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

Board of Trustees' Meeting
Thursday, November 20, 2014, 4:00 – 6:00 p.m.

1.	Welcome	Genell Moore, Vice-Chair
2.	Conflict of Interest Statement	Genell Moore, Vice-Chair
3.	Review of Minutes – September 19, 2014	Genell Moore, Vice-Chair
4.	Member Experience and Communications	Caroline Smart
	A. 2014 Member Satisfaction Survey Results	
	B. Annual Enrollment Results (CDHP, 80/20, 70/30, MAPDP)	
	C. Communication and Open Enrollment Update (HDHP)	
	D. Same-Sex Marriage Qualifying Event Update	
	E. Communication Update – Health Literacy	
5.	Financial Report, Forecasting and Monitoring	
	A. September 2014 Financial Report	Mark Collins
	B. Actuarial Valuation of Retired Employees' Health Benefits – Other Postemployment Benefits (OPEB) as of Dec 31, 2013	Mark Collins
	C. Summary of Audit Results	
	i. Medical Claims	Caroline Smart
	ii. BCBSNC Administrative Costs	Mark Collins
	iii. Pharmacy	Tracy Stephenson
	iv. Early Retiree Reinsurance Program	Caroline Smart
6.	Legislative Update	
	A. Diabetes & Chronic Disease Legislative Reports	Nidu Menon/Sally Morton
7.	Wrap-Up	Genell Moore, Vice-Chair

Our mission is to improve the health and health care of North Carolina teachers, state employees, retirees, and their dependents, in a financially sustainable manner, thereby serving as a model to the people of North Carolina for improving their health and wellbeing.

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

Board of Trustees' Meeting
Friday, November 21, 2014, 9:00 a.m. – 3:00 p.m.

1.	Welcome	Genell Moore, Vice-Chair
2.	Conflict of Interest Statement	Genell Moore, Vice-Chair
3.	Benefit Design, Plan Options and Premiums	
	A. 2016 Benefit Planning	
	i. Comparative Analysis of State Health Plans	Thomas Friedman
	ii. ACA Impact on Benefit Planning	The Segal Company
	BREAK	
	iii. Benefit Design Options for Achieving Strategic Priorities	Mona Moon, Nidu Menon Tracy Stephenson, Tom Friedman
	LUNCH	
4.	Executive Session **(for Board members only)**	Genell Moore, Vice-Chair
	Pursuant to: G.S. 143-318.11 and 132-1.2	
	Pharmacy Benefit Management Core Audit Services Contract ***(Requires Board Vote)***	Tracy Stephenson
5.	Benefit Design, Plan Options and Premiums *(continued)*	
	A. Final Benefit Approvals for 2015 ***(Requires Board Vote)***	Lotta Crabtree
	i. ACA Preventive Services (CDHP, Enhanced 80/20)	
	ii. Alternative Benefit Option – High Deductible Health Plan	
	B. Implementation of Applied Behavior Analysis (ABA) Benefit	Lotta Crabtree
6.	Strategic Planning	
	A. Strategic Plan Scorecard – Measuring Success	Thomas Friedman
	B. Workgroups & Next Steps	Mona Moon
7.	Wrap-Up	Genell Moore, Vice-Chair

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North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

2014 Member Satisfaction Survey Results

Board of Trustees Meeting

November 20, 2014

Methodology Reminder

- A total of 407,093 postcards were mailed inviting subscribers and covered spouses to participate in the survey that was posted on the home page of the State Health Plan's website.

- A total of 7,725 responses were collected from July 14 through August 29, 2014, resulting in a response rate of 2%. The survey length averaged 11 minutes.

Active Employees/ Non-Medicare Retirees	Medicare Primary Retirees
5,171 (67%)	2,554 (33%)

Active/Non-Medicare Retiree Respondent Profile

GENDER	Male	24%
	Female	76%
WORK	University	12%
	Community College	5%
	State Agency	20%
	School System	33%
	UNC Healthcare	2%
	Retired	27%
2014 PLAN	Traditional 70/30 Plan	23%
	Enhanced 80/20 Plan	71%
	Consumer-Directed Health Plan	6%
COVERAGE	Employee/Retiree only	77%
	Employee/Retiree and child/children only	10%
	Employee/Retiree and spouse only	6%
	Family	8%

Active/Non-Medicare Respondents= 5,171

Medicare Primary Respondent Profile

GENDER	Male	33%
	Female	67%
YEARS RETIRED	Less than 1 year	4%
	1-3	16%
	4-6	20%
	7-10	24%
	11+	36%
2014 PLAN	Traditional 70/30 Plan	27%
	Humana (NET)	21%
	Humana Medicare Advantage Base Plan	14%
	Humana Medicare Advantage Enhanced Plan	7%
	UnitedHealthcare (NET)	52%
	UnitedHealthcare Medicare Advantage Base Plan	21%
	UnitedHealthcare Medicare Advantage Enhanced Plan	31%
COVERAGE	Employee/Retiree only	86%
	Employee/Retiree and child/children only	0%
	Employee/Retiree and spouse only	13%
	Family	1%

Medicare Primary Respondents= 2,554

Executive Summary

- The cost of monthly premiums ranked as a top reason behind members' choice of health plans, followed by copays and then annual out-of-pocket or coinsurance maximums. This is true for both Active/Non-Medicare Retirees and Medicare Primary Retirees.
- Cost also played a role in seeking care. Over one-third (36%) of Active/Non-Medicare Retirees stated that they either delayed or didn't receive health care services during the past 12 months because of this. Half as many Medicare Primary Retirees experienced this (16%).
- The vast majority (85%) of Active/Non-Medicare Retirees stated that they had a primary care visit with the provider listed on their ID card in 2014.
- Over half (59%) of Medicare Primary Retirees stated that they have used preventative services and screenings in 2014, but only one-third have taken advantage of the SilverSneakers fitness program.
- Satisfaction with care and service is fairly good among Medicare Primary Members, but the Active/Non-Medicare Retirees do not seem as satisfied.
- Among Active/Non-Medicare Retirees:
  - 59% gave the highest ratings for the customer service they receive when they call.
  - 57% gave the highest ratings for the prescription benefits, while 52% rate the information communicated about the prescription benefits highly.
  - 76% do give the pharmacists' counseling on prescriptions high marks.

Drivers of Choice - *Active Members*

- What were your top reasons for choosing one design over another for the 2014 benefit year? Please rank the items on the list using numbers 1 through 8, where 1 means your top reason, 2 means your second reason, and so on, with 8 being the least important reason for choosing one plan over another.

Reasons Ranked 1-8	Ranked #1	Ranked Top 2	Ranked Top 3	Average Ranking
Cost of monthly premiums	43%	59%	72%	2.5
Copay or cost associated with each doctor visit or prescription	19%	47%	74%	2.8
Annual out-of-pocket or coinsurance maximums on medical and pharmacy services	13%	37%	61%	3.2
Having preventive services, medications, and/or prescriptions covered at 100%	13%	28%	46%	3.5
Presence or lack of wellness activities to lower monthly premiums	5%	13%	22%	4.8
Cost of dependents	3%	8%	12%	6.2
Having a Health Reimbursement Account (HRA) to offset your out-of-pocket expenses	2%	5%	9%	5.9
Existence of other insurance such as TRICARE	2%	3%	4%	7.1

Active/Non-Medicare Respondents= 5,171

Drivers of Choice - *Medicare Members*

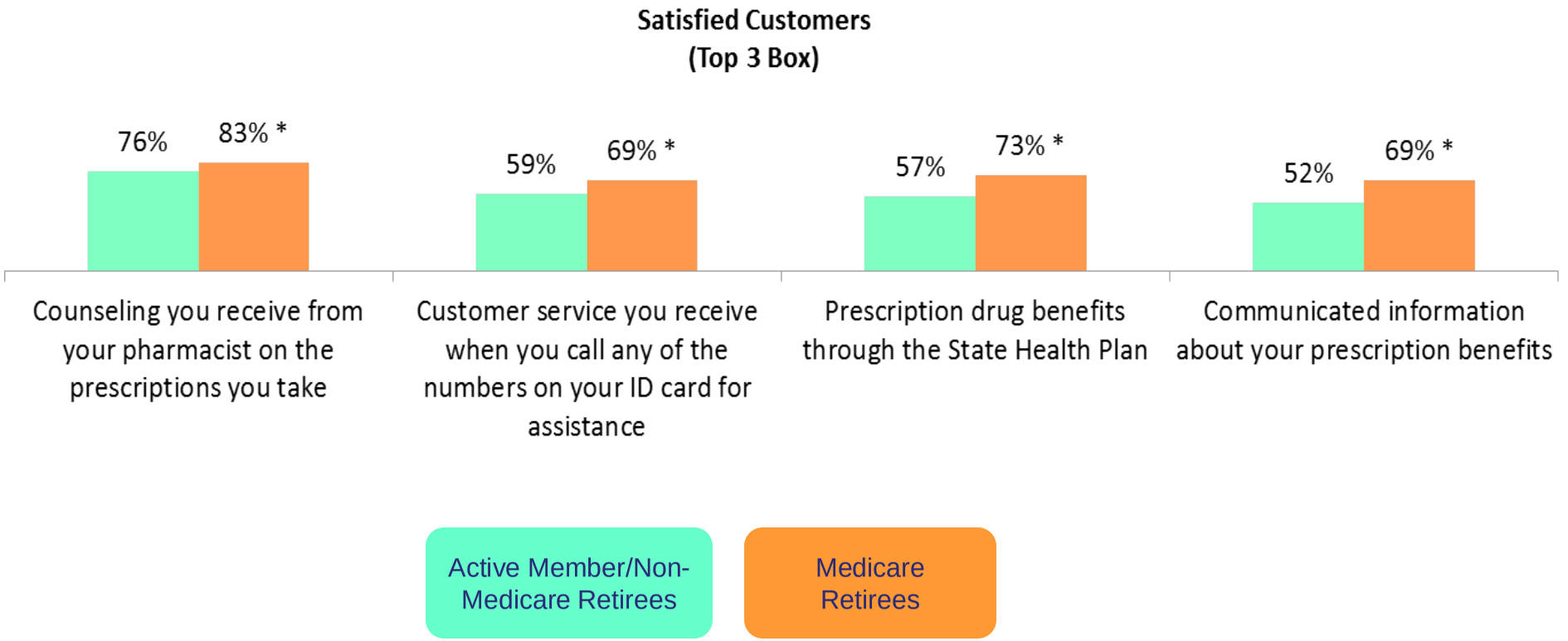
- What were your top reasons for choosing one design over another for the 2014 benefit year? Please rank the items on the list using numbers 1 through 6, where 1 means your top reason, 2 means your second reason, and so on, with 6 being the least important reason for choosing one plan over another.

