North Carolina

State Health Plan

for Teachers and State Employees

High Deductible Health Plan

Benefits Booklet

JANUARY 1 - DECEMBER 31, 2025



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

aetna®

January 24, 2025

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FOR TEACHERS AND STATE EMPLOYEES
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HIGH DEDUCTIBLE HEALTH PLAN BENEFITS BOOKLET

Welcome to the *State Health Plan*'s High Deductible Health Plan, also referred to in this benefits booklet simply as your health benefit plan or the HDHP. Your health benefit plan is administered by *Aetna*. In North Carolina, the Plan has a custom network, the North Carolina State Health Plan Network. Outside of North Carolina, you have access to a national network through *Aetna*.

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

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

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

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

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

The information contained in this booklet is supported by medical policies, which are used as guides to make coverage determinations. For specific detailed information, or medical policies, please call Aetna Health Concierge (Customer Service) at 833-690-1037 or visit the State Health Plan's website at www.shpnc.gov. To obtain a copy of the General Statutes visit the North Carolina General Assembly's website at https://www.ncleg.gov/Laws/GeneralStatutes and search for Article 3B in Chapter 135.

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

Aviso Para Miembros Que No Hablan Ingles

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

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

For your convenience, we have additional ways for you to access your *member* information. Our website offers a variety of health-related resources – including online forms, search tools to help you find a *doctor*, and general information about your plan. Additionally, our prompt and knowledgeable Aetna Health Concierge (Customer Service) is just a phone call away at 833-690-1037.

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WHO TO CONTACT

State Health Plan **Customer Service** Aetna Health Concierge 833-690-1037 8 a.m. - 6 p.m., Monday-Friday, except holidays	For questions regarding your benefits, claim inquiries and new *Identification Card (ID card)* requests.
Medical *Certification* or *Prior Authorization* Aetna Health Concierge 833-690-1037 8 a.m. - 6 p.m., Monday-Friday, except holidays	To request *prior authorization* (*certification*) for certain *out-of-network* services.
Medical Claims Filing	Mail completed medical claims to: North Carolina State Health Plan PO Box 14079 Lexington KY 40512-4079
Eligibility and Enrollment Support Center 855-859-0966 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 *PBM* Customer Service 888-321-3124 24 hours a day, 7 days per week	For questions regarding your *pharmacy* benefits, to obtain a preferred medication list, information on *prior authorizations*, refills, and more. Please note: *Aetna* does not administer your prescription drug benefits.
CVS Caremark *PBM* Specialty Pharmacy 800-238-7828	For information regarding the specialty pharmacy services offered or to obtain *specialty medications*.
CVS Caremark *PBM* - *Prior Authorization* Number 800-294-5979	To initiate a *prior authorization* request for a *prescription medication*.
Prescription Medication **Claims Filing**	Mail completed *prescription medication* claim forms to: CVS/Caremark P.O. Box 52136 Phoenix, Arizona 85072-2136
Medical and Pharmacy *Appeals* 833-690-1037	See "*Appeals* Correspondence" in "What If You Disagree with A Decision?"

N.C. Department of State Treasurer, **Retirement Systems Division** 3200 Atlantic Avenue Raleigh, NC 267604 919-814-4000 or 1-877-NCSECURE (1-877-627-3287) www.myncretirement.com	If you are a benefit recipient (*Retirees*, Beneficiaries, Disability recipients) and you have questions about your retirement benefits.
State Health Plan Website www.shpnc.gov	To obtain information on Pharmacy benefits, search for a *provider*, obtain claim forms, obtain "proof of coverage" portability certificates, and more.
State Health Plan Office 919-814-4400	Enrollment exceptions for Non-Active *Member*s (*Retiree*s, Disabled *Member*s, RIF *Members*, COBRA *Members*, former *Members* of the General Assembly, and other 100% contributory *Members*). Active *members* must contact their *HBR for enrollment exceptions*.
***State Health Plan* Customer Service** Aetna Health Concierge 833-690-1037 8 a.m. - 6 p.m., Monday-Friday, except holidays	For questions regarding your benefits, claim inquiries and new *Identification Card (ID card)* requests.
Medical *Certification* or *Prior Authorization* Aetna Health Concierge 833-690-1037 8 a.m. - 6 p.m., Monday-Friday, except holidays	To request *prior authorization* (*certification*) for certain *out-of-network* services.
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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.*

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*, and a Benefits Booklet and benefits summary. Access an online directory of *in-network provider*s.
- Receive courteous service from the *State Health Plan* and its representatives.
- Receive considerate and respectful care from your *in-network providers.*
- Receive the reasons for the denial of a requested treatment or health care service, including, upon request, an explanation of the *Utilization Management* criteria and treatment protocol used to reach the decision.
- Receive the reasons why *Aetna* denied a request for treatment or health care service, and the rules used to reach those results.
- Receive, upon request, information on the procedure and medical criteria used to determine whether a procedure, treatment, facility, equipment, medication, or device is *investigational*, *experimental*, or requires prior approval.
- Receive accurate, reader friendly information to help you make informed decisions about your health care.
- Expect that measures will be taken to ensure the confidentiality of your health care information.
- File a *grievance* and expect a fair and efficient *appeals* process for resolving any differences you may have with the coverage determination of your health benefit plan.
- Be treated with respect, including 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 policies on *members'* rights and responsibilities.
- Play an active part in your health care and discuss treatment options with your provider without regard to cost or benefit coverage.
- Participate with practitioners in making decisions about your health care.

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 and understand your benefits booklet and all other *member* materials.
- Call Aetna Health Concierge if you have a question or do not understand the material provided by the *State Health Plan*.
- Follow the course of treatment prescribed by your *doctor*. If you choose not to comply, tell your *doctor.*
- Provide complete information about any illness, accident, or health care issues to the *State Health Plan* or its representatives and *provider*s.
- Make and keep appointments for non-*emergency medical care*. If it is necessary to cancel an appointment, give the *doctor's* office adequate notice.
- Ensure any advance *certifications* have been received for *out-of-network* services (see "Prospective Reviews" section for information on *certifications*).
- File claims for *out-of-network* services in a complete and timely manner.
- Participate in understanding your health problems and the medical decisions regarding your health care.
- Be considerate and courteous to North Carolina State Health Plan Network *provider*s, their staff, and *State Health Plan* representatives.
- Use the secure member portal to manage claims and related benefit issues.
- Protect your *ID card* from unauthorized use.
- Notify your employing unit and the *State Health Plan* of any address or phone number changes.
- Notify your employer and the *State Health Plan* if you have any other group coverage or become eligible for Medicare.
- Update eBenefits, the Plan’s enrollment system with any change in a dependent’s status.

UNDERSTANDING YOUR STATE HEALTH PLAN COVERAGE

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

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

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

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

- "Summary of Benefits" to get an overview of your specific benefits, such as *deductible, coinsurance,* and maximum amounts.
- "*Covered Services*" to get more detailed information on what is covered and what is excluded from coverage.
- "What Is Not Covered?" to see general exclusions from coverage.
- "*Utilization Management"* for important information on when *prior authorization* and *certification* are required.

GET THE MOST OUT OF YOUR HEALTH CARE BENEFITS

Understand Your Health Benefit Plan

The more you know about your benefits, the easier it will be to take control of your health. Let the *State Health Plan* help you understand your plan and use it effectively through our customer friendly website, **www.shpnc.gov**, Aetna Health Concierge at 833-690-1037, and your benefits booklet.

Manage Your Out-of-Pocket Costs by Managing the Locations in which You Receive Care

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

Save on Prescription Medications

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

Select a Primary Care Provider (PCP)

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

THE CLEAR PRICING PROJECT

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

CPP providers are noted in the online "*Find a Provider*" tool as CPP Providers.

To learn more about the CPP, visit the Plan's website at **www.shpnc.gov.**

NC HEALTHCONNEX

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

More details on NC HealthConnex, including updated legislation and FAQs, are available at www.hiea.nc.gov.

HOW THE HIGH DEDUCTIBLE HEALTH PLAN WORKS

The High Deductible Health Plan gives you the freedom to choose any *provider* — the main difference will be the cost to you, depending on whether you see an *in-network* or *out-of-network provider*.

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

A *Primary Care Provider* can practice:

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

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

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

In-Network Benefits

By receiving care from an *in-network provider*, you receive a higher level of benefit coverage. *In-network providers* will file claims for you and request *prior authorization* when necessary. You may want to check with your *in-network provider* to make sure that *prior authorization* has been requested. Your *in-network provider* is required to use the North Carolina State Health Plan Network *hospital* where they practice, unless that *hospital* cannot provide the services you need. Aetna contracts with a broad network of *providers* to deliver *covered services* to Plan *members*. Please note that dentists and orthodontists do not participate in the North Carolina State Health Plan Provider Network, but there are a limited number of oral maxillofacial surgeon's available *in-network*. However, if the condition is an *emergency* or if an *in-network provider* is not reasonably available or that *provider* type does not participate in the network, benefits will be paid at the *in-network* level. For more information on *Aetna's* access to care standards, see the *State Health Plan* website at **www.shpnc.gov** or call Aetna Health Concierge at the number given in "Who to Contact." *In-network providers* include:

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

You do not need a referral to see a North Carolina State Health Plan Network *provider*. To see which *providers* are available *in-network*, please refer to the "Find a Provider" section of this Benefits Booklet, on our website at **www.shpnc.gov**, or call *State Health Plan* Customer Service at the number given in "Who to Contact."

The list of *in-network providers* may change from time to time, so please verify that the *provider* is still in the North Carolina State Health Plan Network before receiving care, even if referred by an *in-network provider*.

Please refer to "Summary of Benefits" to see when *deductibles* or *coinsurance* apply to any of your *in-network* benefits. Also see "Understanding Your Share of the Cost" for an explanation of *deductibles*, *coinsurance,* and *out-of-pocket limits*.

Out-of-Network Benefits

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

However, if the condition is an *emergency*, or if *in-network providers* are not reasonably available to the *member* as determined by *Aetna's* access to care standards, benefits will be paid at the *in-network* benefit level. For more information on *Aetna's* access to care standards, see the *State Health Plan* website at **www.shpnc.gov** or call Aetna Health Concierge at the number given in "Who to Contact." If you believe an *in-network provider* is not reasonably available, you can help assure that benefits are paid at the correct benefit level by calling *State Health Plan* Aetna Health Concierge before receiving care from an *out-of-network provider*. See the number for Aetna Health Concierge *Prior authorization* in "Who to Contact."

When you see an *out-of-network provider*, you may be responsible for more of the cost. *Out-of-network* benefits are generally lower than *in-network* benefits. In addition, you may be required to pay the difference between the *provider's* actual charge and the *allowed amount*. You eliminate this additional cost by receiving care from *in-network providers*. The *State Health Plan* encourages you to discuss the cost of services with *out-of-network providers* before receiving care, so you will be aware of your total financial responsibility. *Out-of-network providers* may or may not bill the *State Health Plan* directly for services. If the *provider* does not bill the *State Health Plan*, you will need to submit a claim form to the *State Health Plan*.

Out-of-network providers, unlike *in-network providers*, are not obligated by contract with Aetna to request *prior authorization* by the *State Health Plan*. If you go to an *out-of-network provider*, it is your responsibility to request or ensure that your *provider* requests *prior authorization* by the *State Health Plan* or its representative. Failure to request *prior authorization* and obtain *certification* will result in a $500.00 penalty. Before receiving the service, you may want to verify with the *State Health Plan* or its representative that *certification* has been obtained. See "Prospective Review/*Prior authorization*" in "*Utilization Management*" for additional information.

Note: Some services may not be covered *out-of-network*. See "Summary of Benefits" and "*Covered Services*." See "*Out-of-Network* Benefits Exceptions" and "*Emergency* and *Urgent Care* Services." Also see "Behavioral Health Services" for additional information on *prior authorization* and *certification* requirements for these services.

How to File a Claim

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

For your medical services:	For your *prescription medications*:
North Carolina State Health Plan PO Box 14079, Lexington KY 40512-4079	CVS Caremark P.O. Box 52136 Phoenix, Arizona 85072-2136

You may obtain a claim form, including international claim forms, by visiting the *State Health Plan* website at **www.shpnc.gov** or calling *State Health Plan* Aetna Health Concierge at the number listed in "Who to Contact." For help filing a claim, call *State Health Plan* Aetna Health Concierge at the number given in "Who to Contact."

Making an Appointment

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

Identification Card

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

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

Only *subscriber*s 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.gov**. The *Plan* will seek reimbursement for claims *incurred* with a *State Health Plan ID card* before coverage is effective or after coverage has ended.

If any information on your ID card is incorrect or for *ID card* requests, please visit your secure member portal which can be accessed from eBenefits. For information about how to access eBenefits, visit the *Plan's* website at **www.shpnc.gov** or call Aetna Health Concierge at the number listed in "Who to Contact" or on the back of your *ID card*.

UNDERSTANDING YOUR SHARE OF THE COST

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

Benefits are available for service from an *in- or out-of-network provider* that is recognized as eligible. For a list of eligible *providers*, please visit the *Plan's* website at **www.shpnc.gov** or call Aetna Health Concierge at the number listed in "Who to Contact."

