in which you receive care 3

Save on prescription drugs 3

Pick a Primary Care Provider 3

Take charge of your health 3

Member Rights and Responsibilities **4**

As a State Health Plan member, you have the right to: 4

As a State Health Plan member, you have the responsibility to: 4

Important Notices **6**

Benefits Booklet 6

Introduction to the High Deductible Health Plan **7**

Aviso Para Miembros Que No Hablan Ingles 7

High Deductible Health Plan (HDHP) Summary of Benefits **8**

Who to Contact **12**

How the HDHP Works **13**

Out-Of-Network Benefit Exceptions 15

Carry Your Identification Card 15

The Role of A Primary Care Provider (PCP) 15

Understanding Your Share of the Cost **16**

Covered Services **17**

Office Services 17

Affordable Care Act (ACA) Preventive Services 17

Nutritional Counseling 18

Routine Physical Examinations and Screenings 18

Well-Baby and Well-Child Care 18

Well-Woman Care 18

Contraceptive Methods 18

Immunizations 18

Bone Mass Measurement Services 18

Colorectal Screening 19

Gynecological Exam and Cervical Cancer Screening 19

Newborn Hearing Screening 19

Ovarian Cancer Screening 19

Prostate Screening 19

Table of Contents

Screening Mammograms ---------- 20
Diagnostic Services..... 20
Emergency Care..... 20
What to do in an Emergency ---------- 20
Benefits for services in the *emergency* room---------- 21
Situation ---------- 21
Benefit ---------- 21
Urgent Care..... 21
Family Planning..... 21
Maternity Care ---------- 21
Statement of Rights Under The Newborns' And Mothers' Health Protection Act ---------- 22
Complications of Pregnancy ---------- 23
Complications of Abortion ---------- 23
Infertility Services ---------- 23
Sexual Dysfunction Services ---------- 23
Sterilization ---------- 23
Facility Services..... 24
Other Services..... 24
Ambulance Services ---------- 24
Morbid Obesity and Bariatric Surgery ---------- 25
Blood ---------- 27
Clinical Trials ---------- 27
Dental Treatment Covered Under Your Medical Benefit ---------- 28
Diabetes Related Services ---------- 29
Durable Medical Equipment ---------- 29
Hearing Aids---------- 29
Home Health Care ---------- 29
Home Infusion Therapy Services ---------- 30
Hospice Services ---------- 30
Lymphedema-Related Services ---------- 30
Medical Supplies ---------- 30
Orthotic Devices ---------- 30
Private Duty Nursing ---------- 31
Prosthetic Appliances ---------- 31
Surgical Benefits..... 31
Anesthesia---------- 32

Mastectomy Benefits ---------- 32
Temporomandibular Joint (TMJ) Services 32
Therapies..... 33
Short-Term Rehabilitative Therapies ---------- 33
Other Therapies ---------- 33
Transplants..... 33
Mental Health and Chemical Dependency Benefits 35
Office Visit Services ---------- 35
Outpatient Services ---------- 35
Inpatient Services ---------- 35
Prescription Drug Benefits..... 37
Using an In-network Pharmacy ---------- 38
Affordable Care Act Preventive Medications ---------- 38
Diabetic Testing Supplies---------- 39
Tobacco Cessation Coverage---------- 39
Specialty Pharmacy---------- 39
How to File a Claim for *Prescription Drugs* ---------- 39
Special Programs 41
What is not Covered? 42
Utilization Management 47
Rights and Responsibilities Under the UM Program..... 47
Your Member Rights---------- 47
The State Health Plan's Responsibilities ---------- 47
Prior Review (Pre-Service)..... 47
Urgent Prior Review ---------- 48
Concurrent Reviews..... 48
Urgent Concurrent Review ---------- 48
Retrospective Reviews (Post-Service)..... 49
Case Management..... 49
Continuity of Care 49
Further Review of Utilization Management Decisions 50
What if you disagree with a Decision? 51
Steps To Follow In the Grievance Process 51
First Level *Grievance* Review ---------- 51
Second Level *Grievance* Review ---------- 51
Expedited Review---------- 52

External Review ---------- 52
Standard External Review ---------- 53
Expedited External review ---------- 53
Third Level *Grievance* Review ---------- 54
Pre-Service Claims ---------- 55
Post-Service Claims ---------- 55
Appeals Correspondence ---------- 55
Medical Appeals ---------- 55
Pharmacy Appeals ---------- 56
Additional Terms of Your Coverage 57
Benefits to Which Members are Entitled 57
Disclosure of Protected Health Information (PHI) 57
Administrative Discretion 57
Receiving Care When You Are Outside Of North Carolina. South Carolina and Virginia 57
Provider Reimbursement 58
Services Received In North Carolina, South Carolina and Virginia ---------- 58
Right of Recovery/Subrogation Provision 59
Notice of Claim 60
Limitations of Actions 60
Coordination of Benefits (Overlapping Coverage) 60
Rules for Benefits Plan Payment Order ---------- 61
Medicare as a Secondary Payer ---------- 62
MEDICAID ---------- 63
When Coverage Begins and Ends 64
Eligibility 64
Dependent Eligibility 64
Enrolling in the Plan 64
Dual Enrollment ---------- 64
Timely Enrollees ---------- 65
Adding or Removing a Dependent 65
Qualified Medical Child Support Order 66
Effective Dates of Coverage 66
Types of Coverage 66
Reporting Changes 66
When Coverage Ends 66

Table of Contents

Definitions **68**

Notice of Privacy Practices **77**

Nondiscrimination and Accessibility Notice **81**

Quick Reference – Toll Free Phone Numbers, Websites and Addresses

SERVICES AND INFORMATION

***State Health Plan* Website** www.shpnc.org	To obtain information on Pharmacy benefits, search for a provider and other plan related information.
Member Online Portal www.medcost.com	To enroll in a safe, secure customer service website in order to: Check claim status, or request a new *Identification Card (ID card).*
***State Health Plan* Customer Service** 866-740-3881 8:30 a.m-5 p.m., Monday-Friday, except holidays	For questions regarding your benefits, claim inquiries and new *ID card* requests.
***State Health Plan* Enrollment and Billing Center** 855-442-6272 8 a.m.-5 p.m., Monday-Friday, except holidays	For questions regarding *member* eligibility and enrollment.
COBRA Administration and Individual Billing Services Customer Service 877-679-6272 8 a.m.-5 p.m., Monday-Friday, except holidays	For questions relating to premium payments for Retirees/COBRA/Surviving Spouses.
CVS Caremark Customer Service 888-321-3124 24 hours a day, 7 days per week	For questions regarding your *prescription* benefits, to obtain a preferred drug list, information on *prior authorizations*, refills, and more.
CVS Caremark Specialty Pharmacy 800-238-7828	For information regarding the specialty pharmacy services offered or to obtain *specialty medications*.
TelaDoc Available 7 days a week 800-TelaDoc (835-2362)	Quick answers to medical concerns.

PRIOR AUTHORIZATION (CERTIFICATION)

Certification 866-740-3881	To request *prior authorization* (*certification*) for medical claims for certain *out-of-network* or out-of-state services.
CVS Caremark - *Prior Authorization* Number 800-294-5979	To initiate a *prior authorization* request for a *prescription drug*.

CLAIMS FILING

Medical Claims Filing	Mail completed medical claims to: *State Health Plan* c/o *MedCost* PO Box 25307 Winston-Salem, NC 27114-5307
***Prescription Drug* Claims Filing**	Mail completed *prescription drug* claim forms to: CVS Caremark **ATTN: Direct Claims** P.O. Box 52136 Phoenix, Arizona, 85072-2136

APPEALS

Medical *Appeals* 866-740-3881	See "*Appeals* Correspondence" in "What If You Disagree With A Decision?"
Pharmacy Appeals	See "*Appeals* Correspondence" in "What If You Disagree With A Decision?"

ADDITIONAL RESOURCES

N.C. Department of State Treasurer **Retirement System Division** 325 North Salisbury Street Raleigh, NC 27603-1385 919-733-4191 or 877-733-4191 toll-free www.myncretirement.com	If you are a benefit recipient (*Retirees*, Beneficiaries, Disability recipients) and you have questions about your retirement benefits.

Tips for Getting the Most out of Your Health Care Benefits

Understand your health care plan

The more you know about your benefits, the easier it will be to take control of your health. Let the *State Health Plan* help you understand your plan and use it effectively through our customer friendly website **(www.shpnc.org and click on High Deductible Health Plan)**, toll free Customer Service line 866-740-3881), and your benefits booklet.

Manage your out-of-pocket costs by managing the locations in which you receive care

Generally speaking, care received in a *doctor's* office is the most cost effective for you, followed by *hospital outpatient* services. *Hospital* and *emergency* room services often bear the highest cost. In addition, remember that *in-network* care (services from a MedCost PPO Network participating *provider* who agrees to charge specified rates) will cost you less than similar care provided by an *out-of-network provider*. You should ask the receptionist whether the *provider's* office is *hospital* owned or operated, or provides *hospital* based services. This may subject your *medical services* to the *Outpatient* Services benefit, which requires *deductibles* and *coinsurance*. Know what your financial responsibility is before receiving care.

Save on prescription drugs

Print out the 2017 CVS Caremark standard formulary and take it with you when visiting your *doctor*. Ask your *doctor* to authorize a *generic* substitute whenever a *generic* is available. You will save money using *generics* since they typically have the lowest *cost*.

Pick a Primary Care Provider

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

Take charge of your health

Use a full range of tools to help maintain and improve your health and ensure the best outcomes for chronic conditions. The following tools are available and have qualified staff to work with you to maximize your health resources and your interactions with your *provider*. Learn more by visiting MedCost.com about the following resources:

- Teladoc 24/7 has access to consultations over the phone or online (where available) with board certified physicians for common conditions such as allergies, infections, etc.
- Health*e*Reports is an online provider search, cost and quality tool.
- Personal Care Management is customized health education and one-on-one nurse mentoring and coaching to encourage self-empowerment and self-management. Includes transitional care management.
- Personal Health Suite is an online suite of health and wellness tools and information, including Health and Productivity Assessment (HPA), Healthy Living Programs, personal health record/portal and health trackers.

Member Rights and Responsibilities

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

- Receive, upon request, information about your health benefit plan including its services and *doctors*, a benefits booklet, benefit summary and directory of *in-network* providers
- Receive courteous service from the State Health Plan and its representatives
- Receive considerate and respectful care from your *in-network providers*
- Receive the reasons for the denial of a requested treatment or health care service, including (upon request) an explanation of the Utilization Management criteria and treatment protocol used to reach the decision
- Receive (upon request) information on the procedure and medical criteria used to determine whether a procedure, treatment, facility, equipment, drug or device is investigational, *experimental* or requires prior approval
- Receive accurate, reader friendly information to help you make informed decisions about your health care
- Expect that measures will be taken to ensure the confidentiality of your health care information
- File a *grievance* and expect a fair and efficient *appeals* process for resolving any differences you may have with the coverage determination of your health benefit plan
- Be treated with respect and recognition of your dignity and right to privacy
- Voice complaints or *appeals* about the organization or the care it provides
- Make recommendations regarding the organization's members' rights and responsibilities policies

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

- Present your *ID card* each time you receive services
- Give your *doctor* permission to ask for medical records from other *doctors* you have seen. You will be asked to sign a transfer of medical records authorization form
- Read your benefits booklet and all other member materials
- Call State Health Plan Customer Service if you have a question or do not understand the material provided by them
- Follow the course of treatment prescribed by your *doctor*. If you choose not to comply, tell your *doctor*
- Provide complete information about any illness, accident or health care issues to the State Health Plan or its representatives and providers
- Make and keep appointments for non-*emergency* medical care. If it is necessary to cancel an appointment, give the *doctor's* office adequate notice
- Ensure any advance *certifications* have been received for all required services, including out-of-network services
- File claims for out-of-network services in a complete and timely manner
- Participate in understanding your health problems and the medical decisions regarding your health care

- Be considerate and courteous to MedCost PPO Network providers, their staff and State Health Plan representatives
- Notify your employer and the *State Health Plan* if you have any other group coverage
- Notify your employer and the *State Health Plan* of any changes regarding *dependents* and marital status as soon as possible
- Use *Member* Services to manage claims and related benefit issues
- Protect your *ID card* from unauthorized use
- Notify your employing unit and the *State Health Plan* of any address or phone number changes

Important Notices

According to the applicable provisions and limitations of North Carolina General Statutes Chapter 135, the State of North Carolina provides health care benefits to North Carolina teachers, state *employees*, retirees, members of boards and commissions, and their eligible *dependents*, as well as others eligible such as *employees* of certain counties and municipalities, firemen, rescue squad or *emergency* medical workers, members of the North Carolina Army and Air National Guard, and their eligible *dependents*. These provisions authorize the offering of an optional health plan, which is being offered in the form of a High Deductible Health Plan (HDHP) and which is outlined in this booklet.

The information contained in this booklet is supported by medical policies which are used as guides to make coverage determinations.

For specific detailed information, or medical policies, please call Customer Service at 866-740-3881. To obtain a copy of the General Statutes visit the North Caroline General Assembly at www.ncga.state.nc.us and search for Article 3B in Chapter 135.

Benefits Booklet

This benefits booklet describes the State Health Plan for Teachers and State *Employees* High Deductible Health Plan (HDHP) known as your health benefit plan. MedCost provides administrative services only and does not assume any financial risk or obligation with respect to claims.

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

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

If any information in this booklet conflicts with North Carolina state law or it conflicts with medical policies adopted under your health benefit plan, North Carolina law will prevail, followed by medical policies. If any of the MedCost medical policies conflict with the State Health Plan medical policies, the State Health Plan medical policies will be applied.

Introduction to the High Deductible Health Plan

Welcome to the State Health Plan's High Deductible Health Plan (HDHP), also referred to in this benefits booklet simply as your health benefit plan, or the HDHP. Your health benefit plan is offered under a MedCost PPO Network Plan administered by MedCost. Pharmacy benefits are administered CVS Caremark.

The State Health Plan has contracted with MedCost to use its MedCost PPO Network. As a member of the HDHP, you will enjoy quality health care from the MedCost PPO Network of health care providers and easy access to specialists.

Aviso Para Miembros Que No Hablan Ingles

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

High Deductible Health Plan (HDHP) Summary of Benefits

The following is a summary of your High Deductible Health Plan (HDHP) benefits. A more complete description of your benefits is found in "*Covered Services*." General exclusions may also apply. Please see "What is not Covered?" As you review the Summary of Benefits chart, keep in mind:

- There are no copayments with this plan.
- *Coinsurance* percentages shown in this section are the portion of the *allowed amount* that you pay.
- *Deductible* and *coinsurance* amounts are based on the *allowed amount*.
- Services applied to the *deductible* also count toward any visit or day maximums.
- If your benefit level for services includes *deductibles* and *coinsurance*, your provider may collect an estimated amount of these at the time you receive services.
- To receive *in-network* benefits, you must receive care from a MedCost PPO Network *in-network provider or affiliate*. However, in an *emergency*, or when *in-network providers* are not reasonably available as determined by MedCost's network provisions, you may also receive *in-network* benefits for care from an out-of-network provider. Please see “Out-of-Network Benefits” and "*Emergency* and Urgent Care Services" for additional information on *emergency* care. For questions regarding network providers call the State Health Plan Customer Service number given in “Who to Contact.”
- If you see an out-of-network provider, you will receive out-of-network benefits unless otherwise approved by the State Health Plan or its representative.
- Affordable Care Act (ACA) Preventive Care services are covered at 100% in-network so long as utilization management requirements (if applicable) are met.