Reasons Ranked 1-6 *Base: MP total (n=2554)*	Ranked #1	Ranked Top 2	Ranked Top 3	Average Ranking
Cost of monthly premiums	41%	57%	71%	2.5
Copay or cost associated with each doctor visit or prescription	18%	46%	79%	2.6
Annual out-of-pocket or coinsurance maximums on medical and pharmacy services	16%	48%	75%	2.7
Having preventive services, medications, and/or prescriptions covered at 100%	14%	29%	49%	3.2
Existence of other insurance such as an Individual Medicare Advantage Plan, an Individual Part D Plan or TRICARE	8%	13%	17%	4.7
Cost of dependents	3%	6%	9%	5.3

Medicare Primary Respondents= 2,554

Satisfaction

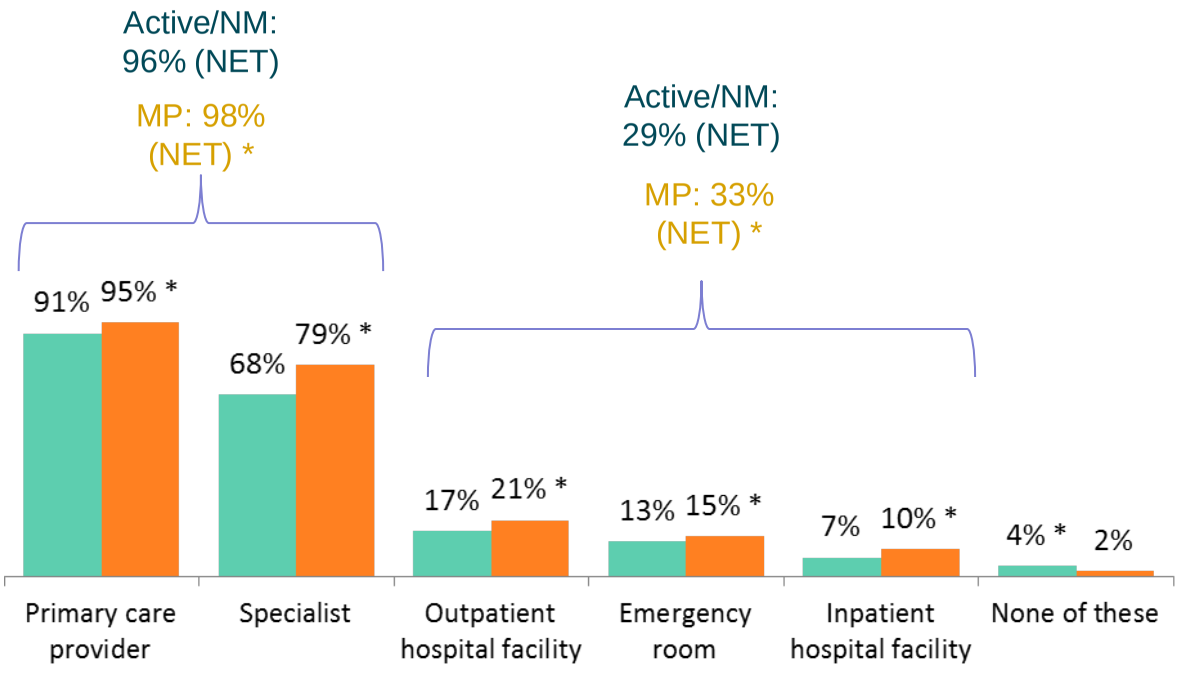
- Using a scale of 1-10, where a “10” means completely satisfied and “1” means completely dissatisfied, how satisfied or dissatisfied are you with the following since January 1, 2014…



* Represents statistically significant differences between Active/Non-Medicare Retirees and Medicare Primary members.

Visits the Last 12 Months

- Which of the following have you visited within the past 12 months? Please check all that apply.
- What reason most closely matches why you have not visited a Primary Care Provider within the last 12 months?



Reason that best explains why Active/Non-Medicare Retirees are NOT visiting PCP:
- No need because I have not been sick, 67%
- Do not have one, 9%
- Difficult to find time, 12% *
- Cannot afford copay, 13% *

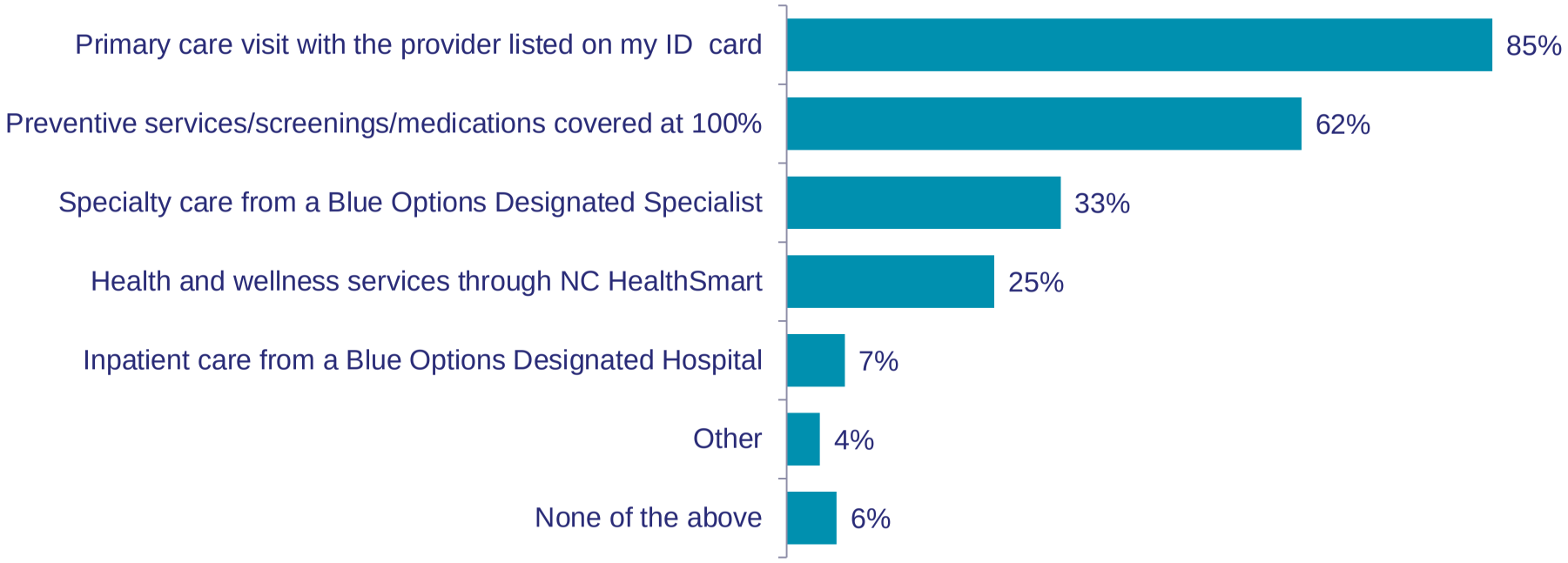
Reason that best explains why Medicare Primary members are NOT visiting PCP:
- No need because I have not been sick, 75%
- Do not have one, 15% *
- Difficult to find time, 5%
- Cannot afford copay, 4%

Active Member/Non-Medicare Retirees

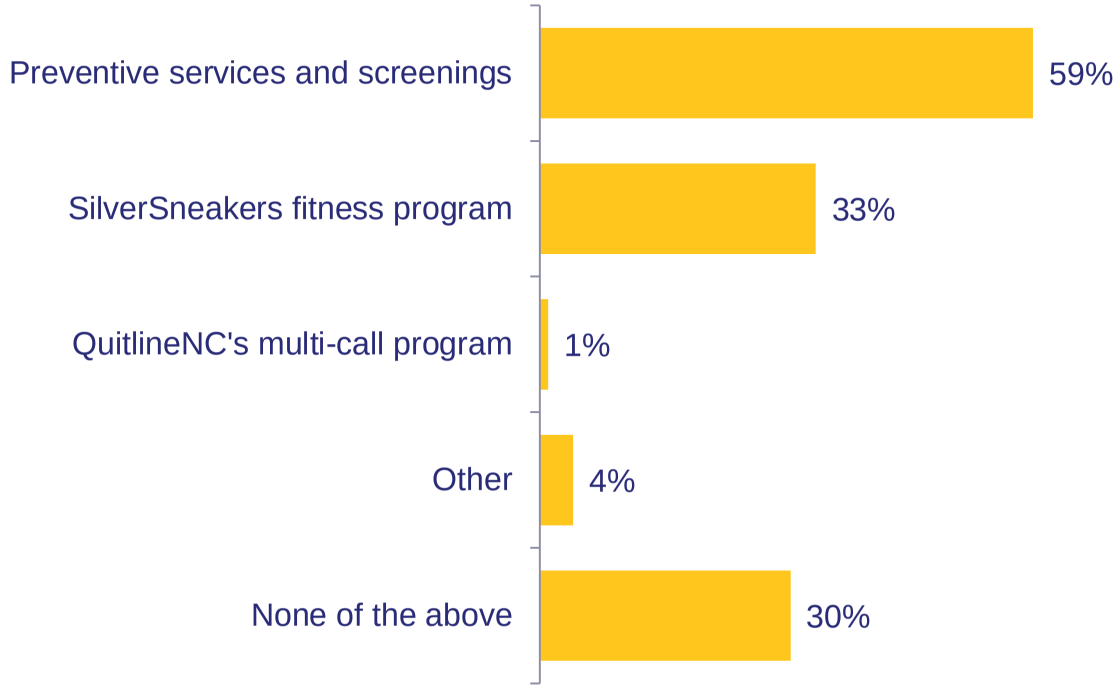
Medicare Retirees

* Represents statistically significant differences between Active/Non-Medicare Retirees and Medicare Primary members.