	In-Network	***Out-of-Network***
Type of *Provider*	*In-network providers* are health care professionals and facilities that have contracted with *Aetna*. *In-network providers* agree to limit charges for *covered services* to the *allowed amount*. Please note that *dentists* and orthodontists do not participate in the North Carolina State Health Plan Network but there are a limited number of oral maxillofacial 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.gov** or call Aetna Health Concierge at the number listed in "Who to Contact."	*Out-of-network providers* are not designated as North Carolina State Health Plan Network *providers*. Also see "*Out-of-Network* Benefit Exceptions."
Allowed Amount 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 will be responsible for any applicable copays, *deductible*, *coinsurance*, and non-covered expenses based on the allowed amount. It is important to note, that there are some instances, due to the provider contract with Aetna, that the *allowed amount* may be greater than the billed amount.	You may be responsible for paying any charges over the *allowed amount* in addition to any applicable *deductible*, *coinsurance*, non-covered expenses, and *certification* amounts, if any, except for emergency services in the case of an *emergency*.
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	Your *ID card* gives you access to participating *providers* outside the state of North Carolina through Aetna's national network, and benefits are provided at the *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* benefit. Also see "*Out-of-Network* Benefit Exceptions."

Prior Authorization	*In-network providers* and *in-network* inpatient facilities, except for Veterans' Affairs (VA) and military providers, are responsible for requesting *prior authorization* when necessary. *prior authorization* For *inpatient* or certain *outpatient* behavioral health services, either in or outside of North Carolina, see the *Behavioral Health number in "Who To Contact."* *Prior authorization* 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 authorization by Aetna.* Failure to request *prior authorization and* obtain *certification* will result in a $500.00 penalty for the member. *Prior authorization* is not required for *emergency services* 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 *Aetna*.	You may have to pay the *out-of-network provider* in full and submit your own claim to *Aetna*. 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. For *emergency services*, see "Out of-Network Benefit Exceptions" and "Emergency and Ambulance Services."

Out-of-Network Benefit Exceptions

You will only be responsible for your in-network share of the cost, and providers may not bill you more than your in-network share of the cost in the following situations:

- When emergency services are provided by an out-of-network provider or an out-of-network emergency facility*
- When you receive emergency medically necessary ground or air transport ambulance from an out-of-network provider*
- When you receive medically necessary air transport ambulance from an out-of-network provider.*
- When non-emergency services are provided by an out-of-network provider.at an in-network health care facility
- When non-emergency services are provided by an out-of-network provider in situations where in-network providers are not reasonably available as determined by *Aetna's* access to care standards
- In continuity of care situations

*These situations may not qualify for an out-of-network benefit exception if the member gives consent. Please see [https://www.cms.gov/nosurprises] for notice regarding surprise billing describing your rights and how consent may impact these situations.]

HIGH DEDUCTIBLE HEALTH PLAN SUMMARY OF BENEFITS

The following is a summary of your High Deductible Health Plan benefits. A more complete description of your benefits is found in "*Covered Services*." General exclusions may also apply. Please see the "What Is Not Covered?" section. 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* are based on the *allowed amount.*
- Services applied to the *deductible* also count toward any visit or day maximums.
- If your benefit level for services includes *deductibles* and *coinsurance*, your *provider* may collect an estimated amount of these at the time you receive services.
- To receive *in-network* benefits, you must receive care from a North Carolina State Health Plan Network *in-network provider.* **However, in an *emergency*, or when *in-network providers* are not reasonably available as determined by *Aetna's* access to care standards, you may also receive *in-network* benefits for care from an *out-of-network provider*.** Please see "*Out-of-Network* Benefits" and "*Emergency* and *Urgent Care* Services" for additional information on *emergency* care. Access to care standards are available on our website at **www.shpnc.gov**, then click "Find a Provider" or by calling the Aetna Health Concierge number given in "Who to Contact."
- If you see an *out-of-network provider,* you will receive *out-of-network* benefits unless otherwise approved by the *State Health Plan* or its representative.
- *Out-of-Network* Labs: If your *provider* sends your lab work to an *out-of-network* lab for processing, your claims will no longer be paid at the in-network *coinsurance*. Your claims for these services will be paid at the appropriate *out-of-network deductible coinsurance* level. This may result in you having to pay more for *out-of-network* lab work. Talk to your *provider* to ensure they are using the North Carolina State Health Plan Network *in-network* labs.
- For some services that are not covered benefits, discounts may be available as "value-added benefits." Please see the section called "Value-Added Programs" in the back of this booklet.
- This plan offers *Wellness Premium Credits* and *Wellness Incentives* to encourage decisions that are good for your health.
- *Preventive Care* as described under the *Affordable Care Act (ACA)* is covered at 100% with an *in-network* provider so long as any applicable medical management requirements are met.
- Designated walk-in clinics such as Minute Clinic are covered at 100%.
- *Preventive medications* listed under the *Affordable Care Act (ACA)* with a *prescription* written by a *provider* and filled at a participating pharmacy, are covered at 100%.

The *Plan* may use reasonable medical management procedures to determine any coverage limitations or restrictions that may apply.

Please note the list of *in-network providers* may change from time to time, so please verify that the *provider* is still in the North Carolina State Health Plan Network before receiving care. A *provider* locator is available through our website at www.shpnc.gov or by calling Aetna Health Concierge at the number given in "Who to Contact."

Lifetime Maximum, Deductible, and Out-of-Pocket Limit

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

	In-Network	***Out-of-Network****
Lifetime Maximum	Unlimited	Unlimited
Unlimited for all *covered services* except where otherwise specifically indicated or excluded. If you exceed any *lifetime maximum,* additional services of that type are not covered. In this case, you may be responsible for the entire amount of the *Provider*'s billed charge.		
Deductible		
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*. • *Inpatient* newborn care for well-baby.		
Out-of-Pocket Limit		
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 *out-of-pocket limit*. The *out-of-pocket limit*, which is the *deductible* plus any *coinsurance* you pay, is the total amount you will pay for *covered services.*		

Preventive Care

	In-Network	***Out-of-Network****
Primary Care Provider	No Charge	60% after deductible
Specialist	No Charge	60% after deductible
Nutrition Counseling	No Charge	60% after deductible
Available in an office-based, *outpatient*, or ambulatory surgical setting, or *urgent care* center. Services include among others: routine physical exams and screenings, well-baby care, well-childcare, well-woman care, immunizations, nutritional counseling, gynecological exams, cervical cancer screening, ovarian cancer screening, screening mammograms, colorectal screening, bone mass measurement, prostate-specific antigen tests, and newborn hearing screening. This benefit is only for services that indicate a primary diagnosis of preventive or wellness. Please visit the *Plan's* website at **www.shpnc.gov** for the most up-to-date information on *preventive care* covered under federal law.		
The following *preventive care* benefits are available both in- and *out-of-network*: gynecological exams, cervical cancer screening, ovarian cancer screening, screening mammograms, colorectal screening, bone mass measurement, newborn hearing screenings and prostate specific antigen tests. See *Covered Services*.		

Provider's Office

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

***Office Visit* Services**	***In-Network***	***Out-of-Network****
Primary Care Provider	50% after deductible	**60% after *deductible***
*Specialist (*includes *Ambulatory Infusion Suite)*	50% after deductible	**60% after *deductible***
Includes office *surgery,* X-rays and lab tests. For MRIs, MRAs, CT scans and PET scans, see *Outpatient Diagnostic Services.*		

CT Scans, MRIs, MRAs, and PET Scans	50% after deductible	60% after *deductible*

Virtual Care Visits

Some primary care provider offices offer virtual visits. The member cost-share for these visits will be the same as an in-person visit. A visit with a Teladoc provider also has the same cost-share as an in-person visit.

	In-Network	***Out-of-Network***
Teladoc	50% after deductible	NA

Designated Walk-In Clinics

Services rendered at a designated walk-in clinic, such as Minuteclinic are free for members. To find a designated walk-in clinic, visit the "Find A Provider" tool on the Plan's web site, shpnc.com

	In-Network	***Out-of-Network***
Designated Walk-In Clinic	$0.00	NA

Short-Term Therapy Services (Includes Evaluation and Management)

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

	In-Network	***Out-of-Network****
Short-Term Rehabilitative Therapies	50% after deductible	60% after *deductible*
Short-Term Rehabilitative Therapies include chiropractic care**,** occupational therapy, and physical therapy. Combined in- and *out-of-network* benefit maximums apply to chiropractic services only. There is a 30-visit limit for Chiropractic care. Any visits in excess of this *benefit period maximum* are not *covered services*.		
Other Therapies	50% after deductible	60% after *deductible*
Includes chemotherapy, dialysis and cardiac rehabilitation provided in the office. See *Outpatient Services* for *other therapies* provided in an *outpatient* setting.		
***Infertility* and *Sexual Dysfunction* Services**		
Primary Care Provider	50% after deductible	60% after *deductible*
Specialist	50% after deductible	60% after *deductible*
Combined in- and out-of-network lifetime limit of 3 ovulation induction cycles and associated services without insemination. Any services in excess of this lifetime limit are not *covered services*.		
Routine Hearing Evaluation Tests		
Primary Care Provider	50% after deductible	**Benefits not available**
Specialist	50% after deductible	**Benefits not available**

Urgent Care Centers, Emergency Rooms, and Ambulance Services

	In-Network	***Out-of-Network****
Urgent Care Centers	50% after deductible	60% after deductible
***Emergency Room* Visit**	50% after deductible	60% after deductible
If admitted to the *hospital* from the *emergency room*, *inpatient hospital* benefits apply to all *covered services* provided. If held for observation, *outpatient* benefits apply to all *covered services* provided. If you are sent to the *emergency* room from an *Urgent Care Center*, you may be responsible for both the *emergency* room *charges* and the *urgent care charges*.		
***Ambulance* Services**	50% after deductible	60% after deductible

Ambulatory Surgical Centers

	In-Network	*Out-of-Network**
Ambulatory Surgical Services	50% after deductible	60% after *deductible*

Outpatient Services

	In-Network	*Out-of-Network**
***Provider* Services**	50% after deductible	60% after *deductible*
***Hospital* and *Hospital Based* Services**	50% after deductible	60% after *deductible*
***Outpatient Clinical* Services**	50% after deductible	60% after *deductible*
Physician Services	50% after deductible	60% after *deductible*
Hospital and *Hospital*-based Services	50% after deductible	60% after *deductible*
***Outpatient* x-rays, ultrasounds, and other diagnostic test, such as EEGs, EKGs and pulmonary function tests**	50% after deductible	60% after *deductible*
CT scans, MRIs, MRAs, and PET scans	50% after deductible	60% after *deductible*
***Outpatient* diagnostic mammography (physician and *hospital*-based services)**	100% after deductible	60% after *deductible*
See "Preventive Care" for coverage of screening mammograms.		
Therapy Services Includes *short-term rehabilitative therapies* and *other therapies*.	50% after deductible	60% after *deductible*

Inpatient Hospital Services

	In-Network	*Out-of-Network**
***Provider* Services**	50% after deductible	60% after *deductible*
***Hospital* and *Hospital Based* Services**	50% after deductible	60% after deductible
Includes maternity delivery, prenatal and post-delivery care. For *inpatient* behavioral health services, refer to the "Behavioral Health Services" section later in this summary. If you are in a *hospital* as an *inpatient* at the time you begin a new *benefit period,* you may have to meet a new *deductible* for *covered services* from *doctors* or *other professional providers.*		

Nursing

	In-Network	*Out-of-Network**
Skilled Nursing Facility	50% after deductible	60% after *deductible*
Combined *in-* and *out-of-network maximum* of 100 days per *benefit period*. Services applied to the *deductible* count towards the day maximum. Any services in excess of this *benefit period maximum* are not *covered services*.		
Private Duty Nursing	50% after deductible	60% after *deductible*
There is a 4 hour per day limit on private duty nursing care for non-ventilated patients and 12 hours per day limit on private duty nursing for ventilated patients.		
Other Services	50% after deductible	60% after *deductible*

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

Behavioral Health Services

	In-Network	*Out-of-Network**
Behavioral Health Services ***Office Services***	50% after deductible	60% after deductible
Behavioral Health Services ***Outpatient* Services**	50% after deductible	60% after *deductible*
Behavioral Health Services ***Inpatient* Services**	50% after deductible	60% after deductible
Residential Treatment Centers	50% after deductible	60% after deductible

***Certification* Requirements**

In-network providers, except for Veterans Affairs (VA) and military providers, are responsible for requesting prior authorization for inpatient facility services. You are responsible for ensuring that you or your provider requests prior authorization by the State Health Plan for an out-of-network provider.

Certain services, regardless of the location, require prior authorization and certification to receive benefits. If you go to an in-network provider, your provider will request prior authorization when necessary. If you go to an out-of-network provider, you are responsible for requesting or ensuring that your provider requests prior authorization. Failure to request prior authorization and receive certification will result in a $500.00 penalty for the member. See "Covered Services" and "Prior authorization (pre-service)" in "Utilization Management."

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

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

Prescription Medications

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

Prescription Drugs (Generic, Brand-Name, and Specialty Drugs) **Diabetic Supplies**	50% after deductible
Affordable Care Act Preventive Medications	Covered at 100%
A list of *Affordable Care Act Preventive Medications* is on the *Plan's* website at **www.shpnc.gov**.	
NOTE: All *specialty medication* covered under the pharmacy benefit, excluding cancer medications, must be obtained through CVS Caremark Specialty Pharmacy.	
Insulin Both preferred and non-preferred insulin is available at no cost.	
For *certification* for certain *prescription medications*, your physician may call CVS Caremark at 800-294-5979 to initiate a *certification* request.	