Please note the list of in-network providers may change from time to time, so please verify that the provider is still in the MedCost PPO Network or before receiving care. A Provider locater is available through our website at www.shpnc.org by clicking High Deductible Health Plan or by calling Customer Service at the number given in "Who to Contact."

High Deductible Health Plan (HDHP) Summary of Benefits

	In-Network	*Out-of-Network**
Lifetime Maximum, Deductible, and Total Out-Of-Pocket Maximum		
Lifetime Maximum	Unlimited	Unlimited
Unlimited for all services, except where otherwise indicated or excluded.		
Deductible		
Individual, per *benefit period*	$5,000	$10,000
Family, per *benefit period*	$10,000	$20,000
Charges for the following do not apply to the *benefit period deductible*: • *Preventive Care* as defined by the *Affordable Care Act* • *In-Network* services do not apply to the *Out-of-Network deductible*.		
Total Out-of-Pocket Maximum		
Individual, per *benefit period*	$6,450	$12,900
Family, per *benefit period*	$12,900	$25,800
Charges over *allowed amounts* and charges for non*covered services* do not apply to the total out-of-pocket maximum. The total out-of-pocket maximum, which is the *deductible* plus the *coinsurance* you pay, is the total amount you will pay for *covered services*.		
Preventive Care		
Preventive Care Services	$0 (covered at 100%)	60% after deductible
Available in an office-based, outpatient, or ambulatory surgical setting, or urgent care center. Services include: routine physical exams and screenings, well-baby care, well-child care, well-woman care, immunizations, nutritional counseling (regardless of diagnosis), gynecological exams, cervical cancer screening, ovarian cancer screening, mammograms (regardless of diagnosis), colorectal screening, bone mass measurement, prostate-specific antigen tests, and newborn hearing screening. This benefit is only for services that indicate a primary diagnosis of preventive or wellness. Please visit the Plan's website at **www.shpnc.org** for the most up-to-date information on preventive care covered under federal law.		
Provider's Office		
Office visits for the evaluation and treatment of obesity are limited to a combined in- and out-of-network maximum of four visits per *benefit period*. Any visits in excess of these *benefit period maximum* are not *covered services*.		
Office Visit Services		
This includes: office surgery, x-rays, diagnostic imaging and lab tests.		
Primary Care Provider or Specialist	50% after *deductible*	60% after *deductible*
Therapy Services		
Short-Term Rehabilitative Therapies	50% after *deductible*	60% after *deductible*
Combined in- and out-of-network benefit maximums apply to chiropractic services, physical therapy and occupational therapy for 30 visits. 30 visits per *benefit period* for speech therapy. Any visits in excess of this *benefit period maximum* are not *covered services*.		
Other Therapies	50% after *deductible*	60% after *deductible*
Includes chemotherapy, dialysis and cardiac rehabilitation provided in the office.		
***Infertility* Services**		
Primary Care Provider or Specialist	50% after *deductible*	60% after *deductible*

Combined in- and out-of-network limit of 3 ovulation induction cycles and associated services per lifetime. Any services in excess of this lifetime limit are not *covered services*. Ovulation induction cycles associated with artificial means of conception are not covered.

Urgent Care Centers and *Emergency* Room		
Urgent Care Centers	50% after *deductible*	50% after *deductible*
***Emergency* Room Visit**	50% after *deductible*	50% after *deductible*
Ambulatory Surgical Center		
Ambulatory Surgical Services	50% after *deductible*	60% after *deductible*
Outpatient		
Outpatient Services	50% after *deductible*	60% after *deductible*

Includes physician services, *hospital* and *hospital*-based outpatient clinic services, outpatient diagnostic services, and therapy services including short-term rehabilitative therapies, and other therapies including dialysis. See provider's office for visit maximums.

Inpatient		
***Inpatient* Services**	50% after *deductible*	60% after *deductible*

Includes physician services, *hospital* and *hospital*-based services, and maternity delivery, prenatal and post-delivery care. If you are in a *hospital* as an *inpatient* at the time you begin a new *benefit period*, you may have to meet a new deductible for *covered services* from *doctors* or other professional providers.

Skilled Nursing Facility		
	50% after *deductible*	50% after *deductible*

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

Other Services	50% after *deductible*	50% after *deductible*

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

TelaDoc	$40 per visit

Mental Health and Substance Abuse Services		
Mental Health Office Services	50% after *deductible*	60% after *deductible*
Mental Health *Inpatient*/Outpatient Services	50% after *deductible*	60% after *deductible*
Substance Abuse Office Services	50% after *deductible*	60% after *deductible*
Substance Abuse *Inpatient*/Outpatient Services	50% after *deductible*	60% after *deductible*

Prescription Drugs

Prescription drug benefits are administered by CVS Caremark. See "*Prescription Drug Coinsurance and Benefits*" in "*Covered Services*" for more information.

	In-Network	***Out-of-Network****
Prescription Drugs (*Generic*, Brand-Name, and Specialty Drugs) **Diabetic Supplies**	50% after *deductible*	*60% after deductible*

Affordable Care Act Preventive Medications	0% *coinsurance*	60% after deductible
A list of *Affordable Care Act Preventive Medications* is listed on the Plan's website at www.shpnc.org under High Deductible Health Plan.		
NOTICE: All non-acute specialty drugs covered under the pharmacy benefit must be obtained through CVS Caremark Specialty Pharmacy.		

Certification Requirements

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

- Hospital admissions
- Hospital observation unit stays of more than 48 hours
- Transplant Services
- MRI, CT and PET scans performed Outpatient or in a Physician's office
- Dialysis

Certain prescription drugs require prior review and *certification* before they are covered. Your physician may call CVS Caremark at 800-294-5979 to initiate a *certification* request.

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

Who to Contact

***State Health Plan* Website**

To obtain information on Pharmacy benefits, search for a *provider*, obtain claim forms, obtain "proof of coverage" portability certificates, and more, visit the *State Health Plan* website at:

www.shpnc.org .....

***State Health Plan* Customer Service**

For questions relating to your benefits, claims inquiries, new *ID card* requests, or call:
State Health Plan Customer Service..... 866-740-3881

Enrollment and Billing Support Center

For questions related to eligibility and enrollment 855-442-6272

COBRA Administration and Individual Billing Services Customer Service

For questions relating to premium payments for *Retirees*/COBRA/Surviving *Spouses*.....877-679-6272

Pharmacy Benefit Manager

The current *Pharmacy Benefit Manager (PBM)* is:
CVS Caremark 888-321-3124
CVS Caremark Prior Authorization.....800-294-5979
CVS Caremark Specialty Pharmacy 800-238-7828

For information regarding the specialty pharmacy services offered or to obtain *specialty medications.*

Out of North Carolina Care

For assistance in obtaining care outside of North Carolina, South Carolina and Virginia including outside of the U.S., visit the MedCost website at www.medcost.com or call:.....866-740-3881

Prior Review

Some medical services require *prior review* and *certification* by the *State Health Plan* or its representative. The list of these services may change from time to time. Please visit our website at www.shpnc.org and click on High Deductible Health Plan or call *State Health Plan* Customer Service at the number given above for current information about which services require *prior review*. See "Prospective Review/*Prior Review*" in "Utilization Management" for information about the review process. To request *prior review*, call:
Prior Review (*Certification*) 866-740-3881

How the HDHP Works

The HDHP gives you the freedom to choose any health care provider — the main difference will be the cost to you depending on whether you see an *in-network* or out-of-network provider.

As a member of the HDHP, you enjoy quality health care from a network of health care providers and easy access to specialists. You also have the freedom to choose health care providers who do not participate in the MedCost PPO Network– the main difference will be the cost to you. Benefits are available for service from an in- or out-of-network provider that is recognized as eligible. For a list of eligible providers, please visit www.medcost.com, click "Locate a Provider and select "MedCost/MedCost ULTRA" or call Customer Service at the number listed in "Who to Contact."

Here's a look at how it works:

	In-Network	**Out-of-Network**
Type of Provider	*In-network providers* are health care professional and facilities that have contracted with MedCost, or a provider participating in the MedCost network. This may also include affiliate networks partnering with MedCost, Ancillary providers outside of North Carolina are considered *in-network* only if they contract directly with MedCost. *In-network providers* agree to limit charges for covered services to the *allowed amount*. Please note that *dentists* and orthodontists do not participate in the MedCost PPO Network *provider* network but there are a limited number of oral maxillofacial surgeons available *in-network*. The list of *in-network providers* may change from time to time. *In-network providers* are listed on the Plan's website at www.shpnc.org or call Customer Service at the number listed in "Who to Contact."	Out-of-network providers are not designated as MedCost PPO Network providers by MedCost. Also see "Out-of-Network Benefit Exceptions."
Usual, Customary and Reasonable (UCR) vs. Billed Amount	If the billed amount for a covered service is greater than the *allowed amount* you are not responsible for the difference. You only pay any applicable deductible, *coinsurance*, and noncovered expenses.	You may be responsible for paying any charges over the allowed amount, determined by UCR ,in addition to any applicable deductible, *coinsurance*, noncovered expenses and *certification* penalty amounts, if any.

Referrals	The Plan does not require you to obtain any referrals.	The Plan does not require you to obtain any referrals.
After-hours Care	If you need non*emergency services* after your provider's office has closed, please call your provider's office for their recorded instructions.	
Care Outside of North Carolina, South Carolina , and Virginia	Your *ID card* gives you access to participating providers outside the state of North Carolina and benefits are provided at the *in-network* benefit level when they meet the defined criteria.	If you are in an area that has participating providers and you choose a provider outside the network, you will receive the lower out-of-network benefit. Also see "Out-of-Network Benefit Exceptions."
Prior Review	*In-network providers* in North Carolina, South Carolina, or Virginia will request prior review when necessary. If you receive services outside of North Carolina, South Carolina, and Virginia (even if you see an *in-network provider*), you are responsible for ensuring that you or your provider requests prior review. For *inpatient* and certain outpatient services, either in or outside of North Carolina, South Carolina and Virginia contact MedCost to request prior review and receive *certification*. Prior review is not required for an *emergency* or for an *inpatient hospital* stay for 48 hours after a vaginal delivery or 96 hours after a cesarean section.	You are responsible for ensuring that you or your out-of-network provider requests prior review. Failure to request prior review and obtain *certification* will result in full denial of benefits. Prior review is not required for an *emergency* or for an *inpatient hospital* stay for 48 hours after a vaginal delivery or 96 hours after a cesarean section.
Filing Claims	*In-network providers* in North Carolina are responsible for filing claims directly with MedCost.	You may have to pay the out-of-network provider in full and submit your own claim to MedCost. Mail claims in time to be received within 18 months of the date the service was provided. Claims not received within 18 months from the service date will not be covered, except in the absences of legal capacity of the member.

Out-Of-Network Benefit Exceptions

This Plan has entered into an agreement with certain Hospitals, Physicians and other health care providers which are called Network Providers. Because these Network Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees. Therefore, when a Plan Participant uses a Network Provider, he or she will receive a higher payment from the Plan than when an Out-of-Network Provider is used. It is the Plan Participant's choice as to which Provider to use.

Under the following circumstances, the Network payment will be made for certain out of network services:

- If a Plan Participant has no choice of Network Providers in the specialty that the Plan Participant is seeking within the Network service area. Travel greater than 30 miles is considered "outside of the service area."
- If a Plan Participant is out of the Network service area and has a Medical Emergency requiring immediate care.
- If a Plan Participant receives the services of an Out-of-Network Provider in a Network facility, when the Plan Participant is not given the opportunity to specify or request the services of a Network Provider.
- If a Covered Dependent to age 26 does not reside in Network service area and seeks care from a provider located where such Covered Dependent is domiciled.

Carry Your Identification Card

Your *ID card* identifies you as a MedCost PPO Network HDHP member. Be sure to carry your *ID card* with you at all times and present it each time you seek health care. Each subscriber will receive two ID cards. Only subscribers and their enrolled eligible *dependents* may seek services with their card. The State Health Plan may consider unauthorized use of this card to be fraud. To find out how to report fraud go to "Report Suspected Abuse and Fraud" in the Contact Us section of the State Health Plan's website at www.shpnc.org.

For *ID card* requests, please visit www.medcost.com or call Customer Service at the number listed in "Who to Contact."

The Role of A Primary Care Provider (PCP)

A Primary Care Provider (PCP) can help you manage your health and make decisions about your health care needs. It is important for you to maintain a relationship with a PCP. If you change PCPs, be sure to have your medical records transferred, especially immunization records, to provide your new *doctor* with your medical history. PCPs are trained to deal with a broad range of health care issues and can help you to determine when you need a specialist.

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

You may be eligible to elect continuing coverage for a period of time if, at the time of the *provider's* termination, you meet the eligibility requirements. See Continuity Of Care in "*Utilization Management*." Please contact the *State Health Plan* Customer Service at the number in "Who to Contact" for additional information.

Understanding Your Share of the Cost

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

Deductible	The dollar amount you must incur for covered services in a *benefit period* before benefits are payable under the Plan. The *deductible* does not include *coinsurance*, charges in excess of the *allowed amount or UCR*, amounts exceeding any maximum, or expenses for noncovered services. Your *deductible* amount is determined by your type of coverage. If one or more *dependents* are covered, all covered family members contribute to the same family *deductible*. Once the family *deductible* is reached, it is met for all covered family members. However, the family *deductible* must be met before benefits are payable by the Plan for any individual in the family unless otherwise noted. Amounts applied to your out-of-network *deductible* are credited to your *in-network deductible*. However, amounts applied to your *in-network deductible* are not credited to your out-of-network *deductible*.
Coinsurance	Your share of the cost of a covered health service, after you have met your *benefit period deductible*. This is stated as a percentage of the *allowed amount or UCR*.
Total out-of-pocket maximum	The total out-of-pocket maximum is the dollar amount you pay for covered services in a *benefit period* before the Plan pays 100%. Your total out-of-pocket maximum is determined by your type of coverage. If one or more *dependents* are covered under the HDHP, all covered family members contribute to the same family out-of-pocket maximum. When either the family *in-network* or out-of-network total out-of-pocket maximum is met, the family total out-of-pocket maximum is met for all covered family members. Charges for *in-network* services apply to the *in-network* total out-of-pocket maximum. However, charges for out-of-network services apply to both the out-of-network and the *in-network* total out-of-pocket maximum.

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

Covered Services

The HDHP covers only those services that are medically necessary. Also keep in mind as you read this section:

Covered services described on the following pages are available at both the *in-network* and out-of-network benefit levels, when medically necessary, unless otherwise noted. If you have a question about whether a certain health care service is covered, and you cannot find the information in "Covered Services," see "Summary of Benefits" or call State Health Plan Customer Service at the number listed in "Who to Contact."