- Which of the following services have you used since January 1, 2014? Please select all that apply.



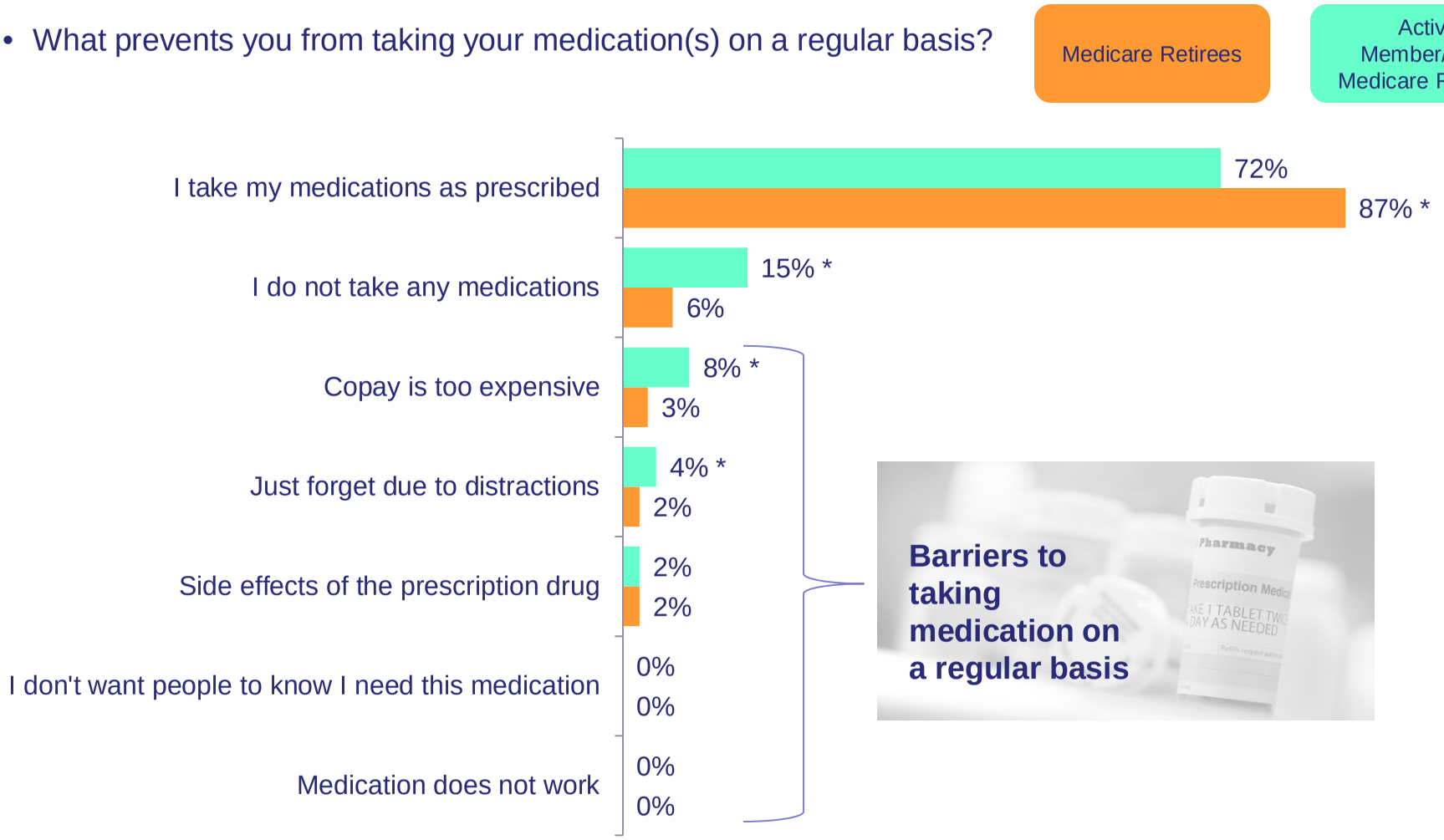
- Which of the following services have you used since January 1, 2014? Please select all that apply.



HEALTHWAYS SilverSneakers® FITNESS

Medication Usage

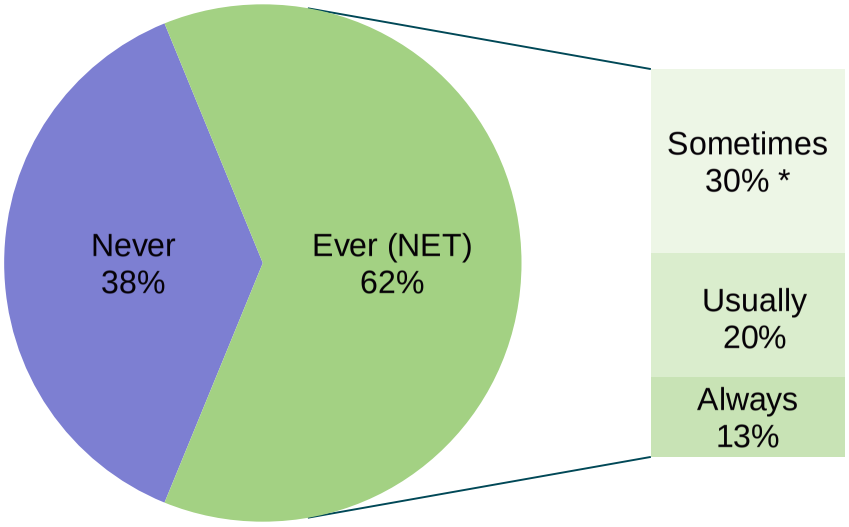
- What prevents you from taking your medication(s) on a regular basis?



* Represents statistically significant differences between Active/Non-Medicare Retirees and Medicare Primary members.

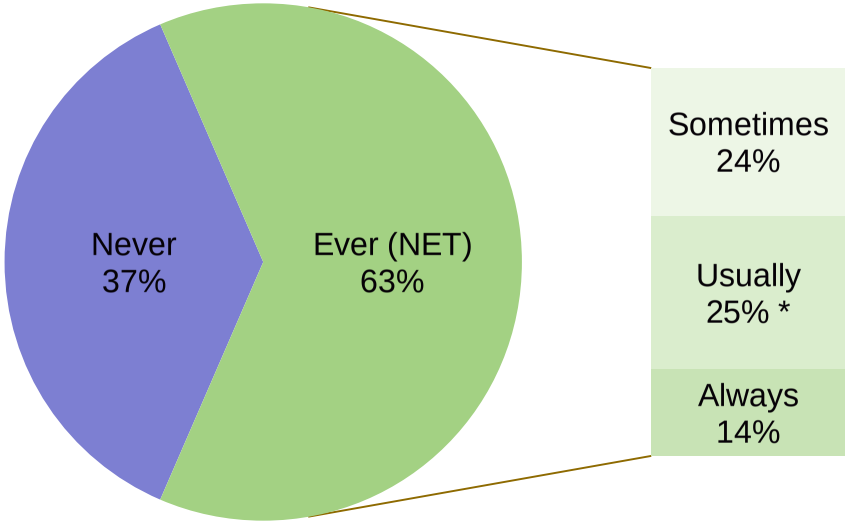
Advance Cost of Service

- In the last 12 months, how often were you able to find out in advance how much you would have to pay for health care services or equipment that you needed?