COVERED SERVICES

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

Also keep in mind as you read this section:

- Certain services require *prior authorization* and *certification* in order for you to avoid a denial of your services. General categories or services are noted in the sections below as requiring *prior authorization,* please see "*Prior Authorization*" in "*Utilization Management*" for information about the review process. Visit our website at **www.shpnc.gov** or call Aetna Health Concierge to ask whether a specific service requires *prior authorization* and *certification*.
- Exclusions and limitations may apply to your coverage. Exclusions that apply to many services are listed in "What Is Not Covered?" To understand the exclusions and limitations that apply to each service, read "*Covered Services*," "Summary of Benefits" and "What Is Not Covered?"
- Certain services are covered pursuant to *Aetna* medical and reimbursement policies, which are updated throughout the plan year. These policies lay out the procedure and criteria to determine whether a procedure, treatment, facility, equipment, medication, or device is *medically necessary* and eligible for coverage, *investigational* or *experimental*, *cosmetic*, or a convenience item. The most up-to-date medical policies are available at **www.shpnc.gov**, or by calling Aetna Health Concierge at the number listed in "Who to Contact."

Office Services

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

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

Cost shares will not apply if you receive *Preventive Care* services or other specific services, such as allergy shots or other injections, and are not charged for an *office visit*.

Preventive Services

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

Under federal law, you can receive certain covered *preventive care* services from an *in-network provider* in an office-based, *outpatient*, ambulatory surgical setting, or *urgent care* center, at no cost to you. The specific services covered change from time to time. The *Plan* follows federal and *Aetna* guidelines that are based on the most current scientific evidence and are adapted from standards published by nationally recognized authorities. For a summary of Preventive Services is available on our website at **www.shpnc.gov**. Please note, this benefit is only for services that indicate a primary diagnosis of preventive or wellness which are identified by recent federal legislation as being eligible.

Services that do not include a primary diagnosis of preventive or wellness will be subject to your *in-network* benefit level for the location where services are received.

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

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

- Adult and Child Obesity Services
  - Obesity screening
  - Behavioral intervention
  - Nutritional counseling
- Adult Preventive Care (Routine Exams)
- Adult Screening Tests
  - Cholesterol (lipid) screening
  - Colorectal screening
  - Depression screening
  - Diabetes screening
  - High blood pressure screening
  - Cervical cancer screening (Pap test and/or HPV)
  - Osteoporosis screening
  - Ovarian Cancer Screening
  - Prostate Screening
  - Screening mammograms
- Women's Health Services include:
  - Breastfeeding Support and Counseling
  - Contraceptive methods and counseling - Contraceptive methods and procedures requiring a *prescription* and approved by the U.S. Food and Drug Administration are covered for each *member* with reproductive capacity through age 50. In addition, over-the-counter contraceptives are covered when a *provider*'s *prescription* is presented at the pharmacy. See "What Is Not Covered" for list of contraceptive methods that are not covered.
  - Gestational diabetes screening (pregnant women)
  - HIV screening and counseling
  - HPV testing
  - Well-woman visits
  - Mammograms

- Immunizations
    - Diphtheria, Pertussis, Tetanus Toxoid
    - Inactivated Poliovirus
    - Measles, Mumps, Rubella (MMR)
    - Influenza
    - Pneumococcal
    - Hepatitis A and B
    - Human Papillomavirus (HPV)
    - Meningococcal
    - Varicella
    - Tetanus, Diphtheria, Pertussis
    - Rotavirus
    - Herpes Zoster
    - COVID-19
- Well-Baby/Well-Childcare
    - Physical examinations
    - Sensory screening (vision and hearing)
    - Developmental/behavioral assessments
    - Oral health

Diagnostic Services

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

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

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

Laboratory, Radiology and Other Diagnostic Testing

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

See “What is Not Covered” for information about diagnostic services exclusions.

Urgent Care Centers, Emergency Rooms, and Ambulance Services

➢ *Ambulance* Services

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

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

Transport to and from a dialysis center:

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

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

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

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

The *Plan* covers services in an air *ambulance* only when:

  - Ground transportation is not medically appropriate due to the severity of the illness, or the pick-up point is inaccessible by land, or
  - Great distances, limited time frames, or other obstacles are involved in getting the member to the nearest hospital that can provide covered services appropriate to your condition.

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

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

➢ *Emergency* Care

The *Plan* provides benefits for *emergency services*.

An *emergency* is the sudden or unexpected onset of a medical condition, including a mental health or substance use disorder 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 authorization* is not required for *emergency services*. Your visit to the *emergency* room will be covered if your condition meets the definition of an *emergency*.

What are my benefits when I receive emergency services?

Situation	Benefit
• You receive in-network or out-of-network ground or air ambulance services prior to admission to an emergency department (ED)	• Ambulance benefits apply. • Prior authorization and certification are required for non-emergency air ambulance services. • Providers may not bill you for more than your in-network share of the cost for these services.*
• You go to an in-network or out-of-network emergency department. • You go to an in-network or out-of-network emergency department and then are held for observation or admitted inpatient to the hospital for additional emergency services. • You receive in-network or out-of-network emergency ground or air ambulance services after admission to an ED.	• Emergency copay waived with an admission or observation stay. • Prior authorization and certification are not required for emergency services. • Providers may not bill you for more than your in-network share of the cost for these services.*
• You get non-emergency follow-up care (such as office visits or therapy) after you are considered stable by your provider and you leave the emergency room 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.

* These situations may not qualify for an out-of-network benefit exception if the member gives consent. If you have questions or feel that you have been billed more than your in-network share of the cost, in addition to the rights under "Need to Appeal our Decision?", please see [https://www.cms.gov/nosurprises] for additional options, how consent may impact these situations, and a full statement of your rights under federal law regarding surprise billing.

➢ *Urgent Care*

The *Plan* also provides benefits for *urgent care* services.

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

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

Family Planning

➢ Maternity Care

Maternity care includes prenatal care, labor and delivery, and post-delivery care, and are available to all *subscriber*s and enrolled *spouse*s of *subscriber*s. 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 *member*s are covered under your *preventive care* benefit. Coverage includes:

- Breastfeeding counseling covered at 100% through *in-network providers*.
- Certain breast pumps for pregnant and post-partum women:
  - One manual or electric breast pump purchase per pregnancy is covered.
  - Benefit available during third trimester or after member has delivered the baby.
  - Breast pumps come with certain supplies, such as tubing, shields and bottles; therefore, replacement breast pump supplies will not be separately reimbursable on the same date as the breast pump, as the supplies are included in the initial purchase.
- Breast pump supplies will be limited to two units per code, per year.
  - Breast pumps must be purchased from participating Durable Medical Equipment (DME) vendors. Electric breast pumps are limited to one per twelve months.
- Contact Aetna Health Concierge for support finding a DME vendor near you. See "What Is Not Covered" for information about breast pump exclusions.

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

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

	Mom	Newborn	Payment
Prenatal care	Care related to the pregnancy before birth.		You may have a cost associated for the first *office visit* to diagnose pregnancy, otherwise *deductible* and *coinsurance* apply for the remainder of your maternity care benefits. If a *member* changes *providers* during pregnancy, terminates coverage during pregnancy, or the pregnancy does not result in delivery, one or more *cost share amounts* may be charged for prenatal services depending upon how the services are billed by the *provider*.
Labor & delivery services	No *prior authorization* 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 authorization* 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. *Inpatient* newborn care is covered under the mother's maternity benefits described above only during the first 48 hours after a vaginal delivery or 96 hours after delivery by cesarean section. This *inpatient* newborn care requires only one admission *cost share* and *benefit period deductible* for both mother and baby.

Post-delivery services	All care for the mother after baby's birth that is related to the pregnancy. *Prior authorization* and *certification* are required for *inpatient* stays extending beyond 48/96 hours or coverage will be denied.	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 and Ends." For *inpatient* services following the first 48/96 hours, *prior authorization* and *certification* are required or coverage will be denied.	

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 Aetna Health Concierge at the number given in "Who to Contact."

- **Complications of Pregnancy**

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

- **Complications of Abortion**

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

- **Newborn Care**

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

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

➢ *Infertility* Services

Benefits are provided for certain services related to the diagnosis, treatment, and correction of any underlying causes of *infertility* for all *member*s except *dependent children*. See "Summary of Benefits" for limitations that may apply.

➢ *Sexual Dysfunction* Services

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

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

➢ Sterilization

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

➢ Contraceptive Medications and Devices

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

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

Facility Services

➢ *Outpatient* Services

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

The following are *covered services*:

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

Certification in advance must be obtained for certain *outpatient* services. See "*Prior authorization* or *Certification"* for more information on *certifications*.

➢ *Inpatient Hospital* Services

Inpatient services received in a *hospital* or non-hospital facility. You are considered an *inpatient* if you are admitted to the *hospital* or non-hospital facility as a registered bed patient for whom a room and board charge is made. Your *in-network provider* is required to use the North Carolina State Health Plan Network *hospital* where they practice, unless that *hospital* cannot provide the services you need. If you are admitted before the *effective date*, benefits will not be available for services received prior to the *effective date*. Take home medications are covered as part of your pharmacy benefit. If you are in the *hospital* as an *inpatient* at the time you begin a new *benefit period*, you may have to meet a new *deductible* for *covered services* from *doctor*s or *other professional providers*.

The following are examples of *covered services*:

- *Medical care* provided by a *doctor* or *other professional provider.*
- A semi-private room; or a private room if *medically necessary* or the *hospital* has only private rooms.
- Operating room, delivery room, recovery room, nursery, and related services.
- General nursing care.
- Intensive care.
- Critical care.

- Medications administered by the *hospital.*
- Diagnostic services and *medical supplies.*
- Use of appliances and equipment ordinarily provided by the *hospital.*
- *Short-term rehabilitative and habilitative therapies* and *other therapies*.
- *Medical supplies.*

Prior authorization must be requested, and *certification* must be obtained, in advance for *inpatient* admissions or coverage will be denied, except for maternity deliveries and *emergencies*. See "Maternity Care," if applicable and "*Emergency* Care."

➢ Ambulatory Surgical Centers

Benefits are provided for surgical services received in an *ambulatory surgical center*.
The following are *covered services*:

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

➢ Skilled Nursing Facilities

Benefits are provided for *covered services* received in a *skilled nursing facility*. *Skilled nursing facility services* are limited to a combined *in-network* and *out-of-network* day maximum per *benefit period*. See "Summary of Benefits."

Prior authorization must be requested, and *certification* must be obtained, in advance for payment of claims. Service for which *prior authorization* is not obtained will not be covered. See "Summary of Benefits."

Other Services

➢ Blood

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

See "What Is Not Covered" section for information on Blood Exclusions.

➢ Certain Medications Covered under Your Medical Benefit

This health benefit plan covers certain provider-administered specialty medications that must be dispensed under a provider's supervision in an office, outpatient setting, or through home infusion. These medications are covered under your medical benefit rather than your pharmacy benefit. Coverage of some of these medications may be limited to certain provider settings (such as office, outpatient, ambulatory surgical center, or provided by home health agency). For a list of medications covered under your medical benefit that are covered only at certain provider settings, click here.

Prior authorization and *certification* may be required for certain drugs covered under your medical benefit or services will not be covered.

➢ Gene and Cellular Therapy

This health benefit plan provides coverage for certain gene and cellular therapies. Gene and cellular therapies must be dispensed by a pharmacy participating in the Specialty Network in order to receive in-network benefits. For a list of specific gene and cellular therapy product restrictions, click here.

Prior authorization and *certification* may be required for gene and cellular therapies covered under your medical benefit or services will not be covered.

➢ Clinical Trials

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

- Involve determinations by treating physicians, relevant scientific data and opinions of relevant medical *specialists;*
- Be approved or funded (which may include funding through in-kind contributions) by centers or groups funded by the National Institutes of Health, the Food and Drug Administration (FDA), the Centers for Disease Control and Prevention, the Agency for Health Care Research and Quality, the Department of Defense or the Department of Veterans Affairs, CMS, and the Department of Energy; and
- Be conducted in a setting and by personnel of high expertise based on training, experience and patient volume.

See "What Is Not Covered" for information on Clinical Trials exclusions.

➢ *Dental Treatments Covered Under Your Medical Benefit*

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

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

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

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

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

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

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

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

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

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

➢ Diabetes Related Services

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

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

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

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

➢ *Durable Medical Equipment*

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

In order to receive the *in-network* benefit, *durable medical equipment* must be provided by an *in-network* supplier. It is important that you or your *provider* verify that the *durable medical equipment* supplier is an *in-network provider*. Certain *durable medical equipment* requires *prior authorization* and *certification,* or services will not be covered.

For coverage of *durable medical equipment* from a provider participating in the North Carolina State Health Plan Network through the Clear Pricing Project, the provider must be licensed and credentialed as a supplier of *durable medical equipment*.

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

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

See "What Is Not Covered" for information on *Durable Medical Equipment* exclusions.

➢ Hearing Aids

Members 22 years of age or older are not covered for any hearing aid related services. Members under the age of 22 are limited to one hearing aid per hearing-impaired ear every 36 months. Members over the age of 22 are not covered for any hearing aid devices or related services.