Also keep in mind as you read this section:

- Certain services require prior review and *certification* in order for you to avoid a denial of your services. General categories or services are noted below requiring prior review. Please see "Prior Review/Pre-Service" in "Utilization Management" for information about the review process, and visit our website at www.shpnc.org or call Customer Service to ask whether a specific service requires prior review and *certification*.
- Exclusions and limitations may apply to your coverage. Service-specific exclusions are stated along with the benefit description in "Covered Services." Exclusions that apply to many services are listed in "What Is Not Covered?" To understand the exclusions and limitations that apply to each service, read "Covered Services," "Summary of Benefits" and "What Is Not Covered?"
- You may receive, upon request, information on the procedure and medical criteria used by the State Health Plan to determine whether a procedure, treatment, facility, equipment, drug or device is medically necessary and eligible for coverage, investigational or *experimental*, or requires prior review and *certification* by the State Health Plan. You may contact the State Health Plan Customer Service at the number listed in "Who to Contact" to request this information.

Office Services

The care you receive as part of an office visit, electronic visit, or house call is covered, except as otherwise noted in this benefit booklet. Some providers may get ancillary services, such as laboratory services, medical equipment or supplies or specialty drugs from third parties. In these cases, you may be billed directly by the ancillary provider. Benefit payments for these services will be based on the type of ancillary provider, its network status, and how the services are billed.

Office Services Exclusions

- Certain self-injectable prescription drugs that can be self-administered. The list of these excluded drugs may change from time to time. In addition, certain specialty medications administered by injection or infusion may also be excluded. In these instances, the specialty medication must be obtained from CVS Caremark Specialty Pharmacy. See our website at www.shpnc.org and click High Deductible Health Plan or call State Health Plan Customer Service for a list of these drugs excluded in the office.

Affordable Care Act (ACA) Preventive Services

The Plan covers ACA recommended preventive medical care services and medications that can help you stay safe and healthy.

Under the ACA, you can receive certain covered preventive care services from an *in-network provider* in an office-based, outpatient, or ambulatory surgical setting, or urgent care center, at no cost to you. Please note, this benefit is only for services that indicate a primary diagnosis of preventive or wellness and which are identified by recent federal legislation as being eligible. Services, such as diagnostic lab tests, that

may be delivered with a preventive care service are not considered preventive care. These services and services that do not include a primary diagnosis of preventive or wellness will be subject to your *in-network* benefit level for the location where services are received. In addition, the Plan may use reasonable medical management to determine coverage limitations.

Please visit the Plan's website at www.shpnc.org or call Customer Service at the number in "Who to Contact" for the most up-to-date information on preventive care that is covered under federal law, including any limitations that may apply.

ACA preventive medications are also covered at no cost to you with a prescription if you meet the coverage criteria and filled at an in-network pharmacy. The ACA Medication List can be viewed at www.shpnc.org under High Deductible Health Plan. Preventive care covered services include:

Nutritional Counseling

The Plan covers nutritional counseling visits from in or out of network providers, which may include counseling specific to achieving or maintaining a healthy weight.

Routine Physical Examinations and Screenings

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

Well-Baby and Well-Child Care

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

Well-Woman Care

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

Contraceptive Methods

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

Contraceptive Methods Exclusions

- Male contraceptives

Immunizations

Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) are covered.

Immunizations Exclusion

- Immunizations required for occupational hazard or international travel, unless specifically covered by the Plan.

Bone Mass Measurement Services

The Plan covers scientifically proven and approved bone mass measurement for the diagnosis and evaluation of osteoporosis or low bone mass during any 23-month period for certain qualified

individuals only. Additional follow-up bone mass measurement tests will be covered if medically necessary. Please note that bone mass measurement tests will be covered under your diagnostic benefit (not your preventive care benefit) if the claim for these services indicates a primary diagnosis of something other than preventive or wellness. Your diagnostic benefit will be subject to your *in-network* benefit level for the location where services are received.

Qualified individuals include members who have any one of the following conditions:

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

Colorectal Screening

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

Gynecological Exam and Cervical Cancer Screening

The cervical cancer screening benefit includes the examination and laboratory tests for early detection and screening of cervical cancer, and a *doctor's* interpretation of the lab results. Coverage for cervical cancer screening includes Pap smear screening, liquid-based cytology, and human papillomavirus detection, and shall follow the American Cancer Society guidelines or guidelines adopted by the North Carolina Advisory Committee on Cancer Coordination and Control.

Newborn Hearing Screening

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

Ovarian Cancer Screening

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

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

Prostate Screening

One prostate-specific antigen (PSA) test or an equivalent serological test will be covered per member per *benefit period*. Additional PSA tests will be covered if recommended by a *doctor*.

Screening Mammograms

The Plan provides coverage for one baseline mammogram for any member between the ages of 35 and 39. Beginning at age 40, one screening mammogram will be covered per member per *benefit period*, along with a *doctor's* interpretation of the results. More frequent or earlier mammograms will be covered as recommended by a *doctor* when a member is considered at risk for breast cancer.

A member is "at risk" if she:

- has a personal history of breast cancer
- has a personal history of biopsy-proven benign breast disease
- has a mother, sister, or daughter who has or has had breast cancer, or
- has not given birth before the age of 30.

Diagnostic Services

Diagnostic procedures such a laboratory studies, radiology services and other diagnostic testing, which may include electroencephalograms (EEGs), electrocardiograms (ECGs), Doppler scans and pulmonary function tests (PFTs), help your *doctor* find the cause and extent of your condition in order to plan for your care. Multiple radiology or imaging procedures on the same date of service and/or during the same patient encounter may not be eligible for separate reimbursement.

Certain diagnostic imaging procedures, such as CT scans, PET scans and MRIs, require prior review and *certification* when received in an outpatient setting or physician's office or services will not be covered.

Your *doctor* may refer you to a freestanding laboratory, radiology center, or a sample collection device for these procedures. Separate benefits for interpretation of diagnostic services by the attending *doctor* are not provided in addition to benefits for that *doctor's* medical or surgical service, except as otherwise determined by the Plan.

Diagnostic Services Exclusion

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

Emergency Care

The Plan provides benefits for *emergency services*.

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

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

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

What to do in an Emergency

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

Benefits for services in the *emergency* room

Situation	Benefit
You go to the *emergency* room for a nonemergency condition.	This is covered as an outpatient service.
You go to an *in-network hospital emergency* room for an *emergency* condition.	Applicable *coinsurance*. Prior review and *certification* are not required.
You go to an out-of-network *hospital emergency* room for an *emergency* condition.	Benefits paid at the *in-network coinsurance* level and based on the billed amount or UCR. You may be responsible for your out-of-network *deductible* if applicable, and for charges billed separately which are not eligible for additional reimbursement. You may be required to pay the entire bill at the time of service and file a claim. Prior review and *certification* are not required.
You are held for observation.	Outpatient benefits may apply to all covered services received in the *emergency* room and during observation. Observation beyond 48 hours is considered an inpatient admission and requires precertification.
You are admitted to the *hospital* from the ER following *emergency services*.	*Inpatient hospital* benefits apply for all covered services received in the *emergency* room and during hospitalization. Prior review and *certification* are required for *inpatient* hospitalization and other selected services following *emergency services* (including screening and stabilization) in order to avoid a penalty. You may need to transfer to an *in-network hospital* once your condition is stabilized in order to continue receiving *in-network* benefits.
You get follow-up care (such as office visits or therapy) after you leave the ER or are discharged.	Use *in-network providers* to receive *in-network* benefits. Follow-up care related to the *emergency* condition is not considered an *emergency*.

Urgent Care

The Plan also provides benefits for urgent care services. When you need urgent care, you should call your Primary Care Provider (PCP), a specialist or go to an urgent care provider.

Family Planning

Maternity Care

Maternity care, which includes prenatal care, labor and delivery, and post-delivery care, is available to all members. However, maternity benefits for *dependent children* cover only the treatment for *complications of pregnancy*. Coverage for breastfeeding counseling and certain breast pumps for

pregnant or postpartum members are covered under your preventive care benefit. Purchase is limited to one per pregnancy and purchase from a retail store is not covered.

	Mom	Newborn	Payment
Prenatal care	Care related to the pregnancy before birth.		*Coinsurance* and any applicable *deductible* apply.
Labor & delivery services	No prior review required for *inpatient hospital* stay for 48 hours after a vaginal delivery or 96 hours after a cesarean section. Mothers choosing a shorter stay are eligible for a home health visit for post-delivery follow-up care if received within 72 hours of discharge.	No prior review required for *inpatient* well baby care for 48 hours after a vaginal delivery or 96 hours after a cesarean section. Benefits include newborn hearing screening ordered by a *doctor* to determine the presence of permanent hearing loss. (Please see preventive care in "Summary of Benefits.")	*Deductible* and *coinsurance* apply. If adding the baby changes your policy from *employee* to family coverage, the family *benefit period deductible* applies.
Post-delivery services	All care for the mother after baby's birth that is related to the pregnancy. In order to avoid a penalty, prior review and *certification* are required for *inpatient* stays extending beyond 48/96 hours.	After the first 48/96 hours, whether *inpatient* (sick baby) or outpatient (well baby), the newborn must be enrolled for coverage as a *dependent child*, according to the rules in "When Coverage Begins Ends." For *inpatient* services following the first 48/96 hours, prior review and *certification* are required in order to avoid a penalty.	

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

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

nurse midwife or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

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

In addition, a plan or issuer may not, under federal law, require that a doctor or other health care provider obtain certification for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain certification. For information on certification, contact State Health Plan Customer Service at the number given in "Who to Contact."

Complications of Pregnancy

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

Complications of Abortion

Benefits for complications of abortion are available to all subscribers and enrolled spouses of subscribers.

Infertility Services

Benefits are provided for certain services related to the diagnosis, treatment and correction of any underlying causes of *infertility* for all members except *dependent children*.

There is a limit of 3 ovulation induction cycles and associated services per lifetime. Ovulation induction cycles associated with artificial means of conception are not covered. See “Summary of Benefits” for more information on this limitation. For information about coverage of prescription drugs for *infertility*, see “Prescription Benefits.”

Sexual Dysfunction Services

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

Sexual Dysfunction Exclusion

Prescription drugs related to sexual dysfunction are not covered. See Prescription Drug Exclusions.

Sterilization

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

Family Planning Exclusions

- Artificial means of conception, including, but not limited to, artificial insemination, in vitro fertilization (IVF), ovum or embryo placement, intracytoplasmic sperm injection (ICSI), and gamete intrafallopian tube placement (GIFT) and associated services
- Donor eggs and sperm
- Surrogate mothers
- Care or treatment of the following:
  - Maternity for *dependent children*
  - *Infertility* and sexual dysfunction services for *dependent children*

  - Reversal of sterilization.
- Abortions except for subscribers and enrolled spouses of the subscribers when the life of the mother would be endangered if the unborn child was carried to term or the pregnancy is the result of rape or incest.
- Benefits for *infertility* or reduced fertility that result from a prior sterilization procedure or when *infertility* or reduced fertility is the result of a normal physiological change such as menopause.
- Any drugs associated with artificial reproductive technology.

Facility Services

Benefits are provided for:

- Outpatient services received in a *hospital*, a *hospital* based facility, nonhospital facility or a *hospital*-based or outpatient clinic.

- *Inpatient* services received in a *hospital* or nonhospital facility. You are considered an *inpatient* if you are admitted to the *hospital* or nonhospital facility as a registered bed patient for whom a room and board charge is made or are in observation longer than 48 hours. Your *in-network provider* is required to use the MedCost PPO Network *hospital* where he/she practices, unless that *hospital* cannot provide the services you need. If you are admitted before the *effective date*, benefits will not be available for services received prior to the *effective date*. Take home drugs are covered as part of your prescription drug benefit.

  Prior review must be requested and c*ertification* must be obtained in advance for *inpatient* admissions to avoid a penalty, except for maternity deliveries and *emergencies*. See "Maternity Care," if applicable, and "*Emergency* Care."

- Surgical services received in an *ambulatory surgical center*

- Covered services received in a skilled nursing facility; skilled nursing *facility services* are limited to a combined in- and out-of-network day maximum per *benefit period*.

  Prior review must be requested and *certification* must be obtained in advance to avoid a penalty. See "Summary of Benefits."

Other Services

***Ambulance* Services**

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

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

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

  Non-*emergency* air *ambulance* requires verification of medical necessity or services will not be covered. Provider must contact State Health Plan Customer Service at the number given in "Who to Contact?"

Ambulance Service Exclusion

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

Morbid Obesity and Bariatric Surgery

Morbid Obesity is a condition of constant weight gain that is uncontrollable and it is a potential threat to life. Morbid Obesity is characterized by a weight that is at least 100 pounds over, or twice the ideal weight for the frame, age, height, and sex specified in the most recently published Metropolitan Life Insurance table (1983).

There are multiple surgeries based on two designs intended to treat Morbid Obesity:
Malabsorptive procedures (alteration of food absorption), or
Gastric restrictive procedures (alteration in the volume of food consumed)

Requirements and Limitations
Eligibility for Coverage
Dependent children are NOT eligible for this benefit.

Guidelines of Coverage
Approved surgery for Morbid Obesity for covered Employees and Spouses is covered by the Plan when it is determined to be Medically Necessary because the guidelines and medical criteria explained below are met.

The State Health Plan covers bariatric surgery using criteria for the procedure as outlined below when ALL of the following criteria are met:

The individual is at least 18 years of age or has reached full expected skeletal growth AND has evidence of EITHER of the following:

- A BMI (Body Mass Index) greater than 40, or
- A BMI (Body Mass Index) 35 - 39.9 with at least one clinically significant co-morbidity, including but not limited to, cardiovascular disease, Type 2 diabetes, hypertension, coronary artery disease, or pulmonary hypertension.
- Failure of medical management including evidence of active participation within the last two (2) years in a weight-management program that is supervised either by a physician or a registered dietician for a minimum of six (6) months without significant gaps in participation. The weight management program must include documentation of **ALL** of the following components:

  (1) Weight; **(2)** Current dietary program; and **(3)** Physical activity (e.g., exercise program).

For individuals with long-standing morbid obesity, participation in a program within the last five (5) years is sufficient if reasonable attendance in the weight management program over an extended period of time of at least six (6) months can be demonstrated. Physician supervised programs consisting exclusively of pharmacological management are not sufficient to meet this requirement.
A thorough multidisciplinary pre-operative evaluation within the previous twelve (12) months which includes the following:

- An evaluation by a bariatric surgeon recommending surgical treatment, including a description of the proposed procedure(s) and all of the associated current CPT codes
- A separate medical evaluation from a physician other than the surgeon recommending the surgery that includes a medical clearance for bariatric surgery

    - Evaluation and counseling by a mental health provider that includes:
        - Eating behaviors
        - Stress management
        - Social functioning
        - Levels of depression
        - Cognitive abilities
        - Self-esteem
        - Other psychological diagnoses or personality traits that may influence treatment
  - Ability and readiness to comply with required lifestyle changes and procedure follow-up / social support
  - A nutritional evaluation by a physician or registered dietician
- The surgical procedure must be performed at a approved network FACILITY. There are no Plan benefits for the surgical procedure if it is performed elsewhere. The Plan does not cover dietary control counseling or weight management programs.
- Regular monitoring must be included with follow-up programs for at least five (5) years.

Note – Surgical removal of redundant skin and fat folds after significant post- surgical weight loss is usually considered cosmetic and is NOT covered. In patients with stable weight following surgery who experience recurrent, severe intertrigo / cellulitis that requires oral antibiotic treatment and is not responsive to conservative treatment (including topical anti-infective medications and adequate hygiene), coverage MAY be considered.