Active/Non-Medicare Retirees

Active/Non-Medicare Respondents excluding n/a= 2,946

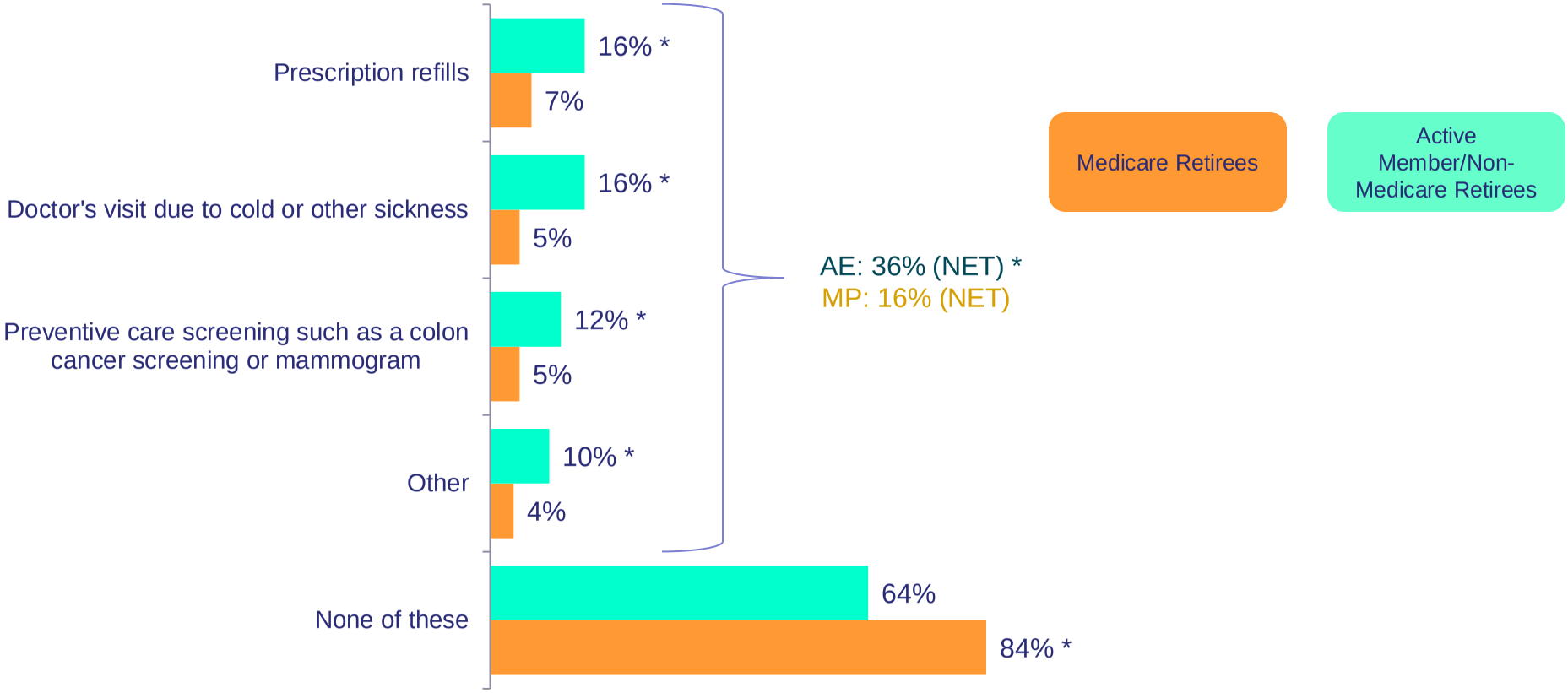


Medicare Retirees

Medicare Primary Respondents excluding n/a =1,438)

Cost as a Barrier

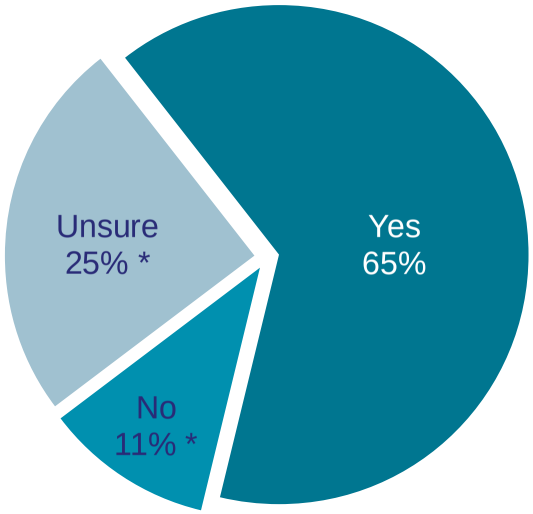
- In the last 12 months, did you delay or not get any of the following services because of the cost?



* Represents statistically significant differences between Active/Non-Medicare Retirees and Medicare Primary members.

PCP and Specialist Communication

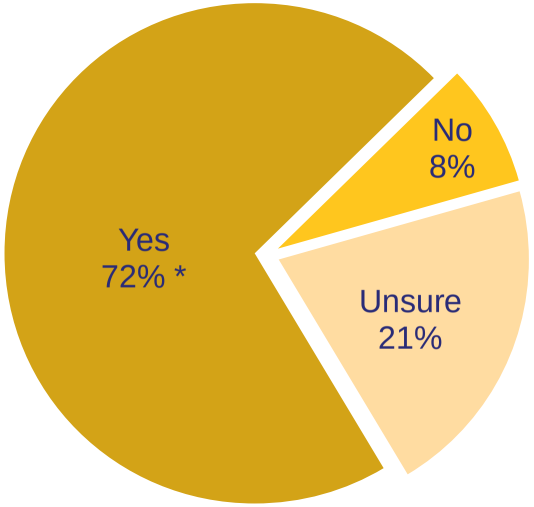
- Does your Primary Care Provider communicate with your specialist(s) to provide you with the highest level of care?



Active/Non-Medicare Retirees

Base: AE who visited doctor/facility P12M who have PCP and have seen specialist (n=4198)

PCP communicates with specialist to provide highest level of care



Medicare Retirees

Base: MP who visited doctor/facility P12M who have PCP and have seen specialist (n=2223)

* Represents statistically significant differences between Active/Non-Medicare Retirees and Medicare Primary members.

PCP Providing Resources

- Does your Primary Care Provider give you resources to help you understand and manage your health? For example, resources to help you manage your diabetes or maintain a healthy weight.

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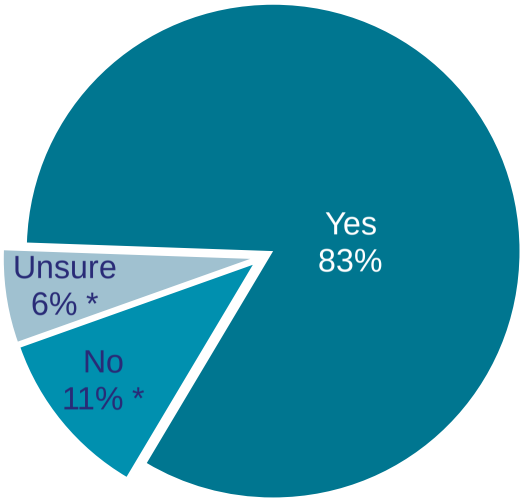
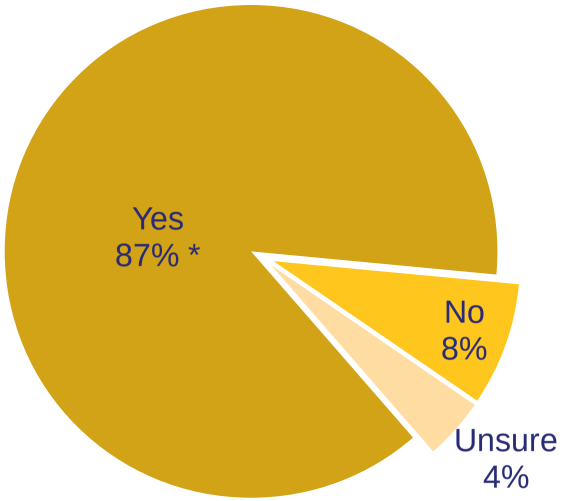


Active/Non-Medicare Retirees

Base: AE who visited doctor/facility P12M who have PCP (n=4933)

PCP gives resources to help understand/manage health



Medicare Retirees

Base: MP who visited doctor/facility P12M who have PCP (n=2483)

* Represents statistically significant differences between Active/Non-Medicare Retirees and Medicare Primary members.

Communication - *Active/Non-Medicare Retirees*

- List your most preferred method or methods of receiving information from the State Health Plan.
- Please rank the items on the list using numbers 1 through 7, where 1 means your most preferred method, 2 means your second most preferred, and so on, with 7 being the least preferred method.

Method Preferences Ranked 1-7 *The lower the ranking, the more preferred the method.*	**Base: AE total (n=5171)**			
	Ranked #1	Ranked Top 2	Ranked Top 3	Average Ranking
Email communications	35% *	63% *	80% *	2.4
Printed material mailed to my home	34%	52%	65%	2.8 *
State Health Plan website (shpnc.org)	16% *	33%	56%	3.3
Member Focus, the monthly electronic State Health Plan newsletter	9%	31%	60%	3.3 *
Through my Health Benefits Representative	3% *	8% *	15% *	5.3
Group meetings or presentations at my worksite	2% *	7% *	13% *	5.5
Mobile application for my phone	2% *	6% *	12% *	5.5

* Represents statistically significant differences between Active/Non-Medicare Retirees and Medicare Primary members.

Communication Methods - *Medicare Retirees*

- List your most preferred method or methods of receiving information from the State Health Plan.
- Please rank the items on the list using numbers 1 through 7, where 1 means your most preferred method, 2 means your second most preferred, and so on, with 7 being the least preferred method.

Method Preferences Ranked 1-7 *The lower the ranking, the more preferred the method.*	**Base: MP total (n=2554)**			
	Ranked #1	Ranked Top 2	Ranked Top 3	Average Ranking
Email communications	25%	56%	75%	2.6 *
Printed material mailed to my home	53% *	68% *	78% *	2.1
State Health Plan website (shpnc.org)	11%	31%	58%	3.3
Member Focus, the monthly electronic State Health Plan newsletter	9%	33%	66% *	3.1
Through my Health Benefits Representative	2%	6%	11%	5.4 *
Group meetings or presentations at my worksite	0%	3%	6%	5.9 *
Mobile application for my phone	0%	3%	6%	5.7 *

* Represents statistically significant differences between Active/Non-Medicare Retirees and Medicare Primary members.

Survey Comparison

Overall Satisfaction with the Plan

- 2012: 44% satisfied with health plan coverage
- 2014: Instead of asking one overall satisfaction question, we asked a series of service questions which the surveyor combined for a overall composite service satisfaction score of "*Moderately Pleased*".

Customer Satisfaction when Calling for Services

- 2012: 63% (Active and Medicare) of the respondents were satisfied
- 2014: Actives, 59%; Medicare, 69% were satisfied

No Treatment or Medication Due to Cost

- 2012: 42% of respondents (Active and Medicare) chose not to seek treatment or fill a medication due to cost
- 2014: Actives, 36%; Medicare, 16% chose not to seek treatment or fill a medication due to cost

Appendix

BlueCross BlueShield of North Carolina

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

Member Satisfaction Survey
September 29, 2014

Methodology

- FGI research conducted an online survey of SHP subscribers and covered spouses. It was a census survey, meaning everyone in this population had a chance to take the survey.
- A total of 407,093 postcards were mailed inviting subscribers and covered spouses to participate in the survey that was posted on the main page of the SHP website.
- A total of 7,725 responses were collected from July 14 through August 29, 2014, resulting in a response rate of 2%. The survey length averaged 11 minutes.
- This report provides the data separately for Active Employees/Retirees (AE) and Medicare Primary Retirees (MP). Counts for each group are below. On questions where both groups answered a question, statistically significant differences at the 95% level between the two groups are noted with a star (*).