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

The following are covered:

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

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

➢ Cochlear Implants

Benefits are provided for medically necessary cochlear implants and necessary related services ordered by a doctor. Benefits are also provided for the evaluation, fitting, and adjustments of cochlear implants, and for supplies, including replacement parts. Cochlear implants require prior authorization and certification, or services will not be covered.

➢ *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 or is actively receiving treatment for a cancer-related problem, and you need part-time or intermittent skilled nursing care from a *registered nurse* (*RN*) or *licensed practical nurse* (*LPN*) and/or other skilled care services like *short-term rehabilitative and habilitative therapies*. Usually, a *home health agency* coordinates the services your *doctor* orders for you. Services from a home health aide may be eligible for coverage only when the care provided supports a skilled service being delivered in the home.

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

Benefits for the following may be provided to a *homebound member*:

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

See "What Is Not Covered" for information on *Home Health Care* exclusions.

➢ Home Infusion Therapy Services

Home infusion therapy is covered for the administration of *prescription medications* directly into a body organ or cavity or via intravenous, intraspinal, intramuscular, subcutaneous or epidural routes, under a plan prescribed by a *doctor*. These services must be provided under the supervision of a licensed, registered, or certified health care professional acting within the scope of their practice.

Prior authorization and *certification* are required for certain home infusion therapy services or services will not be covered.

The following are examples of *covered services*:

- Specimen collection, laboratory testing and analysis.
- Patient and family education.

- Management of *emergencies* arising from home infusion therapy.
- Prescribed medications related to infusion services, and delivery of medications and supplies.

➢ *Hospice* Services

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

The following are *covered services*:

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

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

➢ Lymphedema-Related Services

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

See "What Is Not Covered" for information on *Lymphedema*-related service exclusions.

➢ *Medical Supplies*

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

To obtain *medical supplies* and equipment, please find a *provider* on our website at **www.shpnc.gov** or call Aetna Health Concierge.

See "What Is Not Covered" for information on *Medical Supplies* exclusions.

➢ Obesity Treatment / Weight Management

The *Plan* provides coverage for *office visits* for the evaluation and treatment of obesity; see "Summary of Benefits" for visit maximums. The *Plan* also provides benefits for nutritional counseling visits to an *out-of-network provider* as part of your *preventive care* benefits. The nutritional counseling visits may include counseling specific to achieving or maintaining a healthy weight.

Nutritional counseling visits are separate from the obesity-related *office visits* noted above. Bariatric surgery is also covered. Surgeries for which prior authorization is not obtained will not be covered.

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

➢ Orthotic Devices

Orthotic devices, which are rigid or semi-rigid supportive devices that restrict or eliminate motion of a 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 and are subject to the following limits:

- Unlimited pairs for members up to age 18
- 4 units per calendar year for members 18 or older

Orthotic devices for *positional plagiocephaly* – Device includes dynamic orthotic cranioplasty (DOC) bands and soft helmets.

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

➢ Private Duty Nursing (PDN)

The Plan provides benefits for private duty services of an *RN* or *LPN* when ordered by your *doctor* for a *member* who may be receiving active acute care management services when certain criteria are met. Coverage is limited to 4 hours per day for non-vented *member*s and 12 hours per day for vented *member*s. These services must be ordered by your *doctor* and be *medically necessary.* You should work with your *doctor* to make sure *prior authorization has* been requested.

PDN services provide more individual and continuous skilled care than can be provided in a skilled nursing visit through a home health agency. It is to be used as a short-term solution for a member transitioning from an acute care setting to the home setting and is not meant to be for long-term permanent or custodial care.

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

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

➢ *Prosthetic Appliances*

The *Plan* provides benefits for the purchase, fitting, adjustments, repairs, and replacement of *prosthetic appliances following permanent loss of a body part*. The *prosthetic appliances* must replace all or part of a body part or its function. The type of prosthetic appliance will be based on the functional level of the *member*. Therapeutic contact lenses may be covered when used as a corneal bandage for a medical condition. Benefits include a one-time replacement of eyeglass or contact lenses due to a *prescription* change after cataract *surgery*. Bone-anchored hearing aid (BAHA) devices and all related services are considered hearing aids and, therefore, not considered a prosthetic appliance or durable medical equipment.

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

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

➢ *Varicose Veins*

The treatment of varicose veins is covered when medically necessary and with the following limitations:

- Endovenous Procedures – one procedure per limb per lifetime.
- Sclerotherapy Procedures – three per limb per lifetime.

Surgical Benefits

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

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

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

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

- **Anesthesia**

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

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

- **Mastectomy Benefits**

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

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

See *prosthetic appliances* in Other Services in the "Summary of Benefits."

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

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

Temporomandibular Joint (TMJ) Services

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

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

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

Therapies

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

- ***Rehabilitative Therapy & Habilitative Services***

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

- **Speech therapy** (no visit limits).

➢ Chiropractic Therapy

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

In-network chiropractic *providers* file claims through Aetna. Your *in-network provider* is responsible for filing your claim. If you or your *provider* has a question, please call Aetna Health Concierge at the number listed in "Who to Contact." Refer to "Summary of Benefits" for additional information.

➢ *Other Therapies*

The *Plan* covers:

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

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

See "What Is Not Covered" for information on therapy exclusions.

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* for *Transplants* that provides the transplant services required. Travel and lodging expenses may be reimbursed based on guidelines that are available upon request from a transplant coordinator.

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

For a list of covered *transplants*, call Aetna Health Concierge at the number listed in "Who to Contact" to speak with a transplant coordinator and request *prior authorization. Certification* must be obtained in advance for all transplant-related services to assure coverage of these services. Grafting procedures associated with reconstructive *surgery* are not considered *transplants*.

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

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

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

See "What Is Not Covered" for information on transplant exclusions.

Behavioral Health Benefits

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

➢ *Office Visit* Services

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

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

➢ *Outpatient* Services

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

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

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

➢ *Inpatient* Services

Covered *inpatient* treatment services also include:

- Each service listed under *office visit* services.
- Semi-private room and board.

Prior authorization must be requested, and *certification* must be obtained, within two (2) business days of admission or services will not be covered, except for *emergencies*. The list of services that require *prior authorization* may change from time to time.

Residential Treatment Facility Services

Prior authorization must be requested, and *certification* must be obtained, within two (2) business days of admission for behavioral health services received in a *residential treatment facility*. The list of services that require *prior authorization* may change from time to time.

In-network providers and *in-network* inpatient facilities are responsible for requesting *prior authorization* when necessary. If you receive services from a non-network provider, you are responsible for ensuring your provider requests a prior authorization.

Applied Behavior Analysis

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

- Diagnosed with Autism Spectrum Disorder by a licensed physician (MD or DO) or a licensed doctoral level clinical psychologist (PhD or PsyD) and
- Treatment is determined to be *medically necessary.*

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

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

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

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

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

Coverage of ABA services is limited to:

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

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

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

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

➢ How to Access Behavioral Health Services

Prior authorization is not required for any *office visit* services or in *emergency* situations.
However, in *emergency* situations, please notify *Aetna* of your inpatient admission as soon as reasonably possible.

Prior authorization and *certification* are required for inpatient (including *residential treatment facility* services) or certain outpatient services by *Aetna* or services will not be covered. See the *prior authorization* and *certification* number listed in "Who to Contact?" Information about which services require *prior authorization* as well as a list of *in-network providers* can be found online at shpnc.org or you can call Aetna Health Concierge or the mental health phone number on the back of your ID card.

Certification for *Inpatient* and *Outpatient Services*

Prior to seeking care in an *inpatient hospital*, a *residential treatment facility*, partial day/night programs or specified outpatient services, you or your *provider* must receive *certification.* To receive *in-network* benefits, you must go to a North Carolina State Health Plan Network *provider*. You may want to check with your *in-network provider* to make sure that *certification* has been obtained for services. Your *in-network provider* is required to use the North Carolina State Health Plan Network *hospital* where they practice, unless that *hospital* cannot provide the services needed.

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

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

Emergency inpatient admissions do not require *certification* prior to the admission. However, you or your *provider* should notify *Aetna* of your *inpatient* admissions. See table below for timeframes in order to meet the *Plan's* requirements for *prior authorization* and continuing treatment *certification*s of *covered services*.

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

Outside of North Carolina

Although *prior authorization* is not required in an *emergency,* you may contact *Aetna* for assistance in locating a *provider*.

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

Pharmacy Benefits

➢ *Prescription Medication* Benefits

A *Pharmacy Benefit Manager (PBM)* manages administration of the *pharmacy* benefit.

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

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

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

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

Prescription medication synchronization as follows:

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

In addition, the medications must:

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

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

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

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

➢ *Affordable Care Act* Preventive Medications

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

➢ Immunizations

Certain immunizations are also covered under the pharmacy benefit. A complete list of immunizations can be found on the *State Health Plan*'s website at www.shpnc.gov.

➢ Covered Medication List

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

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

The Comprehensive *Formulary* Document is divided into six categories or tiers: (Tier 1), the most cost-effective non-*specialty medication*s, which would include mostly *generic medication*s; (Tier 2), preferred brand non-*specialty medication*s, including some high-cost *generic medication*s; (Tier 3), non-preferred brand non-*specialty medication*s and compounds; (Tier 4), the most cost-effective *specialty medications*, including *generic*s and some *biosimilar*s; (Tier 5), preferred brand *specialty medications*; and (Tier 6), non-preferred brand *specialty medication*s. The placement of *medication*s in a *formulary* tier determines what *your pay* or *coinsurance* will be charged for a 30-day supply. Tiers 3 and 6 are subject to *deductible*/*coinsurance*.

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

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

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

➢ Refill Guidelines

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

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

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

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

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

➢ Specialty Pharmacy

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

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

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

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

➢ Diabetic Testing Supplies

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

➢ Tobacco Cessation Coverage

Tobacco cessation support is covered as part of your preventive benefits. Tobacco cessation counseling is available at certain Primary Care Provider offices.

➢ Using a Contracting Pharmacy

Most chain and independent pharmacies contract with the *PBM*. You may obtain information about which pharmacies are contracting by:

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

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

The convenience of mail order pharmacy is available for your maintenance medications by using the *PBM's* online pharmacy services, by telephone, or by completing a Mail Service Order Form and returning it with your original *prescription* and appropriate *cost share* 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.gov and click Pharmacy Benefits under your plan.

➢ How to File a Claim for *Prescription Medications*

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

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

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

You can also submit the request online via the CVS Member Portal.

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

- Date *prescription* filled;
- Name and address of pharmacy;

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

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

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

➢ Medicare Part D

IMPORTANT INFORMATION REGARDING **YOUR PRESCRIPTION MEDICATION COVERAGE AND MEDICARE**
Effective January 1, 2006, Medicare began offering *prescription medication* coverage for all persons enrolled in Medicare. The *State Health Plan* will continue to provide *prescription medication coverage* for all *members on this plan*. **When *members* become eligible for Medicare Part D, they will receive a notice of *creditable coverage* from the *State Health Plan*. "*Creditable Coverage*" means that your *prescription medication* coverage is at least as good as Part D coverage.** **If your current *prescription medication* coverage qualifies as "*creditable coverage*," you should not need Part D coverage, unless you are Medicaid-eligible or eligible for low-income assistance. *Members* of the *State Health Plan* should evaluate their own coverage needs prior to purchasing a Medicare *Prescription Medication* Plan.**

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

**High income members may be subject to an income-related monthly adjustment amount by Social Security.*

WHAT IS NOT COVERED?

Exclusions for a specific type of service are stated along with the benefit description in "*Covered Services*." Exclusions that apply to many services are listed in this section, starting with general exclusions and then the remaining exclusions are listed in alphabetical order.[1] To understand all of the exclusions that apply, read "*Covered Services*," "Summary of Benefits" and "What Is Not Covered?" The *Plan* does not cover services, supplies, medications or charges for:

- Anything specifically listed in this benefits booklet as not covered or excluded, regardless of *medical necessity.*
- Any condition, disease, ailment, injury, or diagnostic service to the extent that benefits are provided, or persons are eligible for coverage under Title XVIII of the Social Security Act of 1965, including amendments, except as otherwise required by federal law.
- Conditions that federal, state or local law requires to be treated in a public facility.
- Any condition, disease, illness, or injury that occurs in the course of employment, if the *member*, employer or carrier is liable or responsible for the specific medical charge (1) according to a final adjudication of the claim under a state's workers' compensation laws, or (2) by an order of a state Industrial Commission or other applicable regulatory agency approving a settlement agreement.
- Basic life or work-related or medical disability examinations.
- Benefits that are provided by any governmental unit except as required by law.
- Services that are ordered by a court that are otherwise excluded from benefits under this Plan.
- Any condition suffered as a result of any act of war or while on active or reserve military duty.
- Services in excess of any *benefit period maximum* or *lifetime maximum.*
- Received prior to the *member's effective date.*
- Received after the coverage termination date, regardless of when the treated condition occurred, and regardless of whether the care is a continuation of care received prior to the termination.
- Received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust or similar person or group.
- Day care services, chore services, attendant care services, homemaker services, companion care services, foster care services.
- Hair analysis, excluding arsenic.
- Transportation of portable X-ray equipment and personnel to home or nursing home, transportation of portable EKG to facility or other location.
- *Emergency* response systems.
- Charges incurred due to injuries received in a motor vehicle accident involving any motor vehicle for which no-fault insurance is available, regardless of whether any such policy is designated as secondary to health coverage.