Approved Bariatric Surgery Procedures

When the criteria noted above for bariatric surgery have been met, North Carolina Baptist Hospital will cover any of the following open or laparoscopic bariatric surgery procedures:

- Roux-en-Y gastric bypass
- Laparoscopic adjustable silicone gastric banding (e.g., LAP-BAND ®, REALIZE™)
- Biliopancreatic diversion with duodenal switch (BPD/DS) for individuals with a BMI (Body Mass Index) greater than 50
- Vertical banded gastroplasty

Note – Adjustment of a silicone gastric banding is considered Medically Necessary to control the rate of weight loss and/or treat symptoms secondary to gastric restriction following a Medically Necessary adjustable silicone gastric banding procedure.

Note – Prophylactic vena cava filter placement at the time of the bariatric surgery is considered as Medically Necessary for individuals who are considered to be high risk for venous thromboembolism (VTE).

The following procedures are NOT COVERED:

- Roux-en-Y gastric bypass combined with simultaneous gastric banding
- Biliopancreatic diversion (BPD) without duodenal switch (DS)
- Gastric electrical stimulation (GES) or gastric pacing (e.g., Enterra™ Therapy)
- Gastroplasty (stomach stapling)
- Intestinal bypass (jejunoileal bypass)
- Intragastric balloon Loop gastric bypass

- Mini-gastric bypass Natural Orifice Transluminal Endoscopic Surgery (NOTES™) (e.g., StomaphyX™) (endoscopic oral-assisted procedures)
- Vagus nerve blocking
- Vagus nerve stimulation

Repeat Bariatric Surgery or Reoperation

The Plan covers surgical reversal (i.e., takedown) of bariatric surgery as Medically Necessary when the individual develops complications from the original surgery such as stricture or obstruction.

The Plan covers revisions of a previous bariatric surgical procedure or conversion to another Medically Necessary procedure due to inadequate weight loss as Medically Necessary when ALL of the following are met:

- The surgical procedure must be performed at a MedCost network facility or at another facility approved by the State Health Plan. There are no Plan benefits for the surgical procedure if it is performed elsewhere.
- There must be evidence of full compliance with the post-operative dietary and exercise program.
- There must be documented technical failure of the original bariatric surgical procedure indicated on an upper gastrointestinal series (UGI) or esophagogastroduodenoscopy (EGD) indicated that the individual has failed to achieve adequate weight loss, which is defined as failure to lose at least 50% of the excess body weight or failure to achieve body weight within 30% of ideal body weight at least two (2) years following the original surgery.
- The procedure is one of the previously listed approved procedures.

Note – Upper gastrointestinal endoscopy performed in conjunction with a bariatric surgery procedure to confirm a surgical anastomosis or to establish anatomical landmarks is considered an integral part of the more complicated surgical procedure and is not separately reimbursable.

Blood

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

Blood Exclusion

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

Clinical Trials

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

- Involve determinations by treating physicians, relevant scientific data and opinions of relevant medical specialists

- Be approved by centers or groups funded by the National Institutes of Health, the Food and Drug Administration (FDA), the Centers for Disease Control and Prevention, the Agency for Health Care Research and Quality, or the Department of Defense or the Department of Veterans Affairs
- Be conducted in a setting and by personnel of high expertise based on training, experience and patient volume.

Clinical Trials Exclusions

- Non-health care services, such as services provided for data collection and analysis
- Investigational drugs and devices and services that are not for the direct clinical management of the patient.

Dental Treatment Covered Under Your Medical Benefit

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

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

Replacement of teeth lost as a direct result of chemotherapy or radiation

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

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

When any of the conditions listed above require surgical correction, benefits for surgery will be subject to medical necessity review to examine whether or not the condition resulted in functional impairment. Examples of functional impairment include an impairment that affects speech or the ability to eat, or injury to soft tissue of the mouth. In special cases, benefits are provided only for anesthesia and facility charges related to dental procedures performed in a *hospital* or *ambulatory surgical center*. This benefit is only available to *dependent children* below the age of nine years, persons with serious mental or physical conditions and persons with significant behavioral problems. The treating provider must certify that the patient's age, condition or problem requires hospitalization or general anesthesia in order to safely and effectively perform the procedure. Other dental services, including the charge for surgery, are not covered unless specifically covered by the Plan.

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

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

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

Dental Treatment Excluded Under Your Medical Benefit

Treatment for the following conditions:

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

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

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

Diabetes Related Services

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

Durable Medical Equipment

Benefits are provided for *durable medical equipment* and supplies required for operation of equipment when prescribed by a *doctor*. Equipment may be purchased or rented at the discretion of the State Health Plan or its representative. The State Health Plan provides benefits for repair or replacement of the covered equipment. Benefits will end when it is determined that the equipment is no longer medically necessary or the maximum rental limit has been reached. In order to receive the *in-network* benefit, *durable medical equipment* must be provided by a participating supplier. It is important that you or your provider verify that the *durable medical equipment* supplier is an *in-network provider*. Most out-of-state suppliers are out-of-network providers.

All durable medical equipment is subject to medical necessity. If you have questions contact the State State Health Plan Customer Service at the number given in "Whom Do I Call?"

Durable Medical Equipment Exclusions

- Appliances and accessories that serve no medical purpose or that are primarily for comfort or convenience
- Repair or replacement of equipment due to abuse or desire for new equipment.

Hearing Aids

The Plan provides coverage for medically necessary hearing aids and related services that are ordered by a *doctor* or an audiologist for each member under the age of 22. Benefits are provided for one hearing aid per hearing-impaired ear, and replacement hearing aids when alterations to an existing hearing aid are not adequate to meet the member's needs. This benefit is limited to once every 36 months. Reimbursement will be limited to the usual, customary and reasonable (UCR) amount and you may be billed by the provider for charges greater than the UCR reimbursement. Benefits are also provided for the evaluation, fitting, and adjustments of hearing aids or replacement of hearing aids, and for supplies, including ear molds.

Home Health Care

Home health care services are covered when ordered by a *doctor* for a member who is *homebound* due to illness or injury, and you need part-time or intermittent skilled nursing care from a registered nurse (RN) or licensed practical nurse (LPN) and/or other skilled care services like short-term rehabilitative therapies. Usually, a home health agency coordinates the services your *doctor* orders

for you. Services from a home health aide may be eligible for coverage only when the care provided supports a skilled service being delivered in the home.

Home health care is subject to medical necessity or services will not be covered.

Home Health Care Exclusions

- Dietitian services or meals
- Homemaker services, such as cooking and housekeeping
- Services that are provided by a close relative or a member of your household.

Home Infusion Therapy Services

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

Hospice Services

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

Hospice Services Exclusions

- Homemaker services, such as cooking, housekeeping, food or meals.

Lymphedema-Related Services

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

Lymphedema-Related Services Exclusion

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

Medical Supplies

Coverage is provided for medical supplies. Your benefits are based on where supplies are received, either as part of your medical supplies benefit or prescription drug benefit.

To obtain medical supplies and equipment, please find a provider on our website at www.medcost.com or call Customer Service.

Medical Supplies Exclusion

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

Orthotic Devices

Orthotic devices, which are rigid or semi-rigid supportive devices that restrict or eliminate motion of a weak or diseased body part, are covered if medically necessary and prescribed by a provider. Foot orthotics may be covered only when custom molded to the patient. Orthotic devices for correction of

positional plagiocephaly, including dynamic orthotic cranioplasty (DOC) bands and soft helmets, are subject to a benefit limit. Please see “Lifetime Maximums” in the "Summary of Benefits."

Orthotic Devices Exclusions

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

Private Duty Nursing

The Plan provides benefits for medically necessary private duty services of an RN or LPN when ordered by your *doctor* for a member who is receiving active care management. Private duty nursing provides more individual and continuous skilled care than can be provided in a skilled nursing visit through a home health agency.

Private Duty Nursing Exclusion

- Services provided by a close relative or a member of your household.
- Services provided while the patient is confined inpatient.

Prosthetic Appliances

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

Repair or replacement of a device will not be made more than once every 5 years, unless it is determined Medically Necessary due to a pathological change, such as growth, shrinkage, or atrophy that results in improper fit. Replacements will not be made because the device is lost, misplaced, or stolen.

Prosthetic Appliances Exclusions

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

Surgical Benefits

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

Cosmetic surgery is not covered except as specifically identified.

Multiple surgical procedures performed on the same date of service and/or during the same patient encounter, may not be eligible for separate reimbursement. When multiple procedures are performed during the same operative session, benefits will be based on Medically Necessary services. Allowable expenses will be determined based on the complexity of the procedures. 100% of the allowable expense for the most complex will be considered and 50% of the allowable expense or billed charge will be considered for each additional procedure. An assistant surgeon will be considered eligible when Medical

Necessity has been determined based on standard practices. Benefits will be based on 20% of the allowable expense or billed charge.

Anesthesia

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

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

Mastectomy Benefits

Under the Women's Health and Cancer Rights Act of 1998, the Plan provides for the following services related to mastectomy surgery:

- Reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the nondiseased breast to produce a symmetrical appearance without regard to the lapse of time between the mastectomy and the reconstructive surgery
- Prostheses and physical complications of all stages of the mastectomy, including lymphedemas.

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

The benefits described above are subject to the same applicable *deductibles* and *coinsurance* and limitations as applied to other medical and surgical benefits provided under the Plan.

Mastectomy Exclusions:
Prophylactic mastectomy and hysterectomy surgeries. Prophylactic mastectomy and hysterectomy surgeries other than those specifically covered, Reconstructive Surgery may be excluded and are subject to medical necessity and require review through medical consulting for coverage determination.

Temporomandibular Joint (TMJ) Services

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

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

Temporomandibular Joint (TMJ) Services Exclusions

- Treatment for periodontal disease
- Dental implants or root canals
- Crowns and bridges
- Orthodontic braces
- Occlusal (bite) adjustments
- Extractions.

Therapies

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

Short-Term Rehabilitative Therapies

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

- Occupational therapy and/or physical therapy up to a one-hour session per day
- Speech therapy.

Other Therapies

The Plan covers:

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

Therapy Exclusions

- Applied Behavior Analysis (ABA) therapy
- Cognitive therapy
- Speech therapy for stammering or stuttering
- Group classes for pulmonary rehabilitation.

Transplants

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

MedCost Health Management must be notified PRIOR to a Transplant evaluation.

All Transplant Services MUST be precertified. Failure to precertify may result in a 50% reduction in benefits.

All Transplant Services REQUIRE Case Management. If you choose not to participate in Case Management benefits will be reduced by 50%.

Human organ and tissue transplants are covered except those classified as "Experimental and/or Investigational."

Travel and lodging will be paid by the Plan for the patient and one companion or caregiver (for both parents or for both guardians if the patient is a minor), up to a Lifetime maximum of $10,000. Travel must be to a Designated Transplant Provider that is more than 60 miles from the patient’s home.

Charges for the following are not covered:

- Mileage for sightseeing or visits to friends / relatives.
- Alcohol.
- Clothing.
- Entertainment (i.e., movies or rentals, visits to museums, mileage for sightseeing, compact discs, games, etc.).
- Expense for persons other than the patient and his/her covered companion or caregiver.
- Expenses for lodging when member or companion is staying with a relative or friend.
- Gift cards.
- Groceries (i.e., grocery stores, Wal-Mart, K-Mart, etc.).
- Laundry service / supplies.
- Non-legible receipts (i.e., food or lodging).
- Paper products (i.e., paper plates, paper towels, napkins, etc.).
- Parking fees incurred other than at hotel/motel or hospital.
- Personal care services (1.e., massage, spa, hair care services, etc.)
- Personal hygiene items (i.e., toothbrush, deodorant, etc.).
- Personal services (i.e., child care, house sitting, kennel care, etc.).
- Shoes / slippers.
- Souvenirs (i.e., T-shirts, sweatshirts, toys, etc.).
- Telephone bills / calls / phone cards.
- Tobacco.
- Valet parking.

The Plan will pay for tissue typing, surgical procedure, storage expenses and transportation costs directly related to the donation of a human organ or human tissue used in a covered Transplant procedure. If the donor has other coverage, his or her plan will pay first. The benefits under this Plan will be reduced by those payable under the donor's plan.

If a Plan Participant wishes to be a donor, the Plan will cover donor charges only if the recipient is also a Plan Participant.

Charges for the following are not covered:

- Mileage for sightseeing or visits to friends / relatives.
- Alcohol.
- Clothing.
- Entertainment (i.e., movies or rentals, visits to museums, mileage for sightseeing, compact discs, games, etc.).
- Expense for persons other than the patient and his/her covered companion or caregiver.
- Expenses for lodging when member or companion is staying with a relative or friend.
- Gift cards.
- Groceries (i.e., grocery stores, Wal-Mart, K-Mart, etc.).
- Laundry service / supplies.
- Non-legible receipts (i.e., food or lodging).
- Paper products (i.e., paper plates, paper towels, napkins, etc.).
- Parking fees incurred other than at hotel/motel or hospital.
- Personal care services (1.e., massage, spa, hair care services, etc.)
- Personal hygiene items (i.e., toothbrush, deodorant, etc.).
- Personal services (i.e., child care, house sitting, kennel care, etc.).
- Shoes / slippers.
- Souvenirs (i.e., T-shirts, sweatshirts, toys, etc.).
- Telephone bills / calls / phone cards.
- Tobacco.

- Valet parking.

Mental Health and Chemical Dependency Benefits

The Plan provides benefits for the treatment of mental illness and *chemical dependency* by a *hospital*, *doctor* or other provider.

Office Visit Services

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

- Evaluation and diagnosis
- Medically necessary biofeedback and neuropsychological testing
- Individual and family counseling
- Group therapy.

Outpatient Services

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

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

Inpatient Services

Covered *inpatient* treatment services also include:

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

Prior review must be requested and *certification* must be obtained in advance for *in or out-of-network inpatient* services or services will not be covered, except for *emergencies*.