Active Employees/Retirees	Medicare Primary Retirees
n=5171 (67%)	n=2554 (33%)

Drivers of Choice—AE Plan

For Active Employees/Retirees, the cost of monthly premiums is the top reason for choosing one design over another in 2014. This is followed by copays and then maximums.

The lower the ranking, the more important the reason.

#1

Reasons Ranked 1-8 *Base: AE total (n=5171)*	Ranked #1	Ranked Top 2	Ranked Top 3	Average Ranking
Cost of monthly premiums	43%	59%	72%	2.5
Copay or cost associated with each doctor visit or prescription	19%	47%	74%	2.8
Annual out-of-pocket or coinsurance maximums on medical and pharmacy services	13%	37%	61%	3.2
Having preventive services, medications, and/or prescriptions covered at 100%	13%	28%	46%	3.5
Presence or lack of wellness activities to lower monthly premiums	5%	13%	22%	4.8
Cost of dependents	3%	8%	12%	6.2
Having a Health Reimbursement Account (HRA) to offset your out-of-pocket expenses	2%	5%	9%	5.9
Existence of other insurance such as TRICARE	2%	3%	4%	7.1

Q4a. What were your top reasons for choosing one design over another for the 2014 benefit year? Please rank the items on the list using numbers 1 through 8, where 1 means your top reason, 2 means your second reason, and so on, with 8 being the least important reason for choosing one plan over another.

Drivers of Choice—MP Plan

Just like Active Employees/Retirees, Medicare Primary Retirees also rank the cost of monthly premiums as the top reason, followed by copays and then maximums.

The lower the ranking, the more important the reason.

Reasons Ranked 1-6 *Base: MP total (n=2554)*	Ranked #1	Ranked Top 2	Ranked Top 3	Av... Ranking
#1 → Cost of monthly premiums	41%	57%	71%	2.5
Copay or cost associated with each doctor visit or prescription	18%	46%	79%	2.6
Annual out-of-pocket or coinsurance maximums on medical and pharmacy services	16%	48%	75%	2.7
Having preventive services, medications, and/or prescriptions covered at 100%	14%	29%	49%	3.2
Existence of other insurance such as an Individual Medicare Advantage Plan, an Individual Part D Plan or TRICARE	8%	13%	17%	4.7
Cost of dependents	3%	6%	9%	5.3

Q4b. What were your top reasons for choosing one design over another for the 2014 benefit year? Please rank the items on the list using numbers 1 through 6, where 1 means your top reason, 2 means your second reason, and so on, with 6 being the least important reason for choosing one plan over another.

Satisfaction

SHP members are moderately pleased with key service aspects but a service organization should strive for higher satisfaction ratings, especially among the Active Employees/Retirees. Generally, top 3 box ratings should be higher than the scores Active Employees/Retirees gave below.

Base: AE excluding "n/a" (base varies)

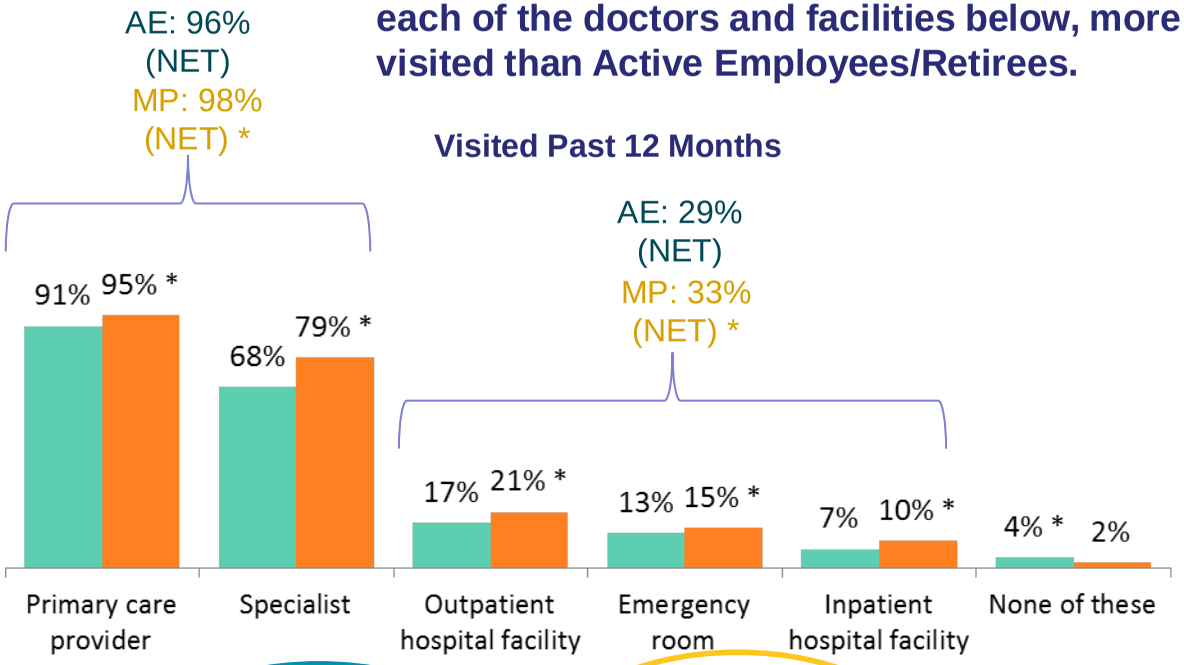
Base: MP excluding "n/a" (base varies)

Satisfied Customers (Top 3 Box)

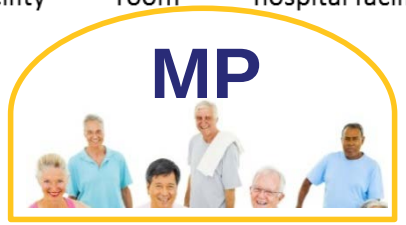
	Counseling you receive from your pharmacist on the prescriptions you take		Customer service you receive when you call any of the numbers on your ID card for assistance		Prescription drug benefits through the State Health Plan		Communicated information about your prescription benefits	
Neutral (Middle 4 Box)	18% *	13%	27% *	19%	30% *	18%	35% *	22%
Dissatisfied (Bottom 3 Box)	5%	5%	14% *	12%	13% *	9%	13% *	10%
Average Rating	8.4	8.7 *	7.2	7.8 *	7.2	8.0 *	7.0	7.8 *

Visits

Nearly all SHP members have visited a primary care provider during the past 12 months, and this is true for both groups. Of those who haven't, the majority didn't do so because they weren't sick and therefore didn't have a need. For each of the doctors and facilities below, more Medicare Primary Retirees have visited than Active Employees/Retirees.



Base: AE total (n=5171)



Base: MP total (n=2554)

Reason that best explains AE NOT visiting PCP:

- No need because I have not been sick, 67%
- Do not have one, 9%
- Difficult to find time, 12% *
- Cannot afford copay, 13% *

Base: AE who have not visited PCP past 12 months (n=464)

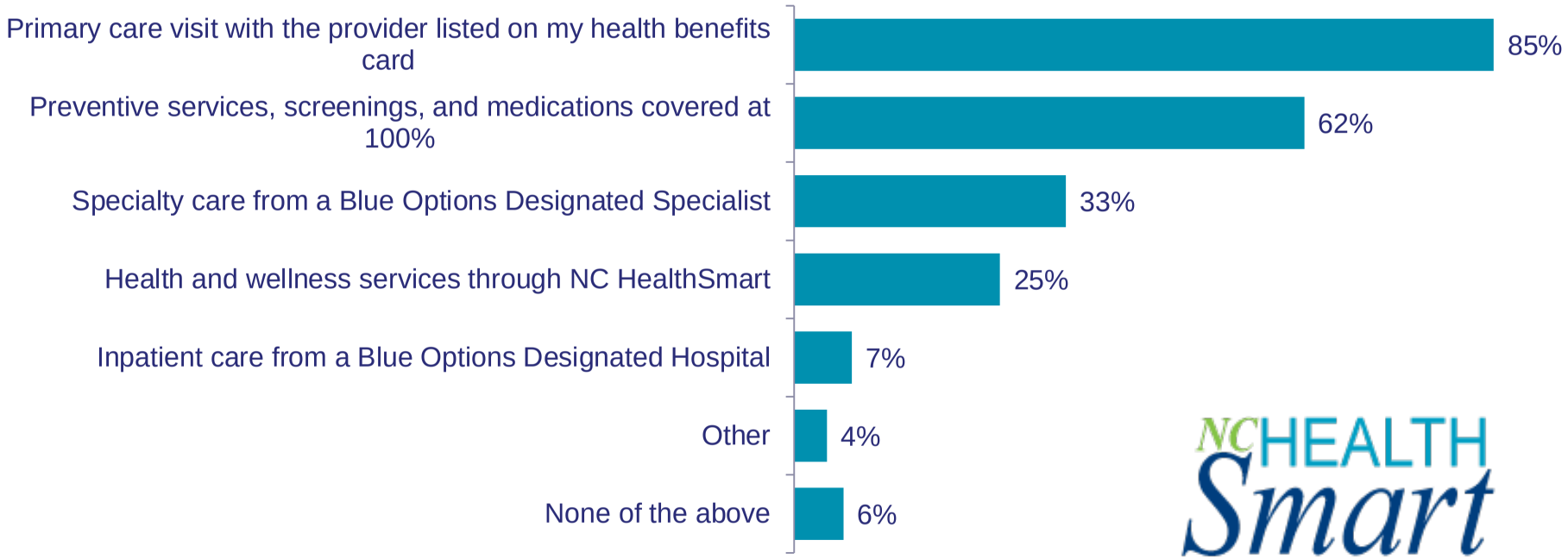
Reason that best explains MP NOT visiting PCP:

- No need because I have not been sick, 75%
- Do not have one, 15% *
- Difficult to find time, 5%
- Cannot afford copay, 4%

Base: MP who have not visited PCP past 12 months (n=136)

AE Services

The majority of Active Employees/Retirees have taken advantage of at least one of the services listed below this year. A visit with a primary care provider was the service utilized by most. Just one-quarter have taken advantage of NC Health*Smart*.