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

A

- **Acupuncture** and **acupressure.**
- **Administrative** charges including, but not limited to: charges billed by a *provider*, including charges for failure to keep a scheduled visit, completion of a claim form, obtaining medical records, late payments, shipping and handling, taxes, and telephone charges.

[1]

- 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.
- Alternative medicine services, which are unproven preventive or treatment modalities, also described as alternative, integrative or complementary medicine, whether performed by a physician or any other provider.
- **Ambulance services:**
  - No benefits are provided primarily for the convenience of travel or where not *medically necessary*.
  - Transportation for the purpose of receiving services that are not considered *covered services,* even if the destination is an appropriate facility.
- **Applied Behavior Analysis** treatments for:
  - *Members* with medical conditions or impairments that would prevent beneficial utilization of services.
  - *Members* requiring 24 hour medical/nursing monitoring or procedures provided in a *hospital* setting.
- **Applied Behavior Analysis** treatments will not be certified for the following services.
  - Occupational therapy.
  - Vocational rehabilitation.
  - Supportive *respite care.*
  - Recreational therapy.
  - Orientation and mobility.
  - *Respite Care.*
  - Equine therapy/Hippotherapy.
  - Dolphin therapy.
  - Service Animals.
  - Other educational services.
- **Athletic** training evaluations or re-evaluations.
- **Audiometric** testing of groups, ear protector attenuation measurements.

B

- **Behavioral Health** exclusions and limitations**:**
  - *Inpatient* confinements that are primarily intended as a change of environment.
  - Marriage counseling.
  - Wilderness camps and stand-alone outdoor treatment programs are not covered as *substance disorder* or *substance disorder residential treatment center* programs.
  - Any services including but not limited to evaluations, consultations, testing or therapy for educational, sensitivity training, professional training, or for investigation purposes relating to employment, insurance, judicial or administrative proceedings.
  - Aversive Treatment.
  - Treatment programs based solely on the 12-step Model.
  - Any personal growth training including Erhard Seminar Training (EST) or similar motivational services.
  - Services that are investigational in nature or obsolete, including any service, drugs, procedure, or treatment directly related to an investigational treatment, except as specifically covered by the Plan.

- Any therapies including but not limited to music therapy, remedial reading, recreational or activity therapy, massage therapy, cognitive rehabilitation, group classes for pulmonary rehabilitation, all forms of special education and supplies or equipment used similarly.
- Telephonic crisis management as a separate charge.
- Environmental ecology treatments.

- Room and Board costs for patients admitted to a partial *hospital* or intensive *outpatient* program are not covered.
- Intensive in-home services.
- 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.
- Long term residential care for behavioral health (non-acute care in a residential treatment program where stay is typically longer than 30 days), with room and board, per diem.
- Community or work integration training, work hardening or conditioning.
- Assertive Community Treatment Team Program.
- Community Support Team.
- Psychosocial Rehabilitation.
- Day Treatment programs license for day treatment by the NC Division of Health Service Regulation but not licensed as a Partial Hospitalization Program.
- Multi-Systematic Therapy.
- Residential treatment services described as follows:
- Level I and Level II therapeutic foster care *provider*s licensed under the NC Division of Social Services (131-D) as family setting homes.
- Level II program type, Level III, and Level IV residential *provider*s/group homes licensed by the NC Division of Health Service Regulation as a Mental Health Facility under 10A NCAC 27G.
- *Substance Disorder* Non-Medical Community Residential Program.
- **Body** piercing.
- Certain **Blood Services**:
    - Collection and storage of **blood** and stem cells taken from the umbilical cord and placenta for future use in fighting a disease.
    - Charges for the collection or obtainment of blood or blood products from a blood donor, including the *member* in the case of autologous blood donation.
- All **Breast Pump Supplies** except what is explicitly listed as covered are excluded (i.e., creams, nursing bras, milk storage bags). Hospital-grade breast pumps are excluded and not covered. Electric breast pump are limited to 1 per 12 months.
- **Breast-Feeding**
    - Human breast milk processing, storage and distribution.

C

- **Childbirth** preparation classes, including but not limited to Lamaze classes, childbirth refresher classes, cesarean birth classes, vaginal birth after cesarean classes, and infant safety classes including CPR by a non-physician *provider.*
- **Claims** not submitted to the *Plan* within 18 months of the date the charge was

incurred, except in the absence of legal capacity of the *member.*

Clinical Trials exclusions include:

- Non-health care services, such as services provided for data collection and analysis.
- Early feasibility, safety and pilot states of device trials.
- CMS Investigational Device Exemption (IDE) Category A devices.
- *Investigational* medications and devices and services that are not for the direct clinical management of the patient.

- **Convenience** items such as, but not limited to, devices and equipment used for environmental control, urinary incontinence devices (including bed wetting devices) and equipment, ice packs and personal hygiene items. Infrared heating pads are covered.
- ***Cosmetic*** services or improvements, which include the removal of excess skin from any area of the body (except panniculectomy), skin tag excisions, cryotherapy, dermabrasion and/or chemical exfoliation for acne and acne scarring, injection of dermal fillers, removal of wrinkles (facelift), services for hair transplants, skin tone enhancements, electrolysis, liposuction/lipectomy from head, neck, trunk/buttocks, and surgery for psychological or emotional reasons, except as specifically covered by the Plan.
- Services received either before or after the ***coverage*** period of the Plan, regardless of when the treated condition occurred, and regardless of whether the care is a continuation of care received prior to the termination.
- ***Custodial care*** designed essentially to assist an individual with activities of daily living, with or without routine nursing care and the supervisory care of a *doctor*. While some skilled nursing services may be provided, the patient does not require continuing skill services 24 hours daily. The individual is not under specific medical, surgical, or psychiatric treatment to reduce a physical or mental disability to the extent necessary to enable the patient to live outside either the institution or the home setting with substantial assistance and supervision, nor is there reasonable likelihood that the disability will be reduced to that level even with treatment. *Custodial care* includes, but is not limited to, help in walking, bathing, dressing, feeding, preparation of special diets and supervision over medications that could otherwise be self-administered. Such services and supplies are custodial as determined by the *Plan* without regard to the place of service or the *provider* prescribing or providing the services.
- **Camisoles**, or other clothing, post-mastectomy.
- **Communication** boards which include the evaluation for the board.
- **Contraception** for males.

D

- **Dental services**
  - provided in a *hospital*, except as specifically covered by the *Plan*.
  - *Treatment for the following conditions:*
    - Injury related to chewing or biting.
    - Preventive dental care, diagnosis or treatment of or related to teeth or gums.
  - Periodontal disease or cavities and disease due to infection or tumor.

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

- ***Diabetes*** *related services including:*
  - Diabetic shoes, including accessories, fittings, and associated services and supplies.
  - Glasses.
- The following **drugs** or medications:
  - Injections by a health care professional of injectable *prescription medications* which can be self-administered unless medical supervision is required.
  - Medications associated with conception by artificial means.
  - For prescribed *sexual dysfunction* medications.
  - Take home medications furnished by a *hospital* or *non-hospital facility.*
  - *Experimental* medication or any medication or device not approved by the Food and Drug Administration (FDA) for the applicable diagnosis or treatment. However, this exclusion does not apply to *prescription medications* used in covered phases I, II, III and IV clinical trials, or medications approved by the FDA for treatment of cancer, if prescribed for the treatment of any type of cancer for which the medication has been approved as effective and accepted in any one of the following nationally recognized medication reference guides:
    - The American Medical Association Drug Evaluations;
    - The American *Hospital Formulary* Service Drug Information;
    - The United States Pharmacopoeia Drug Information;
    - The National Comprehensive Cancer Network Drugs & Biologics Compendium;
    - The Thomson Micromedex DrugDex;
    - The Elsevier Gold Standard's Clinical Pharmacology; or
    - Any other authoritative compendia as recognized periodically by the United States Secretary of Health and Human Services.
  - ***Diagnostic Services*** including:
    - Lab tests that are not ordered by your doctor or other provider
    - Diagnostic tests used to confirm a known diagnosis or condition
    - Tests used only for administrative purposes to measure process or quality improvement
    - Tests that are duplicative or that are inclusive to other covered services
    - Testing when a therapeutic or diagnostic course would not be determined by the outcome of the testing

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

E

- Services primarily for ***educational*** treatment including, but not limited to, books, tapes, pamphlets, seminars, classroom, Web or computer programs, individual or group instruction, counseling, and vocational counseling, educational supplies such as books, tapes, and pamphlets for the patient's education at cost to physician or other qualified health care professional, educational services rendered to patients in a group setting by physician or other qualified health care professional, except as specifically covered by the *Plan.*
- For **educational** or achievement testing for the sole purpose of resolving educational performance questions.
- The following **equipment:**
    - Air conditioners, furnaces, vacuum cleaners, electronic air filters and similar equipment.
    - Room dehumidifiers, room humidifiers. This does not apply to humidifiers and dehumidifiers that are attached to a CPAP machine.
    - Devices and equipment used for environmental accommodation requiring vehicle and/or building modifications such as, but not limited to, positioning seats, chair lifts, stair lifts, home elevators, and ramps.
    - Physical fitness equipment, hot tubs, Jacuzzis, heated spas, whirlpools, pools, or membership to health clubs.
    - Personal computers.
    - Automatic external defibrillators.
    - Postural drainage boards and similar equipment.
    - Standing frames.

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

F

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

G

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

H

- Routine **hearing** examinations and hearing aids or examinations for the fitting of hearing aids, except as specifically covered by the *Plan.*
- ***Home Health Care*** including:
  - Personal comfort or convenience items.
  - Dietitian services or meals.
  - Homemaker services, such as cooking and housekeeping.
  - *Custodial care.*
  - Services that are provided by a close relative or a member of your household.
- Certain ***Hospice Services:***
  - Homemaker services, such as cooking, housekeeping, food or meals.
  - *Medical services* provided by a *doctor* other than as part of your *hospice* care program.

- Funeral arrangements
- Pastoral counseling
- Financial or legal counseling including estate planning and the drafting of a will.
- Homemaker or caretaker services, or any other services note solely related to your care, which may include:
  - Sitter or companion services for you or other family members
  - Transportation
  - House maintenance

- **Hypnosis** except when used for control of acute or chronic pain.

I

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

L

- **Lenses** for keratoconus or any other eye procedure except as specifically covered under the Plan.
- **Low density lipoprotein** (LDL) apheresis using heparin-induced extracorporeal LDL precipitation.
- Over-the-counter compression or elastic knee-high or other stocking products for ***Lymphedema.***

M

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

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

N

- **Necropsies.**
- Side effects and complications of noncovered services, or services that would not be necessary if a **non-covered service** had not been received, except for *emergency services* in the case of an *emergency*. A noncovered service includes, but is not limited to, any services, procedures or supplies associated with *cosmetic* services, *investigational* services, services deemed not *medically necessary*.

O

- **Obesity Treatment / Weight Management**:
  - Any treatment or regimen, medical or surgical, for the purpose of reducing or controlling the weight of a *member* or for treatment of **obesity,** except for surgical treatment of morbid obesity, or as specifically covered by the *Plan*.
  - Removal of excess skin from the abdomen, arms or thighs.
  - Any costs associated with membership in a weight management program except as specifically described above.

- **Orthotic Devices:**
  - Appliances and accessories that serve no medical purpose or that are primarily for comfort or convenience or are upgrades beyond the stated medical purpose.
  - Pre-molded foot orthotics.
  - Over-the-counter supportive devices.
  - Plastazote shoes or sandals.
  - Repair or replacement of equipment due to abuse or desire for new equipment.

P

- Services provided by a close relative, or a member of your household area not considered **Private Duty Nursing**.
- Care or services from a ***provider*** who:
  - Cannot legally provide or legally charge for the services or services are outside the scope of the *provider*'s license or *certification.*
  - Provides and bills for services from a licensed health care professional who is in training.
  - Is in a *member*'s immediate family.
  - Is not recognized by the *Plan* as an eligible *provider.*
- Any **Prescription Medications that:**
  - Are not covered in the *formulary.*
  - Are not FDA approved.
  - Are not federal legend.
  - Are not specifically covered by the *State Health Plan.*
  - Are prescribed for *sexual dysfunction*.
  - Are prescribed for hair growth.
  - Are prescribed for *cosmetic* purposes.
  - Are prescribed in conjunction with artificial reproductive technology.
  - Are in excess of the stated quantity limits.

- Are GLP-1, GIP-GLP-1 agonists, or other similar molecular entities when used for the purpose of weight loss.
- Require *certification* if *certification* is not obtained.
- Can be purchased over the counter without a *prescription*, even though a written *prescription* is provided, except for insulin and other approved over-the-counter medications.
- Has a therapeutic equivalent available over-the-counter as determined by the *State Health Plan.*

- Any **Prescription Compound Medication** that:
  - Contains an *investigational* medication.
  - Has any active ingredient contained within the *compound medication* in which that active ingredient is not a covered *prescription medication* including bulk chemicals.
  - Includes any active ingredients for a non-FDA approved indication as determined by the dosage of the active ingredient, combination of active ingredients or route of administration.
- Any **Prescription** medical foods.
- The following **Prosthetic Appliances:**
  - Dental appliances except when *medically necessary* for the treatment of temporomandibular joint disease or obstructive sleep apnea.
  - Lenses for keratoconus or any other eye procedure except as specifically covered under the *Plan*.
  - Appliances and accessories that serve no medical purpose or that are primarily for the comfort or convenience or are upgrades beyond the stated medical purpose.
  - Repair or replacement of equipment due to abuse or desire for new equipment.
  - Bone-anchored hearing aid (BAHA) devices and all related services are considered hearing aids and, therefore, not considered a prosthetic appliance or durable medical equipment.