Mental Health and Chemical Dependency Services Exclusions

- Care for conditions not classified as psychiatric, emotional, or substance abuse illnesses
- Psychoanalysis
- Counseling with relatives about a patient with mental illness, alcoholism, drug addiction or substance abuse
- *Inpatient* confinements that are primarily intended as a change of environment
- Mental health services received in residential treatment facilities when age 18 or older. Residential treatment facilities are covered for *chemical dependency*.
- Marriage Counseling
- *Inpatient* psychiatric care rendered in a *hospital* not accredited by JCAHO
- *Inpatient chemical dependency* care rendered in a facility which is not currently accredited by a national health care organization approved by the Mental Health Case Manager
- *Inpatient hospital* care for medical detoxification rendered in a facility which is not licensed as a *hospital* and accredited by a national health care organization approved by the Mental Health Case Manager
- Outdoor components of a residential *chemical dependency* treatment program, when such program is licensed as a *chemical dependency* treatment program in the state in which

services are provided, are covered only if facility based services are available as a part of the same program

- Primary treatment of a psychiatric disorder in a residential treatment center (RTC) unless the RTC is licensed as a psychiatric RTC
- Primary treatment of a *chemical dependency* or substance abuse disorder in a residential treatment center (RTC) unless the RTC is licensed as a *chemical dependency* or substance abuse RTC
- Services by providers not currently licensed in the state in which services are provided
- Psychotherapy as part of artificial means of conception
- Psychological assessment and psychotherapy treatment in conjunction with proposed gender transformation
- Psychological testing for those persons with a *chemical dependency* diagnosis until 30 consecutive days of abstinence are obtained.
- Therapeutic boarding schools as a psychiatric residential treatment center (RTC) unless the program is licensed for psychiatric RTC in the state in which services are provided, has registered nurses who are present on-site 24-hours per day, and holds current national accreditation by a national health care accrediting body approved by the Mental Health Case Manager
- Therapeutic boarding schools as a *chemical dependency* or substance abuse residential treatment center (RTC) unless the program is licensed as a *chemical dependency* RTC in the state in which services are provided and has licensed supervision of all residents 24 hours per day, seven days per week
- Wilderness camps, wilderness "step-down" components of a residential program, and stand-alone outdoor treatment programs or outdoor "step-down" components of a residential program are not covered as a psychiatric RTC unless the program is licensed for psychiatric residential treatment in the state in which services are provided, has registered nurses who are present on-site 24-hours per day, and holds current national accreditation by a national health care accrediting body approved by the Mental Health Case Manager
- Wilderness camps and stand-along outdoor treatment programs are not covered as *chemical dependency* or substance abuse RTC programs
- Academic education during residential treatment when charged separately
- Administrative psychiatric services (e.g., expert testimony, report writing, medical records review and maintenance, case management or case coordination, chart review, etc.)
- Consultation with a mental health professional for adjudication of marital, child support, and custody cases
- Evaluations, consultations, testing or therapy for educational, professional training, or for investigation purposes relating to employment, insurance, judicial or administrative proceedings
- Training analysis
- Treatment for personal or professional growth, development, training or professional *certification*
- Aversive Treatment
- Treatment programs based solely on the 12-step Model
- Erhard Seminar Training (EST) or similar motivational services
- Bioenergetic, carbon dioxide, confrontational, hyperbaric or normobaric oxygen, marathon, megavitamin, orthomolecular, primal, rebirthing, or sleep therapies
- Expressive therapies (art, poetry, movement, psychodrama), guided imagery, or stress and relaxation therapy when billed separately
- Telephonic crisis management as a separate charge

- Sedative action, electro stimulation therapy
- Z therapy, also known as "holding therapy"
- Narcotherapy with LSD
- Environmental ecology treatments
- Hemodialysis for schizophrenia
- Rolfing
- Sensitivity training
- Room and Board costs for patients admitted to a partial *hospital* or intensive outpatient program are not covered.
- Intensive in-home services less than two hours per day
- Private duty nursing
- Therapeutic family, foster or home care
- L-tryptophan and vitamins, except thiamine injections on admission for alcoholism when there is a diagnosed nutritional deficiency
- Travel time necessary for service delivery

Prescription Drug Benefits

A Pharmacy Benefit Manager (PBM) manages administration of the prescription drug benefit. The PBM for the HDHP is CVS Caremark.

Prescription drugs are subject to the *benefit period deductible.* Both *deductible* and *coinsurance* amounts apply to the out-of-pocket maximum. After the out-of-pocket maximum is reached, the health benefit plan pays 100% of allowed prescription drug charges.

The HDHP will utilize the CVS Caremark Standard formulary. The CVS Caremark Standard Formulary is a national drug list of the most commonly prescribed drugs that may be covered by the Plan for members of the HDHP. The list is not an all-inclusive list. The formulary represents an abbreviated version of drugs that may be covered. Certain brand-name medication with covered preferred alternatives may not be covered by the Plan and not all the drugs listed are covered by the Plan. The CVS Caremark Standard formulary can be viewed at www.shpnc.org under HDHP.

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

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

Some prescription drugs may require *certification*, also known as prior approval, or be subject to step therapy or formulary coverage review in order to be covered. It is very important to make sure that prior approval is received before going to the pharmacy.

Some prescription drugs may be subject to quantity limits based on criteria developed by CVS Caremark. Prior approval is required before excess quantities of these drugs will be covered. If you need quantities in excess of the limit for a drug that is subject to quantity limits, it is important to make sure your provider has received prior approval before going to the pharmacy. To get a list of prescription drugs that require prior approval to be covered or require approval for additional quantities, you may call Pharmacy Customer Service at the number listed in "Who to Contact" or visit the State Health Plan website. CVS Caremark may change the list of these prescription drugs from time to time.

For *certification* of your prescription drugs, your physician may call the PBM's Prior Authorization number listed in "Who to Contact" to initiate a *certification* request.

Using an In-network Pharmacy

Most chain and independent pharmacies are in-network (contract) with the *PBM*. You may obtain information about which pharmacies are in-network by:

- Visiting the *State Health Plan*'s website, or
- Calling the *PBM* at the number listed in "Who to Contact"

When you use an out-of-network pharmacy, you will be responsible for paying the total amount of the *prescription* at the time of purchase. You or the pharmacy will be required to file a paper claim with the *PBM* for reimbursement. You may obtain a claim form on the *State Health Plan*'s website or by calling the *PBM*. **You are responsible for any amount above the *allowed amount* and your *coinsurance.***

The convenience of mail order pharmacy is available for your maintenance medications by using the *PBM's* online pharmacy services, by telephone, or by completing a Mail Service Order Form and returning it with your original *prescription* and appropriate *coinsurance amount* to the *PBM*. You may obtain a Mail Service Order Form on the *State Health Plan*'s website or by calling the *PBM* at the number in "Who to Contact." To learn how to register for the *PBM's* online pharmacy services, visit the *State Health Plan's* website at www.shpnc.org.

You may use a credit card for *coinsurance amounts* for telephone or online refills.

Affordable Care Act Preventive Medications

Some medications that are identified by the *Affordable Care Act* are covered to *members* on this plan at 100%. *Members* must meet certain criteria for these medications to be covered at 100% and a *PCP* must write a *prescription* for the drug to be filled at an in-network pharmacy in order for the *prescription* to be covered at a $0 coinsurance.

Keep in mind that your *provider* must write a *prescription* and it must be filled at a participating pharmacy. Additionally, there may be some *prescription drugs* that are administered by a *provider* in a medical office that may be limited to coverage under your medical benefit. The HDHP ACA Medication List can be viewed at www.shpnc.org under High Deductible Health Plan.

Prescription Drug Exclusions

- Any *prescription drugs* not FDA approved
- Any *prescription drugs* that are not federal legend.
- Any *prescription drugs* not specifically covered by the *State Health Plan*
- Any *prescription drugs* prescribed for *sexual dysfunction*.
- Any *prescription drugs* prescribed for hair growth
- Any *prescription drugs* prescribed for *cosmetic* purposes
- Any *prescription drugs* prescribed in conjunction with artificial reproductive technology
- Any *prescription drug* in excess of the stated quantity limits
- Any *prescription drug* requiring *certification* if *certification* is not obtained
- Any drug that can be purchased over the counter without a *prescription*, even though a written *prescription* is provided, except for insulin and other approved over-the-counter drugs
- Any *compound drug* that contains an *investigational* drug.
- Any *compound drug* in which any active ingredient is not a covered *prescription drug* including bulk chemicals.
- Any *prescription drug* that has a therapeutic equivalent available over-the-counter as determined by the *State Health Plan*.
- Any *prescription* medical foods

Diabetic Testing Supplies

Diabetic testing supplies are covered under your medical and pharmacy benefit.

Tobacco Cessation Coverage

Members are encouraged to call their physicians or behavioral health care provider about quitting tobacco use.

All Food and Drug Administration (FDA) approved smoking cessation products will be covered at 100% with a prescription for members ≥ 18 years and will have a quantity-duration limit of 180 days within a 365 day period. For a list of covered medications, please visit the Plan's website at www.shpnc.org under High Deductible Health Plan.

Specialty Pharmacy

Specialty and biosimilar medications are designated and classified by the Plan as medications that meet the following criteria and are listed on the Specialty Drug List, which is located on the Plan's website:

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

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

How to File a Claim for *Prescription Drugs*

When you use an in-network pharmacy with the *PBM*, present your *ID card* to the pharmacist and you will not be required to pay more than the appropriate *coinsurance amount* for each 30-day supply. The pharmacist will file the claim.

If you purchased *prescription drugs* from an out-of-network pharmacy, you will be responsible for the total amount of the *prescription* at the time of purchase. You will be reimbursed for your costs minus the applicable *coinsurance amounts* and charges in excess of the *allowed amount*. You will need to complete a *Prescription Drug* Claim Form for reimbursement and submit it to:

CVS Caremark
P.O. Box 52136
Phoenix, Arizona 85072-2136

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

- Date *prescription* filled
- Name and address of pharmacy
- *Doctor* name or *ID number*
- National Drug Code (NDC)
- Name of drug and strength
- Quantity and day supply
- *Prescription* number (Rx number)
- DAW (Dispense As Written)

- Amount paid

Complete a separate form for each family *member* and pharmacy.

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

Special Programs

Complex Case Management	This program provides special intervention during care or treatment for a serious illness and/or Accident. Services include assessing patient needs, care environment and social and economic barriers to care; facilitating care coordination with the patient and his/her care team in navigating and coordinating the best and most appropriate care; evaluating the treatment plan to ensure it meets standard of care and coordinative with the patient and physician; steering members to in-network providers and negotiating discounts on non-network services if in-network providers are not available; and resolving gaps in care.
Personal Care Management including Transitional Care	This service includes customized health education and one-on-one nurse mentoring to encourage self-empowerment and self-management.
Personal Health Suite	This service provides a secure online suite of health and wellness information available to Members via MedCost.com. It includes a health and productivity assessment, healthy living programs, personal health record, participant health portal, and health tools and trackers.
Health eReports	A member price comparison tool to assist in locating quality, cost effective providers.

If you have certain health conditions, the *State Health Plan* or its representative may call you to provide information about your condition, answer questions and tell you about resources available to you. Your participation is voluntary, and you have no obligation to talk about your condition. Your medical information is kept confidential.

What is not Covered?

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

- Any condition, disease, ailment, injury or diagnostic service to the extent that benefits are provided or persons are eligible for coverage under Title XVIII of the Social Security Act of 1965, including amendments, except as otherwise required by federal law
- Conditions that federal, state or local law requires to be treated in a public facility
- Any condition, disease, illness or injury that occurs in the course of employment, if the member, employer or carrier is liable or responsible for the specific medical charge (1) according to a final adjudication of the claim under a state's workers' compensation laws, or (2) by an order of a state Industrial Commission or other applicable regulatory agency approving a settlement agreement
- Benefits that are provided by any governmental unit except as required by law
- Services that are ordered by a court that are otherwise excluded from benefits under this plan
- Any condition suffered as a result of any act of war or while on active or reserve military duty
- Services in excess of any *benefit period maximum* or lifetime maximum
- Received prior to the *member's effective date*
- Received after the coverage termination date, regardless of when the treated condition occurred, and regardless of whether the care is a continuation of care received prior to the termination
- Received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust or similar person or group

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

A

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

B

- Collection and storage of blood and stem cells taken from the umbilical cord and placenta for future use in fighting a disease
- Blood pressure machines, cuffs or other blood pressure monitoring device

C

- **Claims** not submitted to the Plan within 18 months of the date the charge was *incurred*, except in the absence of legal capacity of the member
- Side effects and **complications** of noncovered services, except for *emergency services* in the case of an *emergency*
- **Convenience** items such as, but not limited to, devices and equipment used for environmental control, urinary incontinence devices (including bed wetting devices) and equipment, heating pads, hot water bottles, ice packs and personal hygiene items

- ***Cosmetic*** services, which include the removal of excess skin from the abdomen, arms or thighs, and surgery for psychological or emotional reasons, except as specifically covered by the Plan
- Services received either before or after the **coverage period** of the Plan, regardless of when the treated condition occurred, and regardless of whether the care is a continuation of care received prior to the termination
- ***Custodial care*** designed essentially to assist an individual with activities of daily living, with or without routine nursing care and the supervisory care of a *doctor*. While some skilled nursing services may be provided, the patient does not require continuing skill services 24 hours daily. The individual is not under specific medical, surgical, or psychiatric treatment to reduce a physical or mental disability to the extent necessary to enable the patient to live outside either the institution or the home setting with substantial assistance and supervision, nor is there reasonable likelihood that the disability will be reduced to that level even with treatment. *Custodial care* includes, but is not limited to, help in walking, bathing, dressing, feeding, preparation of special diets and supervision over medications that could otherwise be self-administered. Such services and supplies are custodial as determined by the Plan without regard to the place of service or the provider prescribing or providing the services.

D

- **Dental care**, dentures, dental implants, oral orthotic devices, palatel expanders and orthodontics except as specifically covered by the Plan.
- **Dental services** provided in a *hospital*, except as specifically covered by the Plan.
- Considered as evaluation and treatment of ***developmental dysfunction*** and/or learning disability.
- The following drugs:
  - Any drug on the Prescription Drug Exclusions List
  - Injections by a health care professional of injectable prescription drugs which can be self-administered, unless medical supervision is required
  - Drugs associated with conception by artificial means.
  - For prescribed *sexual dysfunction* medications
  - Take home drugs furnished by a *hospital* or *nonhospital facility*
  - *Experimental* drugs or any drug not approved by the U.S. Food and Drug Administration (FDA) for the applicable diagnosis or treatment. However, this exclusion does not apply to prescription drugs used in covered phases II, III and IV clinical trials, or drugs approved by the FDA for treatment of cancer, if prescribed for the treatment of any type of cancer for which the drug has been proven as effective and accepted in any of the following:
    - The National Comprehensive Cancer Network Drugs & Biologics Compendium
    - The ThomsonMicromedex DrugDex
    - The Elsevier Gold Standard's Clinical Pharmacology
- Any other authoritative compendia as recognized periodically by the United States Secretary of Health and Human Services.

E

- **Ear** piercing
- Services primarily for **educational** purposes including, but not limited to, evaluation, books, tapes, pamphlets, seminars, classroom, Web or computer programs, individual or group instruction, counseling, and vocational counseling except as specifically covered by the Plan
- For **educational** or achievement testing for the sole purpose of resolving educational performance questions
- The following **equipment:**
  - Air conditioners, furnaces, humidifiers, vacuum cleaners, electronic air filters and similar equipment
  - Devices and equipment used for environmental accommodation requiring vehicle and/or building modifications such as, but not limited to, chair lifts, stair lifts, home elevators, and ramps
  - Physical fitness equipment, hot tubs, Jacuzzis, heated spas, pools or membership to health clubs
  - Personal computers
  - Standing frames.
- ***Experimental*** services including services whose efficacy has not been established by controlled clinical trials, or are not recommended as a preventive service by the U.S. Public Health Service except as specifically covered by the Plan
- Routine **eye exams**. Fitting for eyewear, radial keratotomy and other refractive eye *surgery*, and related services to correct vision except for surgical correction of an eye injury. Also excluded are accommodating intraocular lenses or the services related to the insertion of accommodating intraocular lenses that are not required for insertion of standard intraocular lenses
- **Eyeglasses** or contact lenses, except as specifically covered in "*Prosthetic Appliances*"

F

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

G

- **Genetic testing**, except for high risk patients when the therapeutic or diagnostic course would be determined by the outcome of testing

H

- Routine **hearing** examinations and hearing aids or examinations for the fitting of hearing aids except as specifically covered by the Plan
- ***Holistic*** *medicine* services, which are unproven preventive or treatment modalities, generally described as alternative, integrative or complementary medicine, whether performed by a physician or any other provider.
- **Hypnosis** except when used for control of acute or chronic pain.