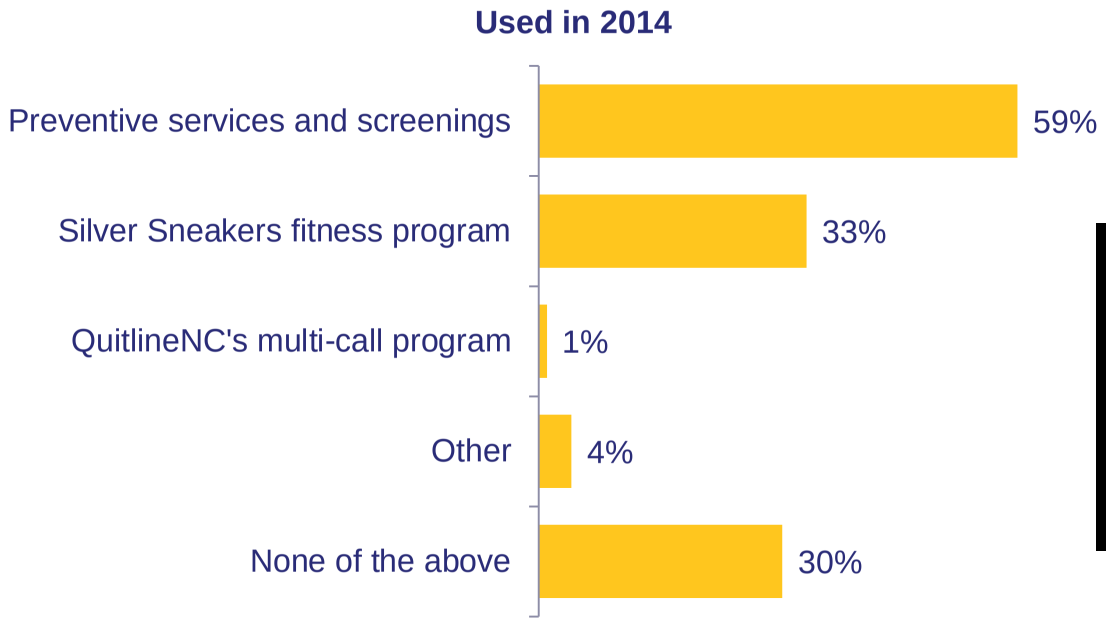


Base: AE not on traditional 70/30 plan (n=4011)

NC HEALTH Smart
An initiative of the State Health Plan

MP Services

From the list below, preventative services and screenings were utilized by the most Medicare Primary Retirees. One-third have taken advantage of the fitness program Silver Sneakers. QuitlineNC was only used by 1%, although 6% use tobacco products (as seen in respondent profile).



Base: MP not on traditional 70/30 plan (n=1894)

QuitlineNC.com
1-800-QUIT-NOW

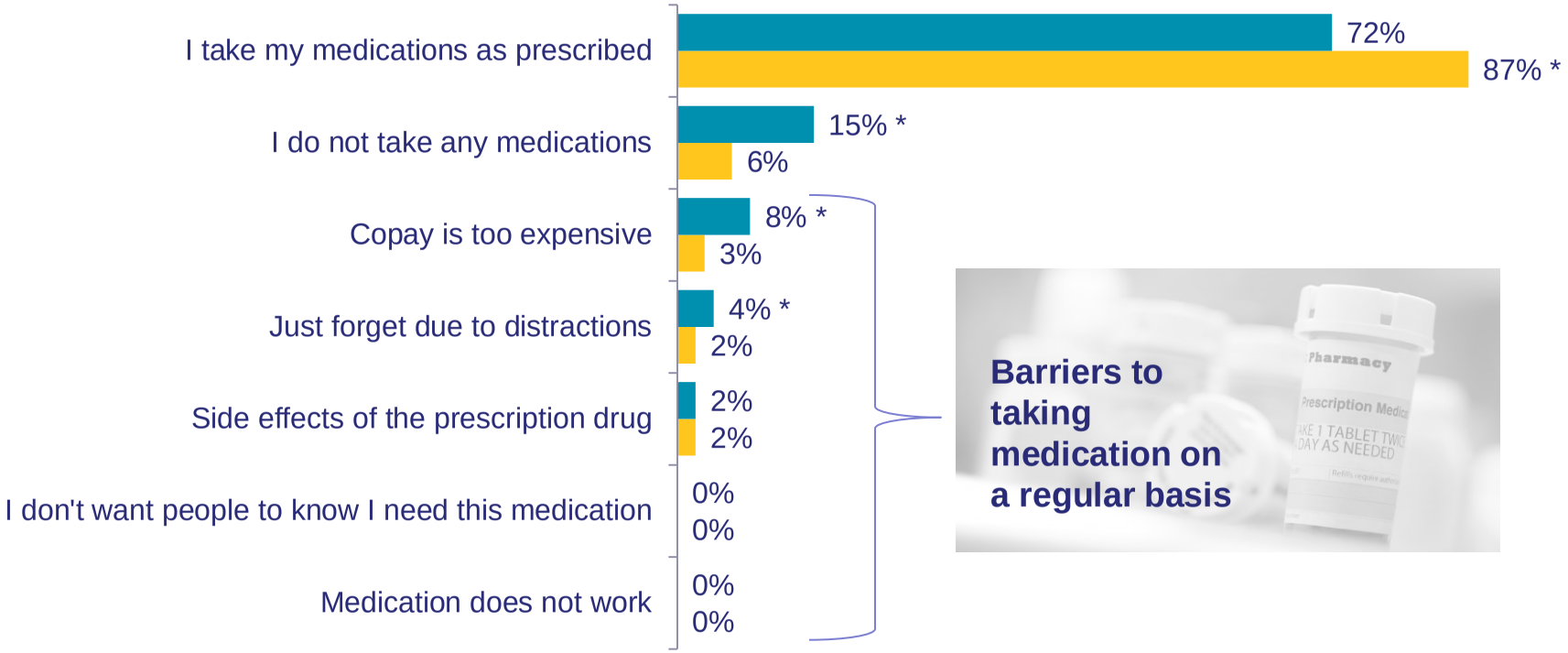
HEALTHWAYS SilverSneakers® FITNESS

Medication

The majority of SHP members take medications as prescribed. More Active Employees/Retirees than Medicare Primary Retirees are likely to say that the copay and forgetting are barriers to taking their medicine on a regular basis.

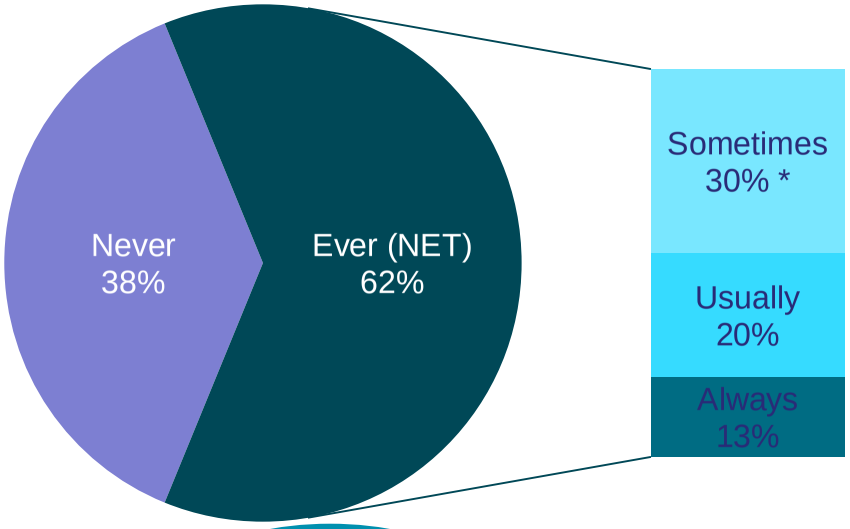
Base: AE total (n=5171)

Base: MP total (n=2554)



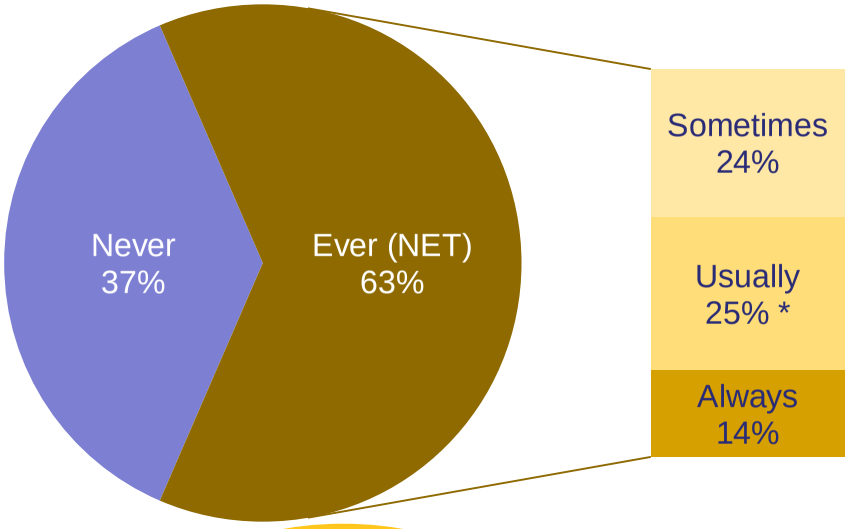
Advanced Notice of Cost

Over the past 12 months, just over one-third of SHP members from each group say they have never been able to find out in advance how much they would have to pay for health care services/equipment they needed. Finding out in advance happens on a more frequent basis for Medicare Primary Retirees than Active Employees/Retirees.