R

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

S

- **Services** or **supplies** that are:
  - Not performed by or upon the direction of a *doctor* or *other provider.*
  - Available to a *member* without charge.
- ***Sexual dysfunction*** unrelated to organic disease.

- **Shoe** lifts, other than heel pads, shoe accessories, attachment, equipment, inserts and other modifications, and shoes of any type unless part of a brace, and except as specifically covered by your health benefit plan.
- Services, supplies, medications or equipment used for the control or treatment of **stammering or stuttering.**

- Unless prescribed, medically necessary and custom made, **safety** equipment, devices or accessories, including but not limited to helmets with face guards and soft interfaces and any type of restraints.
- *Prescription medications* related to ***sexual dysfunction*** are not covered. Also see *Prescription Medication* Exclusions.
- Treatment or studies leading to or in connection with ***sex changes*** or modifications and related care.

T

- **Telehealth** services originating site facility fees.
- The following services are not covered for **Temporomandibular Joint (TMJ)**:
  - Treatment for periodontal disease.
  - Dental implants or root canals.
  - Crowns and bridges.
  - Orthodontic braces.
  - Occlusal (bite) adjustments.
  - Extractions.
- The following types of **therapy:**
  - Applied Behavior Analysis (ABA) therapy except as specifically identified by the *Plan.*
  - Music therapy, recreational or activity therapy, and all types of animal therapy. Remedial reading and all forms of special education and supplies or equipment used similarly, except as specifically covered by the *Plan.*
  - Massage therapy.
  - Alternative therapy.
  - Hypothermia therapy.
  - Cognitive therapy.
  - Pulmonary rehabilitation group sessions.
  - Peripheral arterial disease rehabilitation.
  - Community or work integration training, work hardening or conditioning.
- **Thermography** or **thermograph** examination.
- **Transplant** exclusions include:
  - The purchase price of the organ or tissue if any organ or tissue is sold rather than donated to the recipient *member.*
  - The procurement of organs, tissue, bone marrow or peripheral blood stem cells or any other donor services if the recipient is not a *member.*
  - *Transplants*, including high dose chemotherapy, considered *experimental* or *investigational.*
  - Services for or related to the transplantation of animal or artificial organs or tissues.
- **Travel**, whether or not recommended or prescribed by a *doctor* or other licensed health care professional, except as specifically covered by the *Plan*.

V

- The following **vision** services:
  - Radial keratotomy and other refractive eye *surgery*, and related services to correct vision except for surgical correction of an eye injury. Also excluded are premium intraocular lenses or the services related to the insertion of premium lenses beyond what is required for insertion of conventional intraocular lenses, which are small, lightweight, clear disks that replace the distance-focusing power of the eye's natural crystalline lens.
  - Routine eye examination services except as specifically covered by the *Plan.*
  - Eyeglasses or contact lenses, except as specifically covered in "*Prosthetic appliances.*"
  - Orthoptics, vision training, and low vision aids.
- For over-the-counter and non-federal legend **Vitamins**, food supplements or replacements, medical foods with a prescription, 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**, hair pieces and services for hair implants and electrolysis for any reason.

UTILIZATION MANAGEMENT

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

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

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

Rights and Responsibilities Under the UM Program

➢ **Your *Member* Rights**

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

- A *UM* decision that is timely, meeting applicable regulatory 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 Authorization (Pre-Service)

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

General categories of services with this requirement are noted in "*Covered Services*." You may also visit our website at **www.shpnc.gov** or call Aetna Health Concierge at the number listed in "Who to Contact" for a detailed list of services.

In-network providers, except for Veterans' Affairs (VA) and military *providers*, are responsible for requesting prior authorization You are responsible for ensuring that you or your out-of-network *provider* requests *prior authorization.*

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 three 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. *State Health Plan* or its representative will notify you and your *provider* if additional information is required. You will have 45 days to provide the requested information. As soon as the *State Health Plan* or its representative receives the requested information, a decision will be made within three business days, or at the end of the 45 days. The *State Health Plan* or its representative will notify you and your *provider* of an *adverse benefit determination* electronically or in writing.

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

- **Urgent *Prior authorization***

  You have a right to an urgent authorization when the regular time frames for a decision: (i) could seriously jeopardize your life, health, or safety or the life, health or safety of others, due to your psychological state, or (ii) in the opinion of a practitioner with knowledge of your medical or behavioral condition, would subject you to adverse health consequences without the care or treatment that is the subject of the request. The *State Health Plan*, or its representative, will let you and your *provider* know of its decision within 72 hours of receiving the request. Your *provider* will be notified of the decision, and if the decision results in an *adverse benefit determination*, written notification will be given to you and your *provider*.

  If the *Plan,* or it's representative*, needs* more information to process your urgent authorization, the *Plan* will let you and your *provider* know of the information needed as soon as possible but no later than 24 hours following the receipt of your request. You will then be given, two business days to provide the requested information. The *Plan*, or its representative, will make a decision on your request no later than 48 hours after receipt of the urgent request. Your *provider* will be notified of the decision, and if the decision results in an *adverse benefit determination*, written notification will be given to you and your *provider*.

  An urgent authorization may be requested by calling Aetna Health Concierge at the number given in "Who to Contact."

Concurrent Authorization

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

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

- ***Urgent Concurrent Authorization***

  The State Health Plan or its representative will request additional information within 24 hours of receipt of a request for urgent concurrent review services. The provider is given at least 48 hours to provide all necessary information. Your *provider* will be notified of the decision, and if the decision results in an *adverse benefit determination*, written notification will be given to you and your *provider*.

  If a request for an extension of treatment **is received** at within 24 hours of the expiration of a previously approved *inpatient* stay or course of treatment at the requesting *hospital* or other facility, and contains all necessary information, 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 the request for an extension of treatment does not contain all necessary information, the required information will be requested within 24 hours, allowing 2 business days for all necessary information to be provided. Your *provider* will be notified of the decision, and if the decision results in an *adverse benefit determination*, written notification will be given to you and your *provider*.

Retrospective Authorization **(Post-Service)**

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

In the event of an *adverse benefit determination*, the *Plan* or its representative will notify you and your *provider* in writing within five business days of the decision. All decisions will be based on *medical necessity* and whether the service received was a benefit under the *Plan*. If more information is needed before the end of the initial 30-day period, the *Plan* or its representative will notify you of the information needed. You will then have 90 days to provide the requested information. As soon as the *Plan* or its representative receives the requested information, or at the end of the 90 days, whichever is earlier, the *Plan* or its representative will make a decision within 30 days.

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

Care Management

The Aetna Case Management program is a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality, cost-effective outcomes. Those Plan members with diagnoses and clinical situations for which a specialized

nurse, working with the member and their provider, can make an impact to the course or outcome of care and/or reduce medical costs will be accepted into the program at Aetna's discretion. Case management staff strives to enhance the member's quality of life, support continuity of care, facilitate provision of services in the appropriate setting and manage cost and resource allocation to promote quality, cost-effective outcomes.

Case Managers collaborate with the member, family, caregiver, provider and health care provider community to coordinate care, with a focus on closing gaps in the members' care and maximizing quality outcomes. Aetna operates two types of case management programs: Complex Case Management targets Plan members who have already experienced a health event and are likely to have care and benefit coordination needs after the event. The objective for Case Managers is to identify care or benefit coordination needs which lead to faster or more favorable clinical outcomes and/or reduced medical costs. Proactive Case Management targets Plan members, from Aetna's perspective, who are misusing, over-using or under-utilizing the health care system, leading them towards avoidable and costly health events. This program's objective is to confirm gaps in a member's are leading to their over-use, misuse, or under-use, and to work with the member and their provider to close those gaps.

Continuity of Care

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

If your *PCP* or *specialist* leaves the North Carolina State Health Plan Network and they are currently treating you for an ongoing special condition that meets the *Plan's* continuity of care criteria, the *Plan,* or its representative*,* will notify you 30 days before the *provider's* termination. If a practitioner notifies *Aetna* of termination less than thirty (30) days prior to the effective date, *Aetna* shall notify the affected members as soon as possible, but no later than thirty (30) calendar days after receipt of notification.

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:

- Serious and complex condition:
    - Acute illness (required specialized medical treatment to avoid death or permanent harm)
    - Chronic illness (life threatening, degenerative, potentially disabling, or congenital requiring treatment over a prolonged period of time)
- Course of institutional or inpatient care
- Scheduled to undergo nonelective surgery, including receipt of postoperative care with respect to such a surgery
- Pregnant and undergoing a course of treatment for the pregnancy
- Terminally ill.

The allowed transitional period shall end on the earlier of (i) 90 days from the date of the provider termination; or (ii) the date on which the member is no longer a patient undergoing care of the ongoing special condition with respect to such provider or facility, 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
- 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; and
- Pregnancy which shall extend through the provision of 60 days of postpartum care.

Continuity of care requests must be submitted to *Aetna* within 45 days of the provider termination date or within 45 days of the effective date for members new to the Plan. Continuity of care requests will be reviewed by a medical professional based on the information provided about specific medical conditions. Claims for approved continuity of care services will be paid at the in-network benefit level. In these situations, benefits are based on the billed amount. However, you may be responsible for charges billed separately by the provider which are not eligible for additional reimbursement. If your continuity of care request is denied, you may request a review through our appeals process (see "What if I Disagree with a Decision"). Continuity of care will not be provided when the provider's contract with Aetna was terminated for reasons relating to quality of care or fraud. Such a decision may not be reviewed on appeal. Please call Aetna Health Concierge at the number listed in "Who to Contact" for additional information.

Further Review of Utilization Management Decisions

If you receive a *non-certification* as part of the *prior authorization* 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?"

Evaluating New Technology

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

WHAT IF YOU DISAGREE WITH A DECISION?

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

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

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

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

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

www.ncdoi.gov/consumers/health-insurance/health-claim-denied

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* Aetna Health Concierge at the number given in "Who to Contact."

Any request for review should include:

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

Although you are not allowed to participate in a first level *grievance* review, the *State Health Plan,* or its representative asks that you send all of the written material you feel is necessary to make a decision. The *State Health Plan* or its representative will use the material provided in the request for review, along with other available information, to reach a decision. You will be notified in clear written terms of the decision within a reasonable time but no later than 15 days for a pre-service *Appeal* or 30 days for a post service *Appeal* 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 for services that are not covered due to medical necessity. 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 60 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 15 days for a pre-service *Appeal* or 30 days for a post-service *Appeal* 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* Aetna Health Concierge 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~~ 36hours 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.

You may request a second level review if your claim is denied during the expedited review, which will follow the same expedited review guidelines as above.

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

External Review

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

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

- A *non-certification* decision; or
- An *appeal* decision upholding a *non-certification* decision.

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

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

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

Standard External Review

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

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

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

Expedited External Review

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

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

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

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

An expedited external review is not available for retrospective *non-certifications*.

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

Mail	**In person**	**Web**
NC Department of Insurance Health Insurance Smart NC 1201 Mail Service Center Raleigh, NC 27699-1201	For the physical address for Health Insurance Smart NC, please visit the webpage: **www.ncdoi.gov/Smart** Toll-Free Telephone: 855-408-1212	**www.ncdoi.com/Smart** for external review information and request form

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

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

State Health Plan
C/O Aetna
PO Box 14063
Lexington KY 40512

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

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

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

Appeals Correspondence

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

Medical* & *Pharmacy Appeals
State Health Plan
C/O Aetna
PO Box 14463
Lexington KY 40512

ADDITIONAL TERMS OF YOUR COVERAGE

Benefits

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

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

Benefits for *covered services* specified in your health benefit plan will be provided only for services and supplies that are performed by a *provider* as specified in your health benefit plan and regularly included in the *allowed amount*. The *State Health Plan* or its representative establishes coverage determination guidelines that specify how services and supplies must be billed 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 more than the benefit provided under your health benefit plan coverage may be recovered by the *State Health Plan*. The *State Health Plan* or its representative may recover the amounts by deducting from a *member's* future claims payments or by collecting directly from the *member*. This can result in a reduction or elimination of future claims payments. In addition, under certain circumstances, if the *State Health Plan* pays the *provider* amounts that are your responsibility, such as *deductible*, *coinsurance*, the *State Health Plan* may collect such amounts directly from you.

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

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

Disclosure of Protected Health Information (PHI)

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

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. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect. Medical policies are guides considered when making coverage determinations.

Applicable Law and Venue

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

Jury Trial Waiver

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

Attorneys' Fees and Costs

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

Arbitration and Mediation

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

Care while outside the U.S. or Out of Country Care

The State Health Plan covers emergency inpatient hospital care when medically necessary, around the world.

If you need help and are outside the U.S., call 1-855-888-9046 (TTY: 711) or 959-230-8220 (TTY: 711). Ask for the Aetna Special Case Precertification Unit when you call.