I

- ***Inpatient*** **admissions** primarily for the purpose of receiving diagnostic services or a physical examination. *Inpatient* admissions primarily for the purpose of receiving therapy services, except when the admission is a continuation of treatment following care at an *inpatient* facility for an illness or accident requiring therapy.

	• Services that are **investigational** in nature or obsolete, including any service, drugs, procedure or treatment directly related to an investigational treatment, except as specifically covered by the Plan.
L	• Services provided and billed by a **lactation** consultant, except when covered as preventive care.
M	• Services or supplies deemed not **medically necessary.**
N	• Services that would not be necessary if a **noncovered service** had not been received, except for *emergency services* in the case of an *emergency*. This includes any services, procedures or supplies associated with *cosmetic* services, investigational services, services deemed not medically necessary, or elective termination of pregnancy, if not specifically covered by the Plan.
O	• Any treatment or regimen, medical or surgical, for the purpose of reducing or controlling the weight of a member or for treatment of **obesity,** except for surgical treatment of morbid obesity, or as specifically covered by the Plan.

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

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

S	• **Services** or **supplies** that are:
	  • Not performed by or upon the direction of a *doctor* or other provider
	  • Available to a member with no charge.
	• Treatment or studies leading to or in connection with **sex change or modifications** and related care.
	• **Sexual dysfunction** unrelated to organic disease.
	• **Shoe** lifts, and shoes of any type unless part of a brace.
	• Services, supplies, drugs or equipment used for the control or treatment of **stammering or stuttering.**

T	• The following types of **therapy:**
	  • Applied Behavior Analysis (ABA) therapy
	  • Music therapy, remedial reading, recreational or activity therapy, all forms of special education and supplies or equipment used similarly

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

V	• The following **vision** services:
	  • Radial keratotomy and other refractive eye surgery, and related services to correct vision except for surgical correction of an eye injury. Also excluded are premium intraocular lenses or the services related to the insertion of premium lenses beyond what is required for insertion of conventional intraocular lenses, which are small, lightweight, clear disks that replace the distance-focusing power of the eye's natural crystalline lens.
	  • Orthoptics **vision training**, and low **vision aids**.
	• For over-the-counter and non-federal legend **Vitamins**, food supplements or replacements, nutritional or dietary supplements, formulas or special foods of any kind, except for prescription prenatal vitamins or prescription vitamin B-12 injections for anemias, neuropathies or dementias secondary to a vitamin B-12 deficiency, or certain over-the-counter medications that may be available under your preventive care benefits for certain individuals.

W	• **Wigs**, hairpieces and services for hair implants and electrolysis for any reason.

Utilization Management

To make sure you have access to high quality, cost effective health care, the *State Health Plan* has a *Utilization Management* (*UM*) program. The *UM* program requires that certain health care services be reviewed and approved by the *State Health Plan* or its representative in order to receive benefits. For a complete list of services please refer to Certification Requirements on page 11. As part of this process, the *State Health Plan* determines whether health care services are *medically necessary*, provided in the proper setting and for a reasonable length of time. The *State Health Plan* will honor a *certification* to cover *medical services* or supplies under your health benefit plan unless the *certification* was based on a material misrepresentation about your health condition or you were not eligible for these services under your health benefit plan due to termination of coverage or nonpayment of premiums.

Rights and Responsibilities Under the UM Program

Your Member Rights

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

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

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

The State Health Plan's Responsibilities

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

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

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

Prior Review (Pre-Service)

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

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

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

Urgent Prior Review

You have a right to an urgent review when the regular time frames for a decision: (i) could seriously jeopardize your or your *dependent's* life, health, or ability to regain maximum function; or (ii) in the opinion of your *provider*, would subject you or your *dependent* to severe pain that cannot be adequately managed without the requested care or treatment. The *State Health Plan* or its representative will notify you and your *provider* of its decision as soon as possible, taking into account the medical circumstances. The *State Health Plan* or its representative will notify you and your *provider* of its decision within 72 hours after receiving the request. If the *State Health Plan* or its representative needs additional information to process your expedited review, they will notify you and your *provider* of the information needed as soon as possible but no later than 24 hours following the receipt of your request. You will then be given a reasonable amount of time, but not less than 48 hours, to provide the requested information. As soon as the *State Health Plan* or its representative receives the requested information, or at the end of the time period specified for you to provide the information, whichever is earlier, the *State Health Plan* or its representative will make a decision on your request within a reasonable time but no later than 48 hours.

An urgent review may be requested by calling State Health Plan Customer Service at the number listed in "Who to Contact."

Concurrent Reviews

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

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

Urgent Concurrent Review

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

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

than 72 hours after we receive the request. If the State Health Plan or its representative needs more information to process your urgent review, the Plan will notify the requesting *hospital* or other facility of the information needed as soon as possible but no later than 24 hours after we receive the request. The requesting *hospital* or other facility will then be given a reasonable amount of time, but not less than 48 hours, to provide the requested information. The Plan or its representative will make a decision within 48 hours of the earlier receipt of the requested information, or the end of the time period given to the requesting *hospital* or other facility to provide the information.

In the event of an adverse determination, the Plan or its representative will notify you, your *hospital*'s or other facility's UM department and your provider. Written confirmation of the decision will also be sent to your home by U.S. mail. For concurrent reviews, the Plan or its representative will remain responsible for covered services you are receiving until you or your representatives have been notified of the adverse benefit determination.

***Retrospective Reviews (*Post-Service)**

The *State Health Plan* or its representative also reviews the coverage of health care services after you receive them (retrospective reviews). Retrospective review may include a review to determine if services received in an *emergency* setting qualify as an *emergency*. The *State Health Plan* or its representative will make all retrospective review decisions and notify you of its decision within a reasonable time but no later than 30 days from the date the *State Health Plan* or its representative received the request. In the event of an adverse benefit determination, the Plan or its representative will notify you and your provider in writing within five business days of the decision. All decisions will be based on medical necessity and whether the service received was a benefit under the Plan. If more information is needed before the end of the initial 30-day period, the Plan or its representative will notify you of the information needed. You will then have 90 days to provide the requested information. As soon as the Plan or its representative receives the requested information, or at the end of the 90 days, whichever is earlier, the Plan or its representative will make a decision within 15 days. Services that were approved in advance by the Plan or its representative will not be subject to denial for medical necessity once the claim is received, **unless the *certification* was based on a material misrepresentation about your health condition or you were not eligible for these services under your health benefit plan due to termination of coverage or nonpayment of premiums**. All other services may be subject to retrospective review and could be denied for *medical necessity* or for a benefit limitation or exclusion.

Case Management

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

Continuity of Care

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

An ongoing special condition means:

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

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

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

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

Further Review of Utilization Management Decisions

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

What if you disagree with a Decision?

In addition to the *UM* program, your health benefit plan offers a *grievance* procedure for *members*. *Grievances* include dissatisfaction with a claims denial or any decisions (including an *appeal* of a *noncertification* decision), policies or actions related to the availability, delivery or quality of health care services. If you have a *grievance*, you have the right to request that the *State Health Plan* or its representative review the decision through the *grievance* process. ***Grievances* are not allowed for benefits or services that are clearly excluded by this benefits booklet or for *deductibles, coinsurance* or *coinsurance maximum,* as wells as other aspects of coverage excluded from *appeal* by law.** The *grievance* process is voluntary and may be requested by the *member* or an authorized representative acting on the *member's* behalf with the *member's* written consent. In the event you appoint an authorized representative, references to "you" under this section mean "you or your authorized representative" (i.e., the authorized representative may pursue your rights and shall receive all notices and benefit determinations). For each step in this process, there are specified time frames for filing a *grievance* and for notifying you or your *provider* of the decision.

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

Health Insurance Smart NC
1201 Mail Service Center
Raleigh, NC 27699-1201
Toll-free: (877) 885-0231

Steps To Follow In the *Grievance* Process

First Level *Grievance* Review

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

Any request for review should include:

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

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

Second Level *Grievance* Review

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

- Name, address and telephone number of the *grievance* coordinator
- A statement of your rights, including the right to:

- request and receive from the *State Health Plan* or its representative all information that applies to your case
- participate in the second level *grievance* review meeting
- present your case to the review panel
- submit supporting material before and during the review meeting
- ask questions of any *member* of the review panel
- be assisted or represented by a person of your choosing, including a family *member*, an *employer* representative, or an attorney.

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

Expedited Review

You have the right to a more rapid or expedited review of a denial of coverage if a delay: (i) would reasonably appear to seriously jeopardize your or your *dependent's* life, health or ability to regain maximum function; or (ii) in the opinion of your *provider*, would subject you or your *dependent* to severe pain that cannot be adequately managed without the requested care or treatment. You can request an expedited second level review even if you did not request that the initial review be expedited. An expedited review may be initiated by calling *State Health Plan* Customer Service at the number listed in "Who to Contact." An expedited review will take place in consultation with a medical *doctor*. All of the same conditions for a first level or second level *grievance* review apply to an expedited review. The *State Health Plan* or its representative will communicate the decision by phone to you and your *provider* as soon as possible, taking into account the medical circumstances, but no later than 72 hours after receiving the request. A written decision will be communicated within four days after receiving the request for the expedited *appeal*. Information initially given by telephone must also be given in writing.

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

External Review

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

The *State Health Plan* will notify you of your right to request an external review each time you receive:
- a *noncertification* decision or,
- an *appeal* decision upholding a *noncertification* decision.

In order for your request to be eligible for an external review, the NCDOI must determine the following:
- your request is about a *medical necessity* determination that resulted in *noncertification;*
- you had coverage with the *State Health Plan* when the *noncertification* was issued;
- the service for which the *noncertification* was issued appears to be a *covered* service; and
- you have exhausted the *State Health Plan*'s first and second level *grievance* process as described above.

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

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

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

Standard External Review

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

Expedited External review

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

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

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

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

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

Mail	**In person**	**Web**
NC Department of Insurance Health Insurance Smart NC 1201 Mail Service Center Raleigh, NC 27699-1201 Fax: 919-807-6865	NC Department of Insurance Dobbs Building 430 N. Salisbury Street, 1st Floor, Suite 101 Raleigh, NC 27603 Tel: 919-807-6860 Tel: (toll free in NC) 877-885-0231	www.ncdoi.com/Smart for external review information and request form

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

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

State Health Plan
c/o *MedCost Appeals* Department
MedCost Benefit Services, LLCPO Box 25987
Winston-Salem, NC 27114-5987
Or MBSMedReview@medcost.com

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

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

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

Third Level *Grievance* Review

If you do not agree with the second level decision, you may be able to *appeal* this decision by filing a Petition for Contested Case Hearing with the North Carolina Office of Administrative Hearings (OAH). This *appeal* must be received and filed with OAH within sixty (60) days of the date of the second level decision. Your second level decision and North Carolina General Statute (NCGS) 135-48.24 identifies

those *appeals* that may be filed at OAH, OAH's address, the time period for filing an *appeal*, and any applicable fees. N.C.G.S. 135-48.24, as well as all *State Health Plan* statutes and medical policies, can be found at www.shpnc.org. The OAH statute is found in the North Carolina General Statutes at Chapter 150B. Information is also available on OAH's website at www.oah.state.nc.us.

Pre-Service Claims

A pre-service claim is any claim for a medical benefit under this Plan that requires approval, in whole or in part, in advance of obtaining medical care. These are, for example, Claims that are subject to predetermination of benefits or pre-certification.

For pre-service claims, generally, the Claims Administrator must notify the Covered Person of its determination, whether adverse or not, within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days from receipt of the claim at the initial level.

One 15-day extension of time is available if the Claims Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Covered Person, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

If such an extension is necessary due to a failure of the Covered Person to submit necessary information, the notice of extension shall specifically describe the required information, and the Covered Person shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Written or electronic notice of benefit grants or denials must be provided in the case of pre-service claims.

Post-Service Claims

A post-service claim is a claim for a Plan benefit that is not a claim involving Urgent Care or a pre-service claim; in other words, a claim that is a request for payment under the Plan for covered medical services already received by the claimant.

For post-service claims, generally, the Claims Administrator will notify the Covered Person of any adverse determination within a reasonable period of time, but not later than 30 days from receipt of the claim at the initial level.

One 15-day extension of time is available if the Claims Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Covered Person, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

If such an extension is necessary due to a failure of the Covered Person to submit necessary information, the notice of extension shall specifically describe the required information, and the Covered Person shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Written or electronic notice of benefit grants or denials must be provided in the case of post-service claims.

Appeals Correspondence

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

Medical Appeals

State Health Plan
c/o MedCost
PO Box 25987
Winston-Salem, NC 27114-5987
Or MBSMedReview@medcost.com

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

State Health Plan
c/o MedCost *PO Box 25987*
Winston-Salem, NC 27114-5987
Or MBSMedReview@medcost.com

Pharmacy Appeals

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

Clinical appeal requests
Request for coverage of a medication that is based on clinical conditions of coverage that are set by the Plan, for example, medications that require a prior authorization.

CVS Caremark
Attn: Clinical Appeals Department
P.O. Box 52136
Phoenix, Arizona, 85072-2136
Fax: 866-443-1172

Administrative appeal requests
A request for coverage of a medication that is based on the Plan's benefit.

CVS Caremark
Attn: Administrative Appeals Department
P.O. Box 52136
Phoenix, Arizona, 85072-2136
Fax: 866-443-1172

Additional Terms of Your Coverage

Benefits to Which Members are Entitled

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

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

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

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

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

Disclosure of Protected Health Information (PHI)

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

Administrative Discretion

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

Receiving Care When You Are Outside Of North Carolina. South Carolina and Virginia

Your health benefit plan offers you the choice of receiving either *in-network* or *out-of-network* benefits while outside of North Carolina. Your *ID card* gives you access to participating *providers* outside the state of North Carolina.When you use a *provider* participating in the MedCost PPO *provider* network, or an affiliated network, you will receive the higher *in-network* benefit level. If you are in an area that has participating *providers* and you choose a *provider* outside the network, you will receive the lower *out-of-network* benefits. However, if participating *providers* through MedCost or an affiliated network are not reasonably available to the *member* as determined the network defined in the “Out-of-Network” provisions your benefits will be paid at the *in-network* benefit level. In an *emergency*, you should seek care from an *emergency* room or other similar facility. If you go to an *emergency* room for treatment of an *emergency*, your benefit level will be the same, regardless of whether you

use an *in-network* or *out-of-network provider*. If you receive services outside of North Carolina, South Carolina or Virginia, either *in-network* or *out-of-network*, you are responsible for requesting or ensuring that your *provider* requests *prior review* by the *State Health Plan* or its representative for those services that require *prior review*. For a list of services that require *prior review*, visit the *State Health Plan* website at www.shpnc.org. Failure to request *prior review* and receive *certification* will result in a full denial of benefits. For exceptions to *prior review* requirements, see "*Emergency* and *Urgent Care* Services" and "Maternity Care" in "*Covered Services*."

To see if an *in-network provider* is available in your location within the USA, you should call the number listed in "Whom Do I Call?" and on the back of your *ID card*. If you are traveling outside the USA, you should call collect to the number that is listed in "Who to Contact."