AE

Base: AE excluding n/a (n=2946)

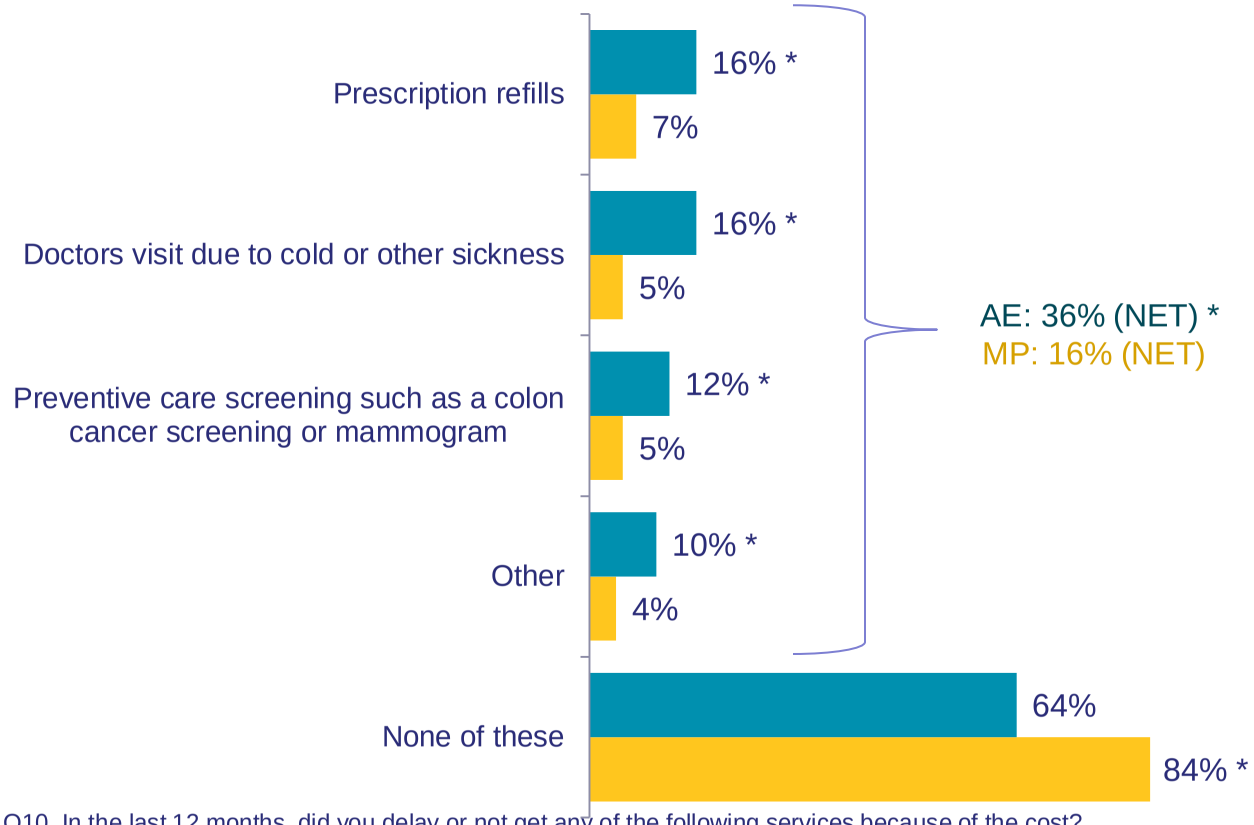


MP

Base: MP excluding n/a (n=1438)

Cost as a Barrier

Over the past 12 months, just over one-third of Active Employees/Retirees say they were delayed in getting health care service or didn't receive it at all because of cost. Less than half as many Medicare Primary Retirees experienced this.



Base: AE total (n=5171)

Base: MP total (n=2554)

Q10. In the last 12 months, did you delay or not get any of the following services because of the cost?

* Represents statistically significant differences between AE and MP.

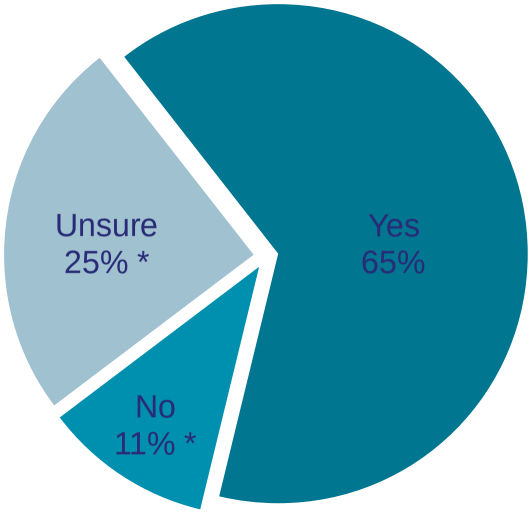
Communication Methods

Although there are various differences between the groups when it comes to how they would like to receive information about the SHP , they both consider email communications and mailed printed materials among their top two preferences. Email is most preferred by Active Employees/Retirees and printed materials through the mail are most preferred by Medicare Primary Retirees.

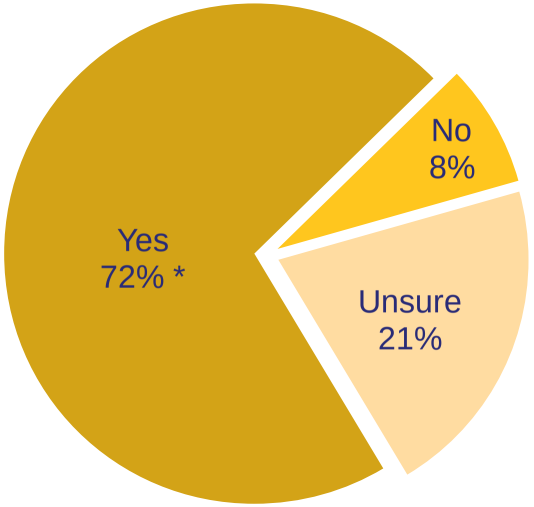
Method Preferences Ranked 1-7 *The lower the ranking, the more preferred the method.*	Base: AE total (n=5171)				Base: MP total (n=2554)			
	Ranked #1	Ranked Top 2	Ranked Top 3	Average Ranking	Ranked #1	Ranked Top 2	Ranked Top 3	Average Ranking
Email communications	35% *	63% *	80% *	2.4	25%	56%	75%	2.6 *
Printed material mailed to my home	34%	52%	65%	2.8 *	53% *	68% *	78% *	2.1
State Health Plan website (shpnc.org)	16% *	33%	56%	3.3	11%	31%	58%	3.3
Member Focus, the monthly electronic State Health Plan newsletter	9%	31%	60%	3.3 *	9%	33%	66% *	3.1
Through my Health Benefits Representative	3% *	8% *	15% *	5.3	2%	6%	11%	5.4 *
Group meetings or presentations at my worksite	2% *	7% *	13% *	5.5	0%	3%	6%	5.9 *
Mobile application for my phone	2% *	6% *	12% *	5.5	0%	3%	6%	5.7 *

PCP & Specialist Communicating

Two-thirds of Active Employees/Retirees say their primary care provider communicates with their specialist(s) to provide them with the highest level of care. It is slightly higher for Medicare Primary Retirees. A considerable number from both groups say they are unsure.



PCP communicates with specialist to provide highest level of care



AE

Base: AE who visited doctor/facility P12M who have PCP and have seen specialist (n=4198)

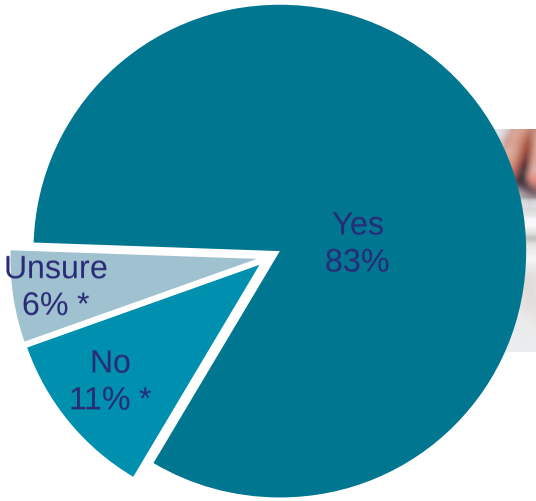
MP

Base: MP who visited doctor/facility P12M who have PCP and have seen specialist (n=2223)

PCP Providing Resources

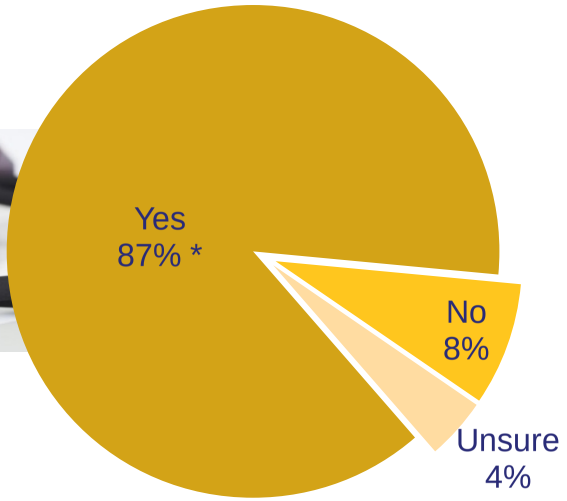
Just over four-in-five Active Employees/Retirees say their primary care provider gives them resources to help them understand and manage their health. It is slightly higher for Medicare Primary Retirees.