Aetna's team will:

- Check if a hospital can treat you. Or we'll help you transfer to the closest facility that can provide care.
- Arrange for medical air ambulance transport with a participating provider, if needed (we must approve this in advance), and coordinate coverage.

Keep in mind:

- You must need emergency care that can't wait until you return to the U.S.
- You'll have to pay for services at the time of care.
- Aetna will need an itemized bill and receipt for all services. Translation is not required, but it's helpful to have when we process your claim. Please include the following:
  - Provider name and address

- Patient name
- Member ID
- Date of service
- Type of service and diagnosis
- U.S. dollar amount charged for each service

North Carolina Provider Reimbursement

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

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

Right of Recovery/Subrogation Provision

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

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

Further, the *State Health Plan* will automatically have a lien, to the extent of benefits advanced, upon any recovery whether by settlement, judgment or otherwise, that a *member* receives from a responsible third party, the responsible 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* is not required to participate in or pay court costs or attorney fees to any attorney hired by the *member*.

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

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

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

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

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

If any information in this booklet conflicts with North Carolina state law or it conflicts with medical policies adopted under your health benefit plan, North Carolina law and such medical policies will prevail. Please see the above section titled “Administrative Discretion” for more information.

The Rawlings Company, LLC (Rawlings) is the State Health Plan’s representative to perform subrogation services. The member shall contact Rawlings at 877-229-0872 if they have any new cases or would like to report their settlement information. The member or their duly authorized representative can also email NCStatemanualreferrals@rawlingscompany.com with any subrogation requests.

Notice of Claim

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

Notice of Benefit Determination

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

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

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

- The specific reason(s) for the denial of benefits;
- Reference to the benefit booklet section on which the denial of benefits is based;
- A description of any additional information needed for you to perfect the claim and an explanation of why such information is needed;
- A description of the review procedures and the time limits applicable to such procedures, including the *member's* right to bring a civil action under Section 502(a) of ERISA following a denial of benefits;
- A copy of any internal rule, guideline, protocol or other similar criteria relied on, if any, in making the benefit determination or a statement that it will be provided without charge upon request;
- In the case of a denial of benefits based on *medical necessity*, *experimental* treatment, or a similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying the terms of the Plan to the *member's* medical circumstances, or a statement that this will be provided without charge upon request; and
- In the case of a denial of benefits involving *urgent care*, a description of the expedited review process available to such claims.

Upon receipt of a denial of benefits, you have the right to file an appeal with *Aetna*. Please see "What If You Disagree With A Decision?" for more information.

Limitations of Actions

No legal action may be brought to recover benefits until you have exhausted all administrative remedies. No legal action may be taken later than three years from the date services are *incurred*. For clarity, the State Health Plan does not consent to be sued in federal courts. Please see "What If You Disagree With A Decision?" for details regarding the *grievance* review process.

Coordination of Benefits (Overlapping Coverage)

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

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

➢ **Order of Benefits Determination**

Subscriber or *Spouse*:

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

Dependent Children**:**

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

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

➢ **Other Rules**

- For proper coordination of your benefits, you are required to notify the *State Health Plan* of Medicare eligibility immediately.
- The benefits of a plan that covers the person as an active *employee* (neither laid off nor retired) or as a *dependent* of an active *employee* are determined before those of a plan that covers that person as a laid-off or retired *employee* or as that *employee's dependent.* If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
- The health benefit plan that has covered the person the longest will be primary if none of the rules listed above determine order of benefits payment.
- If the other health benefit plan does not have rules that establish the same order of benefits as under this health benefit plan*,* the benefits under the other plan will be determined primary to the benefits under this health benefit plan.

Benefit Coordination

➢ **Active *Member*s and Non-Active Members who are not Medicare Primary**

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

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

When You Become Medicare Primary

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

Medicare consists of two parts:

Part A: Pays *inpatient hospital* bills and *skilled nursing facility* bills. It is normally provided at no charge to those eligible for Medicare.

Part B: Pays *outpatient hospital*, *doctor* and other professional bills and requires a monthly payment from the person eligible for Medicare.

If you or your covered *dependent* are 65 and are not eligible for either part of Medicare, the *State Health Plan* requires written documentation from the Social Security Administration (SSA) explaining the reason for ineligibility. Benefits cannot be paid unless this documentation is received. Any *member* who becomes eligible for Medicare may remain covered under the *State Health Plan*. For proper coordination of your benefits, you are required to notify the *State Health Plan* of Medicare eligibility immediately. If Medicare becomes your primary health coverage, you must elect Medicare Part B to maintain your same level of coverage.

- ***State Health Plan* Benefit Coordination with Medicare**

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

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

Important Information for *Member*s Eligible for Medicare

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

➢ Medicare as a Secondary Payer

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

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

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

If your Employer has 100 or more *Employee*s, medical benefits under the *Plan* will be paid before Medicare benefits for you and your covered *Dependent,* when your covered *Dependent* 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 *Dependent*s, medical benefits will be paid in accordance with the *Coordination of Benefits* provisions of the *Plan*.

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

➢ Medicaid

If you or any of your covered *Dependent*s qualify for coverage under Medicaid:

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

WHEN COVERAGE BEGINS AND ENDS

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

Eligibility

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

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

people will cease, however, as of the end of the month in which the former *employee* is no longer eligible for disability retirement benefits.

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

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

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

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

- Former *members* of the General Assembly who enrolled before October 1, 1986.
- Former *members* of the General Assembly who are enrolled in the *State Health Plan* at termination of membership in the General Assembly and elect to continue coverage within 30 days of the end of their term of office.
- Surviving *spouses* of deceased *members* of the General Assembly who enrolled before October 1, 1986.
- *Employees* of the General Assembly, not otherwise covered by this section, as determined by the Legislative Services Commission, except legislative pages and interns.
- Surviving *spouses* of deceased former *members* of the General Assembly, if covered at the time of death of the former *member* of the General Assembly.
- All permanent part-time *employees* (designated as half-time or more) who are paid from general or special state funds.
- Retired *employees* with 5, but less than 10 years of retirement service credit who were first hired on or after October 1, 2006, or first taking office on or after February 1, 2007, for General Assembly members.
- *Spouses* and eligible *dependent children* of enrolled teachers, State *employees*, *retirees,* former *members* of the General Assembly, and Disability Income Plan beneficiaries.
- Former *employees* whose jobs were eliminated because of reduction in funds beyond the initial 12-month separation period.
- Certain blind persons licensed by the state as operators (or former operators) of vending facilities under contract with the Department of Health and Human Services.
- Surviving *spouses* of deceased *retirees* and surviving *spouses* of deceased teachers, State *employees*, and *members* of the General Assembly if the *spouse* was covered at the time of death and the death occurred after September 30, 1986.
- Certain surviving *dependent children* who are covered by the *State Health Plan* at the time of the *employee's* death are entitled to coverage as a surviving *dependent* or who were covered under the *State Health Plan* on September 30, 1986. In the absence of an eligible surviving parent, each child is eligible for *member only* (individual) coverage until attaining one of the usual *dependent children* ineligibility events. If a surviving child was certified and covered as a disabled *dependent*, the *dependent* is eligible for life, or until the *dependent* ceases to be disabled. When coverage ceases for a surviving *dependent child*, they may be eligible for continuation coverage.

- The *spouses* and eligible *dependent children* of former *employees* whose jobs were eliminated because of reduction in funds.
- An *employee* on official leave of absence without pay.
- An *employee* with less than five years of retirement membership services, who is on leave without pay due to illness or injury for up to 12 months.

Under certain conditions the following are eligible:

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

Dependent Eligibility

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

- *Spouse.*
- Your dependent children up to age 26, who are (1) a natural or legally adopted child of the *subscriber*, (2) *foster child* of the subscriber, (3) a child for which the *subscriber* is a court-appointed guardian, or (4) stepchild of a member who is married to the stepchild's natural parent.
- Your *dependent children* who meet the requirements of SHP-POL-1006-SHP, including being covered by the Plan when they turn 26 and qualifying as disabled.

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

- First, the *dependent child* is disabled.
- Second, the *dependent* was covered by the Plan on the *dependent child's* 26th birthday.

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

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

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

Enrolling in the Plan

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

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

➢ **Dual Enrollment**

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

➢ **Qualifying Life Events that Allow Coverage Changes**

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

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

- If you, your spouse or your dependent loses eligibility for coverage (as defined by HIPAA) under any group health plan or health insurance coverage (e.g., coverage in the individual market, including the marketplace), you may change your participation election.

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

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

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

Enrollment Exceptions

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

Adding or Removing a Dependent

If you want to add or remove a *dependent* due to a qualifying life event, you will need to do so through eBenefits, the *Plan's* enrollment system. To access eBenefits, visit **www.shpnc.gov** and click "eBenefits."

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

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

The effective date for an adopted child can be the date of adoption, or date of placement in the adoptive parents' home, or the first of the month following the date of adoption or placement. An adopted child must be enrolled within 30 days of the date of adoption or placement. A *subscriber* changing from *employee*-only or *employee*-spouse coverage will be required to pay any additional premiums for

employee/child(ren) or *employee*-family coverage retroactive to the first of the month in which the date of adoption or placement occurred if either is the effective date.

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

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

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, permanent *employees* is determined based on the following:

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

Types of Coverage

Your health benefit plan offers the following types of coverage:

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

Reporting Changes

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

When Coverage Ends

Coverage for you or your *dependents* ends the last day of the month in which an ineligibility event occurs. Some examples of ineligibility events are divorce, entering active military service, and termination of

employment. For additional ineligibility events, contact the Plan's Eligibility and Enrollment Support Center at the number in "Who to Contact." You must make the change request through eBenefits when there is a change of eligibility for a *dependent*. If notification is not made within the 30 days following the *dependent's* ineligibility event, the *dependent* will be removed from coverage on the last day of the month in which the notification is received, and the coverage type change will be the first of the month following notification, except in the case of death, in which case the coverage type change will be made retroactively to the first of the month following death.

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

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

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

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

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

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

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

VALUE-ADDED PROGRAMS

The State Health Plan offers telephonic coaching for disease and case management for members with conditions such as asthma, chronic obstructive pulmonary disease (COPD), chronic kidney disease, coronary artery disease (CAD), heart failure, hypertension, hyperlipidemia, diabetes and more. Case management will also be provided for members with complex health care needs and with conditions such as chronic and end stage renal disease.

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

Get Connected Via Aetna's' Secure Member Portal
State Health Plan subscribers have access to Aetna's member portal, a protected online resource to help you manage your health plan and maximize your benefits. Registered users can complete a variety of self-service tasks online, 24 hours a day, without ever picking up the phone.

- Check your plan summary to see what's covered.
- Track your spending and understand your progress toward meeting your deductibles.
- Access your digital ID card anytime.
- Check up to two years of claims.
- Use the robust **Find a Provider** tool to find quality in-network providers.
- Get cost estimates before getting care.
- View your Explanation of Benefits (EOB).
- Research health and wellness topics to help you make more informed health care decisions.
- Register for discount programs.

Aetna offers State Health Plan members telemedicine services through Teladoc® Health. Members can receive general medical, behavioral health, dermatology and caregiver services virtually using the Teladoc® secure website and app. To access Teladoc® Health services, call the number on the back of your member ID card.

Health information is a phone call away with Aetna's 24-Hour Nurse Line. Members can get information on a wide range of health and wellness topics, make better health care decisions, find out more about an upcoming medical test or procedure, and more. The 24-Hour Nurse Line can be accessed by calling the number on the back of your member ID card.

Aetna offers member discount programs to help you take charge of your care and save you money, called LifeMart® and ChooseHealthy®. These innovative programs complement your health plan and are available at no additional cost. These programs include discounts on major brands, information and more on a variety of health-related products, services, and topics. To get started, go to the Plan's website at www.shpnc.gov and click on eBenefits to log in to the Plan's enrollment system. Then, click on the Aetna Member Portal under Quick Links. Click on Heath & Wellness, then Health & Wellness Discounts. Select the discount you are interested in. You will need to use your member ID to sign up and register for the LifeMart® and ChooseHealthy® programs.

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

DEFINITIONS

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

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

AETNA - Aetna Life Insurance Company

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

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

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

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

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

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

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

a) Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an *outpatient* basis;
b) Provides nursing services and treatment by or under the supervision of *doctors* whenever the patient is in the facility;

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

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

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

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

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

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

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

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

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

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

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

COMPLICATIONS OF PREGNANCY — medical conditions whose 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 MEDICATION — is prepared by a pharmacist when mixing or altering ingredients to create a unique *prescription* medication that is specific for an individual patient.

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

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

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

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

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

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

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

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

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

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. A doctor of psychology who must have 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 covered service is performed, regularly charge and collect fees as a personal right, subject to any licensure or regulatory limitation as to location, manner, or scope of practice. All services performed must be within the scope of license or *certification* to be eligible for reimbursement.

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

EDUCATIONAL TREATMENT — services provided to foster acquisition of skills and knowledge to assist development of an individual's cognitive independence and personal responsibility. These services include academic learning,

socialization, adaptive skills, communication, amelioration of interfering behaviors, and generalizations of abilities across multipole environments.