Provider Reimbursement

Services Received In North Carolina, South Carolina and Virginia

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

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

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

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

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

Charges are subject to Usual, Customary and Reasonable (UCR) determination. To determine UCR, the Claims Administrator shall consider the following factors:

- The provider's "usual" charges comprised of the fees that an individual provider most frequently charges for a specific type of treatment or service.
- The "customary" charges, based on one or more of the following:
  - Statistically credible health care services data (updated no less than quarterly); or
  - A Preferred Provider (PPO) fee schedule; or
  - Medicare-Based Reimbursement.
- The "reasonable" charges, based on consideration of charges based on a negotiated discount arrangement with the provider at issue for the charges in question or:
- For out-of-network charges, each of the following:
  - The complexity or severity of the treatment or service at issue;
  - The level of skill and experience involved in delivery of the treatment or service; and
  - The value of the treatment or service compared to other treatments or services.

Charges that are not coded in compliance with industry standards are presumed to be unreasonable.

Charges will be considered in excess of UCR if they exceed any of these three factors (usual, customary, and reasonable). Charges in excess of UCR will not be considered Covered Medical Expenses. When charges are in excess of UCR, you may incur costs associated with charges that exceed Usual, Customary and Reasonable charges.

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

Right of Recovery/Subrogation Provision

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

In addition, if a *member* receives any payment from any potentially responsible party as a result of an injury or illness, the *State Health Plan* has the right to recover from, and be reimbursed by, the *member* for all amounts the *State Health Plan* has paid and will pay as a result of that injury or illness, up to and including the full amount the *member* receives from all potentially responsible parties. Further, the *State Health Plan* will automatically have a lien, to the extent of benefits advanced, upon any recovery whether by settlement, judgment or otherwise, that a *member* receives from a third party, the third party's insurer or any other source as a result of the *member's* injuries. The lien is in the amount of benefits paid by the *State Health Plan* for the treatment of the illness, injury or condition for which another party is responsible.

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

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

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

The *member* shall do nothing to prejudice the *State Health Plan's* recovery rights as herein set forth. This includes, but is not limited to, refraining from entering into any settlement or recovery that attempts to reduce, waive, bar or exclude the full cost of all benefits provided by your health benefit plan as provided by law.

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

The *member* agrees that any legal action or proceeding with respect to this provision may be brought in any court of competent jurisdiction as the *State Health Plan* may elect. Upon receiving benefits under your health benefit plan, the *member* hereby submits to each such jurisdiction, waiving whatever rights may correspond to the *member* by reason of the *member's* present or future domicile.

If any information in this booklet conflicts with North Carolina state law or it conflicts with medical policies adopted under your health benefit plan, North Carolina law and such medical policies will prevail.

Notice of Claim

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

Limitations of Actions

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

Coordination of Benefits (Overlapping Coverage)

When a Plan Participant is covered by this Plan and another plan, or the Plan Participant's spouse is covered by this Plan and by another plan or the couple's covered children are covered by two or more plans, the plans will coordinate benefits when a claim is received.

Coordination of Benefits (COB) sets out rules for the order of payment of Covered Charges when two or more plans, including Medicare, are paying. The insurance companies and/or third party administrators involved work together to pay up to 100% of the Plan Participant's covered expenses. This Plan uses the standard method of COB. With the standard method, the secondary plan pays the difference between the total allowable expense and the amount paid by the primary plan.

COB applies to health care coverage that provides medical, vision, dental or health benefits by means of:

- A group plan on an insured basis;
- Plans that cover people as a group, including self-funded plans;
- Plans that are arranged through an Employer, trustee or union;
- A prepayment plan such as an HMO, POS or PPO;
- Government plans; except Medicaid; and
- Single or family subscribed plans issued under a group plan.

The term "benefit plan" does not include:

- Hospital indemnity type plans;
- Types of plans for students;

- Franchise policies purchased by an individual;
- Automobile policies;
- Homeowners policies; and
- Other individual or family insurance policies for which premiums are paid by the Plan Participant.

For a charge to be considered under COB it must be a Usual, Customary and Reasonable (UCR) Charge and at least part of it must be covered under this Plan.

In order for COB to work, the Plan may release or obtain claim information from any insurance company, organization or person. Accepting benefits under this Plan for incurred medical and/or dental expenses automatically requires a Plan Participant to give this Plan the information it requests about other plans and their payment of covered expenses.

If the Plan Administrator determines that this Plan has paid in error, the Plan will:

- Recover the amount paid to the Plan Participant or another benefit plan when the benefits should have been paid by the other benefit plan; or
- Repay other plans for benefits the Plan should have paid.

Benefits are coordinated on a Plan Year basis.

Note: COB does not apply to prescription drug benefits. If this plan is secondary for medical benefits, the assumption is that there will be no coverage under this plan.

Rules for Benefits Plan Payment Order

When two or more plans provide benefits for the same charge, insurance companies and/or third party administrators will follow these rules.

1. Plans that do not have a coordination provision will pay first. Plans with such a provision will be considered after those without one.

2. Plans with a coordination provision will pay their benefits up to the allowed charge:
   a. The benefits of the plan that covers the person directly (that is, as an Employee, Member or Subscriber) ("Plan A") are determined before those of the plan that covers the person as a Dependent ("Plan B").

   b. The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or Retired Employee. Coverage provided an individual as a Retired Employee and as a Dependent of that individual's spouse as an Active Employee will be determined under item 2.a. above. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

   c. The benefits of a plan which covers a person as an Employee who is neither laid off nor retired or a Dependent of an Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.

3. When a child is covered as a Dependent and the parents are not separated or divorced, these rules will apply:
   a. The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;
   b. If both parents have the same birthday, the benefits of the benefit plan that has covered the parent for the longer time are determined before those of the benefit plan which covers the other parent.

4. When a child's parents are divorced or legally separated, these rules will apply:
   a. This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.

b. This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered last.
c. This rule will be in place of items above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent.
d. If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are not separated or divorced.
e. For parents who were never married to each other, the rules apply as set out above as long as paternity has been established.

5. If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of allowed charges when paying secondary.

6. Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts.

7. If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

8. When there is dual coverage through both COBRA and other group health coverage the rules for determining which plan is primary will be applied in the standard order as they are listed above; in other words, the first rule that describes the situation is the rule to follow.
   a. Non-Dependent or Dependent (2.a. above). A plan covering an individual as an Employee, member, subscriber, or Retiree, is primary and the plan that covers the person as a Dependent is secondary.
   b. Active or inactive Employee (2.c. above). A plan covering an individual as an active Employee (neither laid-off nor retired) or as the Employee's Dependent is primary.
   c. Child covered under more than one plan (2.d. and 2.e. above). The second rule describes which parent's plan will be primary and which will be secondary in a variety of circumstances.
   d. Continuation coverage. A plan covering an individual as an Employee, member, subscriber or Retiree (or as that person's Dependent) is primary, and the continuation coverage (pursuant to state or federal law) is secondary.

Medicare as a Secondary Payer

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

- **If your Employer has 20 or more Employees**, either Medicare or the Plan can be chosen as the primary coverage for you, if you are an Employee who is eligible for Medicare because you are age 65 or older; and your covered spouse is age 65 or older, regardless of your age.
- **If Medicare is elected as primary coverage, the law does not permit the Company's medical plan to provide benefits supplementing Medicare.** Therefore, if you or your Dependent wishes to elect Medicare as your primary coverage, ***you must terminate participation in the Company's medical plan*** and have Medicare as your only coverage. You should contact the Company if you wish to terminate your participation in the Plan

and have Medicare provide your medical benefits. Otherwise, participation in the Company's medical plan will continue to provide your primary medical benefits, with Medicare providing supplemental coverage.

- **If your Employer has 100 or more Employees,** medical benefits under the Plan will be paid before Medicare benefits for you and your covered Dependent who is under age 65; is eligible for Medicare because of disability; and is covered under the Plan because of your current employment status.
- **For all Employers,** medical benefits under the Plan will be paid before Medicare benefits for you or any covered Dependent qualifying for Medicare due to end-stage renal disease. The Plan will remain the primary payer only during the first thirty (30) months after the earlier of: (1) the date renal dialysis treatments are begun; or (2) the date of Medicare entitlement following a kidney transplant.

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

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

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

MEDICAID

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

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

When Coverage Begins and Ends

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

Eligibility

The following individuals are eligible for contributory coverage under this plan:

- Employees determined by their employing units to be full-time employees in accordance with Section 4980H of the Internal Revenue Code and the employee does not qualify for coverage under subdivision (1), (5), (6), (7), (8), (9), or (10) of G.S. 135-48.40(b). Eligibility is also subject to G.S. 135-48.43.

Dependent Eligibility

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

- *Spouse*
- A natural, legally adopted or *foster child* of the *subscriber* and/or *spouse* up to age 26. *Dependent child* includes a child for whom the *subscriber* is a court-appointed guardian, and a stepchild of the *subscriber* who is married to the stepchild's natural parent. *Foster child* requires legal documentation.

Coverage will end at the end of the month during which the dependent child's 26th birthday occurs, or in the event of the covered employee's termination and refusal of, or loss of, COBRA continuation, whichever occurs first.

Dependent child coverage may be extended beyond the 26th birthday under the following condition:

- The *dependent* is physically or mentally incapacitated to the extent that he or she is incapable of earning a living and such handicap developed or began to develop before the *dependent*'s 26th birthday if the *dependent* was covered by the *State Health Plan.* When requesting extension of coverage, or for further information, *employees* should contact Customer Service at the number listed in "Whom Do I Call?"

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

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

Enrolling in the Plan

It is very important that you apply for coverage and/or add *dependents* when you or your *dependents* are first eligible to enroll on the *State Health Plan*.

New *employees* who do not elect to enroll themselves or their *dependents* on the *State Health Plan* within 30 days of hire or when first identified for eligibility will not be allowed to enroll unless they experience a qualifying life event or enroll during Open Enrollment.

Dual Enrollment

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

Timely Enrollees

You are a timely enrollee if you apply for coverage and/or add *dependents* within a 30-day period following any of the qualified life events listed below.

- You are newly hired
- You get married or obtain a *dependent* through birth, adoption, placement in anticipation of adoption, or foster care placement of an eligible child
- You or your *dependents* lose coverage under another health benefit plan, and each of the following conditions is met:
- You and/or your *dependents* are otherwise eligible for coverage under the *State Health Plan*, and
- You and/or your *dependents* were covered under another health benefit plan at the time this coverage was previously offered and declined enrollment due to the other coverage, and
- You and/or your *dependents* lose coverage under another health benefit plan due to (i) the exhaustion of the COBRA continuation period, or (ii) the loss of eligibility for that coverage for reasons including, but not limited to, divorce, loss of *dependent* status, death of the *employee*, termination of employment, or reduction in the number of hours of employment, or (iii) the termination of the other plan's coverage, or (iv) the offered health benefit plan not providing benefits in your service area and no other health benefit plans are available, or (v) the termination of employer contributions toward the cost of the other plan's coverage, or (vi) meeting or exceeding the *lifetime maximum*, or (vii) the discontinuance of the health benefit plan to similarly situated individuals.
- You or your dependents become Medicare eligible
- *Members* of the General Assembly upon the convening of each Session of the General Assembly or within 30 days after the end of the term of office.

Completion of the enrollment must occur within 30 days of employment or the qualifying life event. Proof of prior coverage, if applicable, must be returned to the *HBR* of the *employee's* employing unit.

Adding or Removing a Dependent

If you want to add or remove a *dependent* due to a qualifying life event, contact your *HBR*. Failure to timely notify your *HBR* of the need to remove a *dependent* could result in loss of eligibility for continuation of coverage. To add a *dependent*, you must notify the *HBR* or add your *dependent* through your online enrollment system. For coverage to be effective on the date the *dependent* becomes eligible due to a qualifying life event or the first day of the month following the qualifying life event, the completion of the enrollment must occur within 30 days after the *dependent* becomes eligible.

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

In order for a newborn child to be covered from the date of birth, the coverage *effective date* must be the first day of the month in which the child is born. If you choose to enroll your newborn the first day of the month following

delivery, you will be responsible for any claims *incurred* in the birth month by the newborn. For more information, see "Newborn Care" in "*Covered Services*."

For *members* with *employee*-only or *employee-spouse* coverage, a newborn child, a child legally placed for adoption or a *foster child* may be covered on their *effective date* - as long as the child is enrolled within 30 days of their *effective date* **and the *subscriber* changes to *employee*/child(ren) or *employee*-family coverage and pays any additional premiums required for the selected coverage type retroactive to the first of the month in which the child is born or to the first of the month in which the date of placement occurred for adoptive and *foster children*.**

You may remove *dependents* from your coverage by contacting your *HBR* or through your online enrollment system when there is a qualifying life event. *Dependents* **must** be removed from coverage when they are no longer eligible, such as when a child is no longer eligible due to age, or when the *spouse* is no longer eligible due to divorce or death.

Qualified Medical Child Support Order

A qualified medical child support order (QMCSO) is any judgment, decree or order that is issued by an appropriate court or through an administrative process under state law that: (1) provides for coverage of the child of a *member* under the *State Health Plan*; and (2) is either issued according to state law or a law relating to medical child support described in Section 1908 of the Social Security Act. A QMCSO must be specific as to the plan, the participant whose child (ren) is (are) to be covered, the type of coverage, the child(ren) to be covered and the length of coverage.

Effective Dates of Coverage

The *effective date* for new *employees* is determined based on the following:

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

Types of Coverage

Your health benefit plan offers the following types of coverage:

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

Reporting Changes

Have you moved, added or changed other health coverage, changed your name or phone number? If so, contact your *HBR* or follow the online process for updating your information through your enrollment system. It will help us give you better service if the *State Health Plan* or its representative is kept informed of these changes.

When Coverage Ends

Coverage for you or your *dependents* ends the last day of the month in which an ineligibility event occurs. Some examples of ineligibility events are divorce, *dependent child* becomes eligible for their own health coverage, and termination of employment. For additional ineligibility events, contact Customer Service at the number in "Who to Contact." You must notify your *HBR* when there is a change of eligibility or make the change request through your online enrollment system. If notification is not made within the 30 days following the *dependent's* ineligibility event, the *dependent* will be retroactively removed the end of the month of the *dependent's* ineligibility event, and the coverage type change will be the first of the month following written notification, except in the case of death, in which case the coverage type change will be made retroactively to the first of the month following death.

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

Coverage ends when your coverage is fully contributory and your premium is not received within 60 days after your premium due date. After 30 days, claims for you and any *dependents* will be placed on hold or will be denied during the period for which a premium has not been paid.

You or your *dependents* may be eligible for continuation coverage under COBRA or to convert to a non-employer sponsored plan the first day of the month following an eligibility event.

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

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

Definitions

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

AFFORDABLE CARE ACT (ACA) PREVENTIVE CARE PRESCRIPTION DRUGS – prescription drugs identified by the *Affordable Care Act* covered at 100%.

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

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

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

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

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

c) Does not provide *inpatient* accommodations,

d) Is not other than incidentally, a facility used as an office or clinic for the private practice of a *doctor* or *other provider*.

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

BENEFIT PERIOD — the period beginning January 1, 2015, and ending on December 31, 2015, which charges for *covered services*, if applicable, are applied to the annual *deductible* and *coinsurance maximum* and during which annual benefit maximums accumulate.