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

EMERGENCY(IES) — a medical condition, including a mental health or substance use disorder condition, manifesting itself by acute symptoms of sufficient severity, including, but not limited to, severe pain, or by acute symptoms developing from a chronic medical condition that would lead a prudent layperson, possessing an average knowledge of health and medicine, to 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 member, the health of the pregnant member or their unborn child in serious jeopardy, serious physical impairment to bodily functions, serious dysfunction of any bodily organ or part. Heart attacks, strokes, uncontrolled bleeding, poisonings, major burns, prolonged loss of consciousness, spinal injuries, shock, and other severe, acute conditions are examples of emergencies.

EMERGENCY SERVICES — health care items and services furnished or required to screen for or treat an *emergency* medical condition, including but not limited to, pre-*hospital* care and ancillary services routinely available in the *emergency* department.

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

EXPERIMENTAL — see *Investigational*.

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

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

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

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

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

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

HBR — see *Health Benefits Representative*.

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

HEALTH BENEFITS REPRESENTATIVE — an *employee* of an employing unit, as defined under N.C.G.S. 135-48.1(11), who has been designated by the employing unit to be responsible for administering the *State Health Plan* for that employing unit, its employees, and their dependents. Duties include accurately enrolling new *employees*, timely

reporting changes, accurately explaining benefits and enrollment, reconciling group statements, and remitting group fees. The State Retirement System is the *HBR* for retired *members*.

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

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

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
e) Is acceptable to *Aetna*

HOSPICE — a *non-hospital 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
c) Is acceptable to *Aetna*

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 *members* upon enrollment which provides your *member* identification numbers, names of the *members,* and key benefit information, phone numbers and addresses.

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

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

IN-NETWORK — designated as participating in the North Carolina State Health Plan Network or Aetna's Open Access Choice II network. The *State Health Plan's* payment for *in-network covered services* is described in this benefit booklet as *in-network* benefits or *in-network* benefit levels.

IN-NETWORK PROVIDER — a *hospital*, *doctor*, other medical practitioner, or *provider* of *medical services* and supplies that has been designated as a North Carolina State Health Plan Network or Aetna's Open Choice II provider.

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

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

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

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

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

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

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

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

MEDICAL SUPPLIES — health care materials that include, but are not limited to ostomy supplies, catheters, oxygen and diabetic supplies.

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

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

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

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

MENTAL ILLNESS — when applied to an adult *member*, is in general a set of symptoms or behavior associated with distress and interference with personal function. ; and (2) when applied to a *dependent child*, in accordance with North Carolina law, a mental condition, other than intellectual disability alone, that so impairs the *dependent child's* capacity to exercise age adequate self-control or judgment in the conduct of his/her activities and social relationships so that he/she is in need of treatment; or a mental disorder defined in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association, Washington, DC ("DSM-V").

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

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

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

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

OUT-OF-NETWORK — not designated as participating in the North Carolina State Health Plan Network ® and not certified in advance by *Aetna* to be considered as *in-network*. Payment for *out-of-network covered services* is described in this benefit booklet as *out-of-network* benefits or *out-of-network* benefit levels.

OUT-OF-NETWORK PROVIDER — a *provider* that has not been designated as participating in the North Carolina State Health Plan Network

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

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

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

PHARMACY BENEFIT MANAGER (PBM) — the company with which the North Carolina *State Health Plan* contracts to manage the *pharmacy* benefit for its *members*.

PLAN — North Carolina *State Health Plan.*

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

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

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

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

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

a) Immunizations
b) Medications
c) Screening Services
d) Counseling Services

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

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

PROSTHETIC APPLIANCES — a device that temporarily or permanently replaces all or part of an external body part lost or impaired as a result of illness or injury or congenital defects.

PROVIDER — A physician, other health professional, hospital, skilled nursing facility, home health care agency or other entity or person licensed or certified under applicable state and federal law to provide health care services to you. If state law does not specifically provide for licensure or certification, the entity must meet all Medicare accreditation standards (even if it does not participate in Medicare).

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

RESIDENTIAL TREAMENT FACLITY — a *residential treatment facility* is an institution specifically licensed as a residential treatment facility by applicable state and federal law to provide for mental health residential treatment programs. It must be credentialed by Aetna or be accredited by one of the following agencies, commissions or committees for the services being provided: The Joint Commission (TJC); The Committee on Accreditation of Rehabilitation Facilities (CARF); The American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP); The Council on Accreditation (COA).

In addition to the above requirements, an institution must meet the following for residential treatment programs treating mental disorders:

- A behavioral health provider must be actively on duty 24 hours per day for 7 days a week
- The patient must be treated by a psychiatrist at least once a week
- The medical director must be a psychiatrist
- The program is not a wilderness treatment program (whether or not the program is part of a licensed residential treatment facility or otherwise license institution).

RESPITE CARE — services provided by an alternate caregiver or facility to allow the primary caregiver time away from those activities for care of a terminally ill member. *Respite care* is provided in-home or at an alternative location for a short stay often in an inpatient hospice setting. Services include support of activities of daily living such as feeding, dressing, bathing, routine administration of medicines, and can also include intermittent skilled nursing services that the caregiver has been trained to provide.

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

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

SERIOUS AND COMPLEX CONDITION – The term "serious and complex condition" means, with respect to a member under a group health plan or group or individual health insurance coverage:

a) in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or
b) in the case of a chronic illness or condition, a condition that is:
    i. life-threatening, degenerative, potentially disabling, or CONGENITAL; and
    ii. requires specialized medical care over a prolonged period of time.

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 & Habilitative THERAPY — services help you restore or develop skills and functioning for daily living and have to follow a specific treatment plan. Eligible health services include short-term rehabilitative services your physician prescribes. These services have to be performed by

- A licensed or certified physical, occupational or speech therapist
- A hospital, skilled nursing facility or hospice facility
- A home health care agency

SKILLED NURSING FACILITY — A facility specifically licensed as a skilled nursing facility by applicable state and federal laws to provide skilled nursing care. Skilled nursing facilities also include rehabilitation hospital and a hospital designated for skilled or rehabilitation services. Skilled nursing facility does not include institutions that provide only

- Minimal care
- Custodial care services
- Ambulatory care
- Part-time care services
- Care and treatment of mental disorders or substance abuse

SPECIALIST — a physician who practices in any generally accepted medical or surgical sub-specialty.

SPECIALTY MEDICATION — specialty and *biosimilar* medications are designated and classified by the *Plan* as medications that are generally prescribed by a specialist and typically include high-cost drugs that require special handling, special storage or monitoring and may include things such as oral, topical, inhaled and injected routes of delivery.

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

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

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

SUBSTANCE USE DISORDER — a physical or psychological dependency, or both, on a controlled substance or alcohol agent. These are defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association. This term does not include conditions that you cannot attribute to a mental disorder that are a focus of attention or treatment, or an addiction to nicotine products, food, or caffeine intoxication.

a) **SURGERY** — the diagnosis and treatment of injury, deformity and disease by manual and instrumental means, such as cutting abrading, suturing, destruction, ablation, removal, lasering, introduction of a catheter (e.g., heart or bladder catheterization) or scope (e.g., colonoscopy or types of endoscopy), correction of fracture, reduction of dislocation, application of plaster casts, injection into a joint, injection of sclerosing solution, or otherwise physically changing body tissues and organs.

TRANSPLANTS — include organ transplant services provided by a physician and hospital. Organ means:

- Solid organ
- Hematopoietic stem cell
- Bone marrow

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

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

WALK-IN CLINIC – a health care facility that provides limited medical care on a scheduled and unscheduled basis. A *Walk-In Clinic* may be located in, near or within a:

- Drug Store
- Pharmacy Retail Store
- Supermarket

The following is not considered a *Walk-In Clinic:*

- Ambulatory Surgical Center
- Emergency Room
- Hospital
- Outpatient department of a hospital
- Physician's office
- Urgent care facility

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

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

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

LEGAL NOTICES

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Original Effective Date: April 14th, 2003

Introduction

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

Your Rights

You have the right to:

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

Your Choices

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

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

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

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

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

Get a copy of this privacy notice

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

Choose someone to act for you

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

File a complaint if you feel your rights are violated

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

Your Choices

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

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

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

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

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

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

Our Uses and Disclosures

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

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

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

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

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

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

How else can we use or share your health information?

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

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

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

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

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

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

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

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

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

Other Uses and Disclosures

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

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.

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

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

Changes to the Terms of this Notice

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

Complaints

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

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

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

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

Privacy Contact

The Privacy Contact at the Plan is:

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

Enrollment in the Flexible Benefit Plan (under IRS Section 125) for the State Health Plan

Your health benefit coverage can only be changed (dependents added or dropped) during the Open Enrollment period or following a qualifying life event. These eventsinclude, but are not limited to the following:

- Your marital status changes due to marriage, death of spouse, divorce, legalseparation, or annulment.
- You increase or decrease the number of your eligible dependents due to birth, adoption, placement for adoption, or deathof the dependent.
- You, your spouse, or your eligible dependent experiences an employment status change that results in the loss or gainof group health coverage.
- You, your spouse, or your dependents become entitled to Medicare, or Medicaid.
- Your dependent ceases to be an eligibledependent (e.g., the dependent child reaches age 26).
- You, your spouse, or your dependents commence or return from an unpaid leaveof absence such as Family and Medical Leave or military leave.
- You receive a qualified medical child support order (as determined by the planadministrator) that requires the plan to provide coverage for your children.
- If you or your dependents change your country of permanent residence by movingto or from the United States, you or your dependents will have 30 days from the dateof entering or exiting the United States to change your health benefit plan election.
- If you, your spouse or dependents experience a cost or coverage change under another group health plan for which an election change was permitted, you maymake a corresponding election change under the Flex Plan (e.g., your spouse's employer significantly increases the cost ofcoverage and as a result, allows the spouseto change his/her election).
- If you change employment status such that you are no longer expected to average 30 hours of service per week but you do not lose eligibility for coverage under the State Health Plan (e.g., you are in a stability periodduring which you qualify as full time), you may still revoke your election provided that you certify that you have or will enroll yourself (and any other covered family members) in other coverage providing minimum essential coverage (e.g., the marketplace) that is effective no later than the first day of the second month followingthe month that includes the date the original coverage is revoked.
- You may prospectively revoke your State Health Plan election if you certify your intent to enroll yourself and any covered dependents in the marketplace for coverage that is effective beginning no later than theday immediately following the last day of the original coverage that is revoked.
- You or your children lose eligibility under Medicaid or a state Children's Health Insurance Program. In this case you must request enrollment within 60 days of losingeligibility.
- If you, your spouse or your dependent loses eligibility for coverage (as defined by HIPAA) under any group health plan orhealth insurance coverage (e.g., coveragein the individual market, including the marketplace), you may change your participation election.

In addition, even if you have one of these events, your election change must be "consistent" with the event, as defined by the IRS. Consequently, the election changethat you desire may not be permitted if notconsistent with the event as determined by IRS rules and regulations. When one of these events occurs, you must complete your request through your online enrollmentsystem within 30 days of the event (except as described above). If you do not process the request within 30 days, you must wait until the next Open Enrollment to make the coverage change.

Notice of HIPAA Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibilityfor that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days afteryour or your dependents' other coverage
ends (or after the employer stops contributingtoward the other coverage).

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

become eligible for a state premiumassistance subsidy from Medicaid or througha state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and yourdependents in this plan. However, you mustrequest enrollment within 60 days after your or your dependents' determination of eligibility for assistance.

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

Notice Regarding Mastectomy-Related Services

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

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under your elected plan. If you would like more information on WHCRA benefits, call Customer Service.

Notice of Patient Protections for Non-Grandfathered Plans

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

You do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participatinghealth care professionals who specialize in obstetrics or gynecology, contact Customer Service.

Notice Regarding Availability of Health Insurance Marketplace Coverage Options (Employer Exchange Notice)

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[1,2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution—as well as your employee contribution to employment-based coverage—is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.
[2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact Customer Service. The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

Notice Regarding Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network. "Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit. "Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.
You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed. If you get other types of services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly. Generally, your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact the U.S. Department of Health and Human Services (Phone: 800-985-3059) regarding enforcement of federal balance or surprise billing protection laws and the North Carolina Department of Insurance regarding enforcement of North Carolina balance or surprise billing protection laws (Phone: 855-408-1212; Address: 325 N. Salisbury Street, Raleigh, NC 27603).

Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

Visit ncdoi.gov for more information about your rights under North Carolina law.

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)
  - The State Health Plan website is Americans with Disabilities Act (ADA) compliant for the visually impaired.
  - Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator identified below (the "Coordinator"): State Health Plan Compliance Officer at 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 (Section 1557 Coordinator, 3200 Atlantic Avenue, Raleigh, NC 27604) or email (1557Coordinator@nctreasurer.com).

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

U.S. Department of Health and Human Services
200 Independence Avenue SW Room 509F, HHH Building Washington, DC 20201
1-800-368-1019, 800-537-7697 (TDD)
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

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **919-814-4400.**

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.**

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.**

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **919-814-4400.**

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **919-814-4400.**

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **919-814-4400.**

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau **919-814-4400.**

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **919-814-4400.**

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **919-814-4400.**

સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિઃશુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો **919-814-4400.**

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ **919-814-4400.**

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **919-814-4400.**

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **919-814-4400.**

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ **919-814-4400.**

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.**

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**

Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**INDIANA – Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**

Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**

Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

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

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