BENEFIT PERIOD MAXIMUM — the maximum amount of allowed charges for *covered services* in a *benefit period* that will be reimbursed on behalf of a *member* while covered under the health benefit plan.

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

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

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

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

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

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

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

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

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

COVERED SERVICE(S) — a service, drug, supply or equipment specified in this benefit booklet for which *members* are entitled to benefits in accordance with the terms and conditions of their health benefit plan.

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

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

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

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

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

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

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

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

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

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

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

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

EXPERIMENTAL — see *Investigational*.

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

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

FOSTER CHILD(REN) — children under age 18 i) for whom a guardian has been appointed by a clerk of superior court of any county in North Carolina or ii) whose primary or sole custody has been assigned by order of a court with proper jurisdiction and who are residing with a person appointed as guardian or

custodian for so long as the guardian or custodian has assumed the legal obligation for total or partial support of the children with the intent that the children reside with the guardian or custodian on more than a temporary or short term basis.

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

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

HBR — see *Health Benefits Representative*.

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

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

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

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

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

a) Provides skilled nursing and other services on a visiting basis in the *member's* home,

b) Is responsible for supervising the delivery of such services under a plan prescribed by a *doctor,*

c) Is accredited and licensed or certified in the state where located,

d) Is certified for participation in the Medicare program, and

e) Is acceptable to *MedCost*.

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

a) Is accredited, licensed or certified in the state where located,

b) Is certified for participation in the Medicare program, and

c) Is acceptable to *MedCost*.

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

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

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

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

IN-NETWORK —designated as participating in CVS Caremark's National Network of Pharmacies or MedCost's PPO Network or affiliate. The *State Health Plan's* payment for *in-network covered services* is described in this benefit booklet as *in-network* benefits or *in-network* benefit levels.

IN-NETWORK PROVIDER — a pharmacy, *hospital*, *doctor*, other medical practitioner or *provider* of *medical services* and supplies that has been designated as a MedCost PPO and Affliated Network *provider*.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

a) Cardiac rehabilitative therapy — reconditioning the cardiovascular system through exercise, education, counseling and behavioral change

b) Chemotherapy (including intravenous chemotherapy) — the treatment of malignant disease by chemical or biological antineoplastic agents which have received full, unrestricted market approval from the Food and Drug Administration (FDA)

c) Dialysis treatments — the treatment of acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body to include hemodialysis or peritoneal dialysis

d) Pulmonary therapy — programs that combine exercise, training, psychological support and education in order to improve the patient's functioning and quality of life

e) Radiation therapy — the treatment of disease by x-ray, radium, or radioactive isotopes

f) Respiratory therapy — introduction of dry or moist gases into the lungs for treatment purposes.

OUT-OF-NETWORK — not designated as participating in CVS Caremark National Pharmacy Network or MedCost's PPO or affiliate network and/or not certified in advance by *MedCost* to be considered as *in-network*. Payment for *out-of-network covered services* is described in this benefit booklet as *out-of-network* benefits or *out-of-network* benefit levels.

OUT-OF-NETWORK PHARMACY – a pharmacy that has not been designated as participating in CVS Caremark Pharmacy Network.

OUT-OF-NETWORK PROVIDER — a *provider* that has not been designated as participating in the MedCost PPO or affiliate network.

OUT-OF-POCKET MAXIMUM – This is the most you pay for covered expenses (medical and pharmacy) in a calendar year. It includes *deductibles* and *coinsurance*, but excludes *premiums*.

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

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

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

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

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

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

PREVENTIVE CARE — *medical services* provided by or upon the direction of a *doctor* or *other provider* related to the prevention of disease. Certain services are identified by the *Affordable Care Act* as being "*Preventive Care*" and are covered at 100%.

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

PRIOR REVIEW — the consideration of benefits for an admission of care, continued stay, or other services, supplies or drugs, based on the information provided and requirements for a determination of

medical necessity of services and supplies, appropriateness, health care setting, or level of care and effectiveness. *Prior review* results in *certification* or *noncertification* of benefits.

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

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

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

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

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

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

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

b) Physical therapy — treatment by physical means, hydrotherapy, heat or similar modalities, physical agents, biomechanical and neurophysiological principles and devices to relieve pain, restore maximum function and prevent disability following disease, injury or loss of body part

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

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

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

SPECIALTY MEDICATION – Specialty and biosimilar medications are designated and classified by the Plan as medications that meet the following criteria and are listed on the Specialty Drug List, which is located on the Plan's website: treats complex medical conditions(s), requires frequent clinical monitoring, e.g. dosing adjustments, requires special patient education, training and/or coordination of care and generally prescribed by a specialist provider.

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

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

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

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

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

a) The correction of fractures and dislocations

b) Usual and related preoperative and postoperative care

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

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

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

USUAL, CUSTOMARY AND REASONABLE (UCR) — the amount the *provider* charges based on the most typical charge for medical service that does not exceed the customary fee in that geographic area, and is reasonable based on the circumstance.

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

Notice of Privacy Practices

Original *Effective Date*: April 14th, 2003

Revised *Effective Date*: September 23rd, 2013

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

PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Introduction

A federal law, the Health Insurance Portability and Accountability Act (HIPAA), requires that health Plan and health care providers protect the privacy of certain medical information. This notice covers the medical information practices of the State Health Plan for Teachers and State *Employees*. This notice is intended to inform you of your rights under the privacy provisions of HIPAA and the HIPAA obligations imposed on the Plan. The Plan is required to maintain the privacy of PHI in accordance with HIPAA (as summarized herein), provide this Notice to covered individuals, and notify affected individuals following a "breach" of unsecured PHI (as defined by HIPAA). The privacy laws of a particular state or other federal laws might impose a stricter privacy standard than HIPAA. If these stricter laws apply, the Plan will comply with the stricter law to the extent such laws are not otherwise preempted. It is necessary that certain *employees* of the plan sponsor be permitted to access, use, and/or disclose the minimum amount of your PHI to perform certain plan administration functions. In accordance with HIPAA, we restrict access to your health plan information only to certain *employees* who need to know that information to perform plan administration and we maintain physical, electronic, and procedural safeguards that comply with federal regulations to guard your health plan information. If you have general questions about your medical claims information maintained by the Plan, call or write to the privacy contact identified at the end of this notice.

What information is protected?

Only identifiable health information that is created or received by or on behalf of the Plan is protected by HIPAA. This health information is called "protected health information" (PHI).

How the Plan May Use and Disclose your PHI

This section describes how the Plan can use and disclose PHI. Please note that this notice does not list every use or disclosure; instead it gives examples of the most common uses and disclosures.

It is necessary for certain third parties to assist the Plan in administering your health benefits under the Plan. These entities keep and use most of the PHI maintained by or on behalf of the Plan such as information about your health condition, the health care services you receive, and the payments for such services. They use and disclosure your PHI to process your benefit claims and to provide other services necessary to plan administration. They are legally obligated to use the same privacy protections as the Plan.

Primary Uses and Disclosures of PHI

- The Plan may disclose your PHI so that your *doctors*, dentists, pharmacies, *hospitals* and other health care *providers* may provide you with medical treatment.
- The Plan also may send your PHI to *doctors* for patient safety or other treatment-related reasons.
- The Plan may use and disclose your PHI to facilitate payment of benefits under the Plan; including

determining eligibility for benefits, calculating your benefits under the Plan, paying your health care *providers* for treating you, calculating your co-pays and *coinsurance* amounts, deciding claims *appeals* and inquiries, and/or coordinating coverage. For example, the Plan may disclose information about your medical history to a physician to determine whether a particular treatment is *experimental*, *investigational*, or *medically necessary* or to decide if the Plan will cover the treatment.

- The Plan may use and disclose your PHI for additional related health care operations necessary to operate the Plan, including but not limited to: underwriting and soliciting bids from potential insurance carriers; merger and acquisition activities; setting premiums; deciding *employee* premium contributions; submitting claims to the Plan' stop-loss (or excess loss) carrier; conducting or arranging for medical review; legal services; audit services; and fraud and abuse detection programs. NOTE: The Plan will not use or disclose "genetic information" (as defined in 45 C.F.R. 160.103) for purposes of underwriting.
- The Plan may use your PHI to contact you or give you information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Other Uses and Disclosures of PHI

- The Plan is required to disclose your PHI to the Secretary of the U.S. Department of Health and Human Services if the Secretary is investigating or determining compliance with HIPAA.
- The Plan will disclose PHI about you when required to do so by federal, state or local law.
- The Plan may release your PHI for Workers' Compensation or similar programs.
- The Plan may use and disclose PHI about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
- If you are an organ donor, the Plan may release your PHI to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.
- If you are a *member* of the armed forces, the Plan may release your PHI as required by military command authorities.
- The Plan may disclose your PHI for certain public health activities including but not limited to:
- Disclosure to a public health authority that is authorized by law to collect or receive information for the purpose of preventing or controlling disease and conducting public health surveillance and public health investigations;
- Disclosure to a person who has responsibility to the FDA regarding the quality, safety, or effectiveness of an FDA-regulated product or activity; and
- Disclosure to a person who may have been exposed to a communicable disease or who may be otherwise at risk of contracting or spreading a disease or condition, if the covered entity is authorized by law to notify such person.
- If the Plan reasonably believe that you or a child has been the victim, of domestic or child abuse or neglect, the Plan may disclose PHI to certain entities authorized by law to receive such information provided certain conditions are satisfied (in most cases your agreement is necessary unless you are incapacitated or the Plan reasonably believe that disclosure is necessary to prevent harm or threat to life).
- The Plan may disclose your PHI to a health oversight agency for activities authorized by law (for example, audits, investigations, inspections, and licensure).
- If you are involved in a lawsuit or a dispute, the Plan may disclose your PHI in response to a court or administrative order.
- The Plan may also disclose your PHI in response to a subpoena, discovery request, or other lawful process provided that, if the Plan is not a party to the litigation, good faith attempts have been made to tell you about the request or to obtain an order protecting the information requested.
- The Plan may release your PHI if asked to do so by a law enforcement official in certain instances.
- The Plan may disclose PHI to a coroner or medical examiner for purposes of identifying a deceased person,

determining the cause of death, or other duties as authorized by law.

- The Plan may disclose your PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
- If you are an inmate of a correctional institution or under the custody of a law enforcement official, the Plan may release your PHI to the correctional institution or law enforcement official.
- Using its best judgment, the Plan may disclose your PHI to a family *member*, other relative, or close friend. Such a use will be based on how involved the person is in your care or payment that relates to that care.
- The Plan may release claims payment information to *spouses*, parents, or guardians, unless you specifically object in writing to the Privacy Manager identified in the Notice.
- Other uses and disclosures of your PHI that are not described above will be made only with your written authorization. For example, an authorization is required in the following instances: (i) any use or disclosure of psychotherapy notes except as otherwise permitted in 45 C.F.R. 164.508(a)(2); (ii) any use or disclosure for "marketing" except as otherwise permitted in 45 C.F.R. 164.508(a)(3); (iii) any disclosure which constitutes a sale of PHI. If you authorize the Plan to use or disclose your PHI, you may revoke the authorization at any time in writing. However, your revocation will only stop future uses and disclosures that are made after the Plan receives your revocation. It will not have any effect on the prior uses and disclosures of your PHI.

Your Rights Regarding PHI

You have the following rights regarding PHI the Plan has about you:

- You have the right to inspect and copy your PHI that may be used to make decisions about your benefits. To inspect and copy your PHI that may be used to make decisions about you, you must submit your request in writing to the appropriate privacy contact listed on page 92. If you request a copy of this information, the Plan may charge a fee for the costs of copying, mailing or other supplies associated with your request. The Plan may deny your request to inspect and copy your PHI in certain very limited circumstances. HIPAA provides several important exceptions to your right to access your PHI. For example, you will not be permitted to access psychotherapy notes or information compiled in anticipation of, or for use in, a civil, criminal or administrative action or proceeding. The Plan will not allow you to access your PHI if these or any of the exceptions permitted under HIPAA apply. If you are denied access to your PHI, you may request a review of the denial.
- If you feel that PHI the Plan have about you is incorrect or incomplete, you may ask the Plan to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, you must submit your request in writing to the appropriate Privacy Contact listed below. Your request must list the specific PHI you want amended and explain why it is incorrect or incomplete. The Plan may deny your request for an amendment if it is not in writing or does not list why it is incorrect or incomplete. In addition, the Plan may deny your request if you ask the Plan to amend information that is:
    - Not part of the PHI kept by or for the Plan;
    - Not created by the Plan or its third party administrators;
    - Not part of the information which you would be permitted to inspect and copy; or
    - Accurate and complete.

If the Plan denies your request, they must provide you a written explanation for the denial and an explanation of your right to submit a written statement disagreeing with the denial no later than 60 days after receipt of your request.

- When you request, we are required to disclose to you the portion of your PHI that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. You also have the right to request an "accounting" of certain disclosures of your PHI. The accounting will not

include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures. To request an accounting, you must submit a written request to the Privacy Contact identified in this Notice. Your request must state a time period of no longer than six (6) years.

- You have the right to request that the Plan communicate with you about health plan matters in a certain way or at a certain location. We are only obligated to comply with such a request if the disclosure will endanger you. For example, you can ask that the Plan only contact you at work or by mail. You also have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations or for disclosures to other individuals involved in your care. We are generally not obligated to comply with any request for restrictions or limitations. To request alternative communications or restrictions and/or limitations, you must submit your request in writing to the appropriate privacy contact listed below or you can call **866-740-3881**. Your request must specify how or where you wish to be contacted.

Changes to This Notice

The Plan has the right to change this notice at any time. The Plan also have the right to make the revised or changed notice effective for medical information the Plan already have about you as well as any information received in the future. The Plan will post a copy of the current notice at *www.shpnc.org.* You may request a copy by calling **866-740-3881**.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the Plan or with the Secretary of the Department of Health and Human Services.

To file a complaint with the Plan, contact the Privacy Contact identified in this Notice. You will not be penalized or retaliated against for filing a complaint.

Privacy Contact

The Privacy Contact is:

State Health Plan
Attention: HIPAA Privacy Officer,
3200 Atlantic Avenue

Raleigh, NC 27604

919-814-4400

Nondiscrimination and Accessibility Notice

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

The State Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact the Civil Rights Coordinator identified below (the "Coordinator"):

State Health Plan Compliance Officer
(919)-814-4400

If you believe that the State Health Plan has failed to provide these services or discriminated against you, you can file a grievance with the Coordinator. You can file a grievance in person or by mail, fax, or email. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, available at:

U.S. Department of Health and Human
Services, 200 Independence Avenue SW.,
Room 509F, HHH Building, Washington, DC 20201,
1–800–868–1019, 800–537–7697 (TDD).

File complaint electronically at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 919-814-4400.
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 919-814-4400.
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 919-814-4400.
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 919-814-4400.
French	ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 919-814-4400.
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 919-814-4400.
Hmong	LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 919-814-4400.

Notice of Privacy Practices

Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 919-814-4400.
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 919-814-4400.
Gujarati	સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 919-814-4400.
Mon-Khmer, Cambodian	ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 919-814 4400.
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 919-814-4400.
Hindi	ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 919-814-4400.
Laotian	ໂປດຊາບ: ຖ້າວ່າທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 919-814-4400.
Japanese	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。919-814-4400.