PCP gives resources to help understand/manage health



AE

Base: AE who visited doctor/facility P12M who have PCP (n=4933)



MP

Base: MP who visited doctor/facility P12M who have PCP (n=2483)

AE Respondent Profile

GENDER	Male	24%
	Female	76%
WORK	University	12%
	Community College	5%
	State Agency	20%
	School System	33%
	UNC Healthcare	2%
	Retired	27%
2014 PLAN[1]	Traditional 70/30 Plan	23%
	Enhanced 80/20 Plan	71%
	Consumer-Directed Health Plan	6%
COVERAGE	Employee/Retiree only	77%
	Employee/Retiree and child/children only	10%
	Employee/Retiree and spouse only	6%
	Family	8%
HEALTH HABITS	I always wear my seatbelt	98%
	I do not use tobacco products	93%
	I am mindful of my eating habits	86%
	I work with my doctor and other health care professionals to improve my health	76%
	I receive a flu shot every year	68%
	I exercise on a regular basis	53%
	I maintain a low level of stress	45%
	Other	3%

Base: AE total (n=5171)

[1]Excludes n=102 who were not sure

MP Respondent Profile

GENDER	Male	33%
	Female	67%
YEARS RETIRED	Less than 1 year	4%
	1-3	16%
	4-6	20%
	7-10	24%
	11+	36%
2014 PLAN[1]	Traditional 70/30 Plan	27%
	Humana (NET)	21%
	Humana Medicare Advantage Base Plan	*14%*
	Humana Medicare Advantage Enhanced Plan	*7%*
	UnitedHealthcare (NET)	52%
	UnitedHealthcare Medicare Advantage Base Plan	*21%*
	UnitedHealthcare Medicare Advantage Enhanced Plan	*31%*
COVERAGE	Employee/Retiree only	86%
	Employee/Retiree and child/children only	0%
	Employee/Retiree and spouse only	13%
	Family	1%
HEALTH HABITS	I always wear my seatbelt	98%
	I do not use tobacco products	94%
	I am mindful of my eating habits	90%
	I work with my doctor and other health care professionals to improve my health	89%
	I receive a flu shot every year	84%
	I exercise on a regular basis	61%
	I maintain a low level of stress	63%
	Other	3%

Base: MP total (n=2554)

[1]Excludes n=140 who were not sure

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

Annual Enrollment Results

CDHP, Enhanced 80/20, Traditional 70/30 & MAPDP

Board of Trustees Meeting

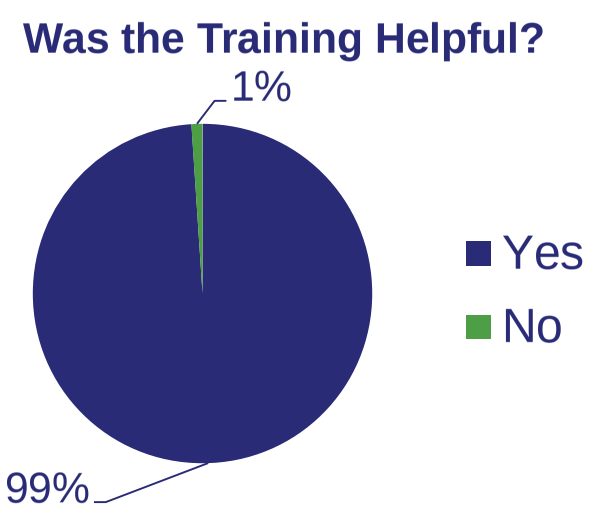
November 20, 2014

Summary of Member Outreach

- HBR Trainings
- State Health Plan Website
  - Guides
  - Videos
  - Premium Rate Calculator
  - Plan Comparisons
- Direct Mail Campaign
  - Medicare Invitation to Outreach Meetings
  - Decision Guides
  - Reminder Postcards
- 19 Active/Non-Medicare Member Webinars were held with 665 members attending.
- 67 Medicare Primary Outreach Events

HBR Training Efforts

- HBR Trainings were held at locations across the state and via webinars.
  - The Plan joined NCFlex for 8 trainings with 450 HBRs attending
  - 4 onsite trainings were held with 109 HBRs attending
  - 6 webinars were held with 402 HBRs attending
- Of the 405 HBRs attending the webinars, 206 completed a brief survey the Plan conducted following the trainings.



Medicare Primary Retiree Outreach Events

- 67 Medicare Primary Outreach Events were conducted in 38 counties.
- Received 3,805 RSVPs
- 3,419 individuals attended Outreach Events
- 53% of attendees completed a survey
  - 97% were pleased that the State Health Plan has multiple choices for Medicare primary retirees.
  - 98% agreed that the information presented was helpful and easy to understand.
  - 99% agreed that the presenters were clear and knowledgeable.
  - 95% agreed that the location was convenient.
  - 87% heard about Annual Enrollment through the 1st mailer this year; 5% through a friend/family member; 8% through other means, such as SHIIP or the Internet.

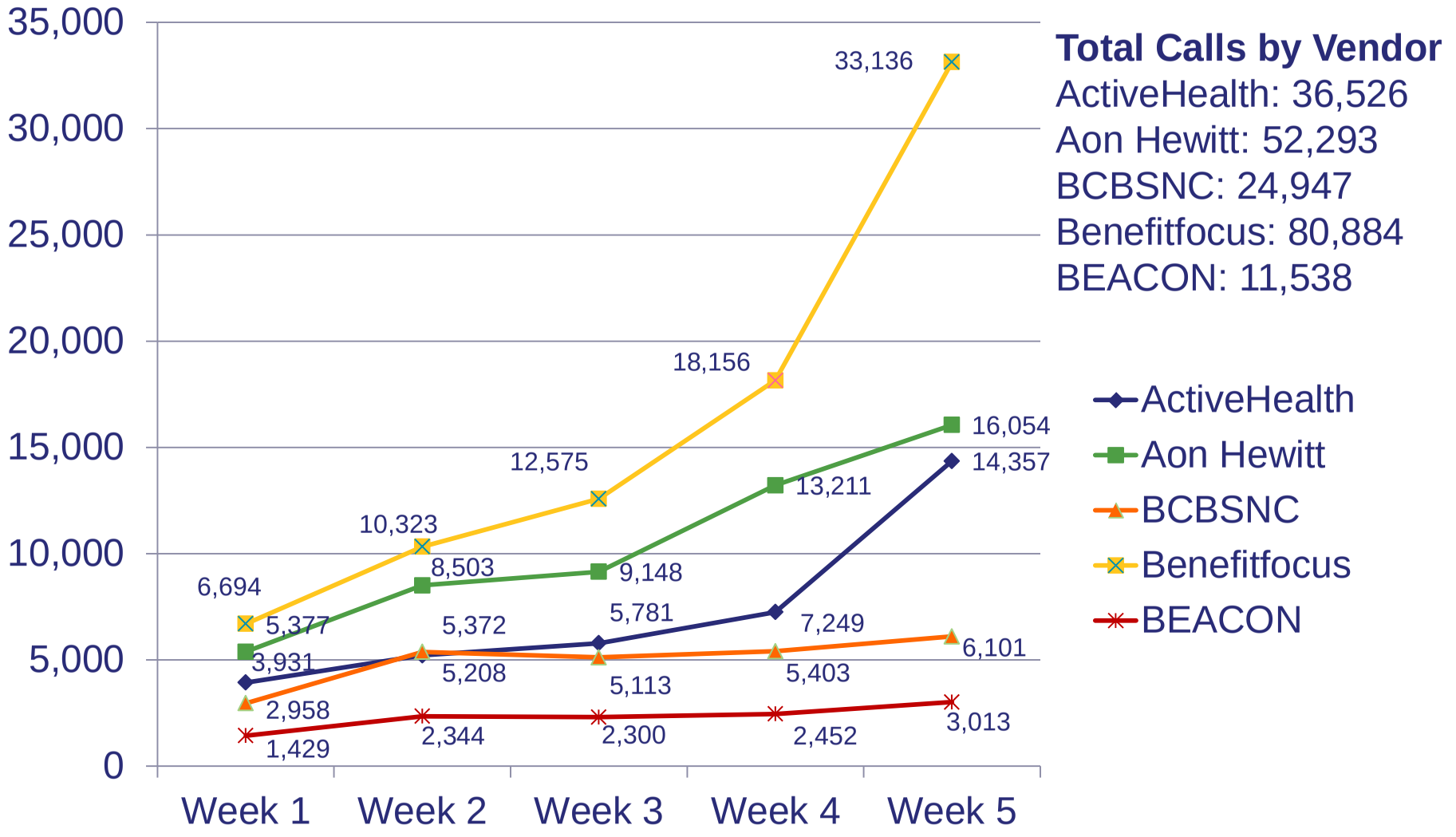
Website Activity

Activity	Dates	Number of Clicks
SHPNC.org	Aug. 15-Oct. 31	1,962,405
2015 Plan Option Overview Video	Sept. 8-Oct. 31	1,268
2015 Plan Option Self-Directed Tutorial	Sept. 8-Oct. 31	1,870
How Does the CDHP Work? Video	Sept. 8-Oct. 31	1,439
Premium Rate Calculator	Sept. 8-Oct. 31	23,064

Enrollment Activity by Week

AE Week	Logins	Observations
Week 1	19,971	Heaviest day was day 1 with the majority of the calls coming in the first couple of hours of the day
Week 2	27,863	Enrollment activity peaked on Monday and reduced slightly every day
Week 3	35,843	Enrollment activity peaked on Monday and reduced slightly every day - HBR Alert Issued on Thursday, October 17, reminding HBRs to encourage their employees to complete premium wellness activities
Week 4	50,212	Reminder postcards began arriving at members' homes - HBR Update issued - Additional Member AE Webinars added - Enrollment activity began to rise
Week 5	82,819	Two HBR Alerts issued during the last week of AE - Enrollment hit record highs

Weekly Call Volume by Vendor

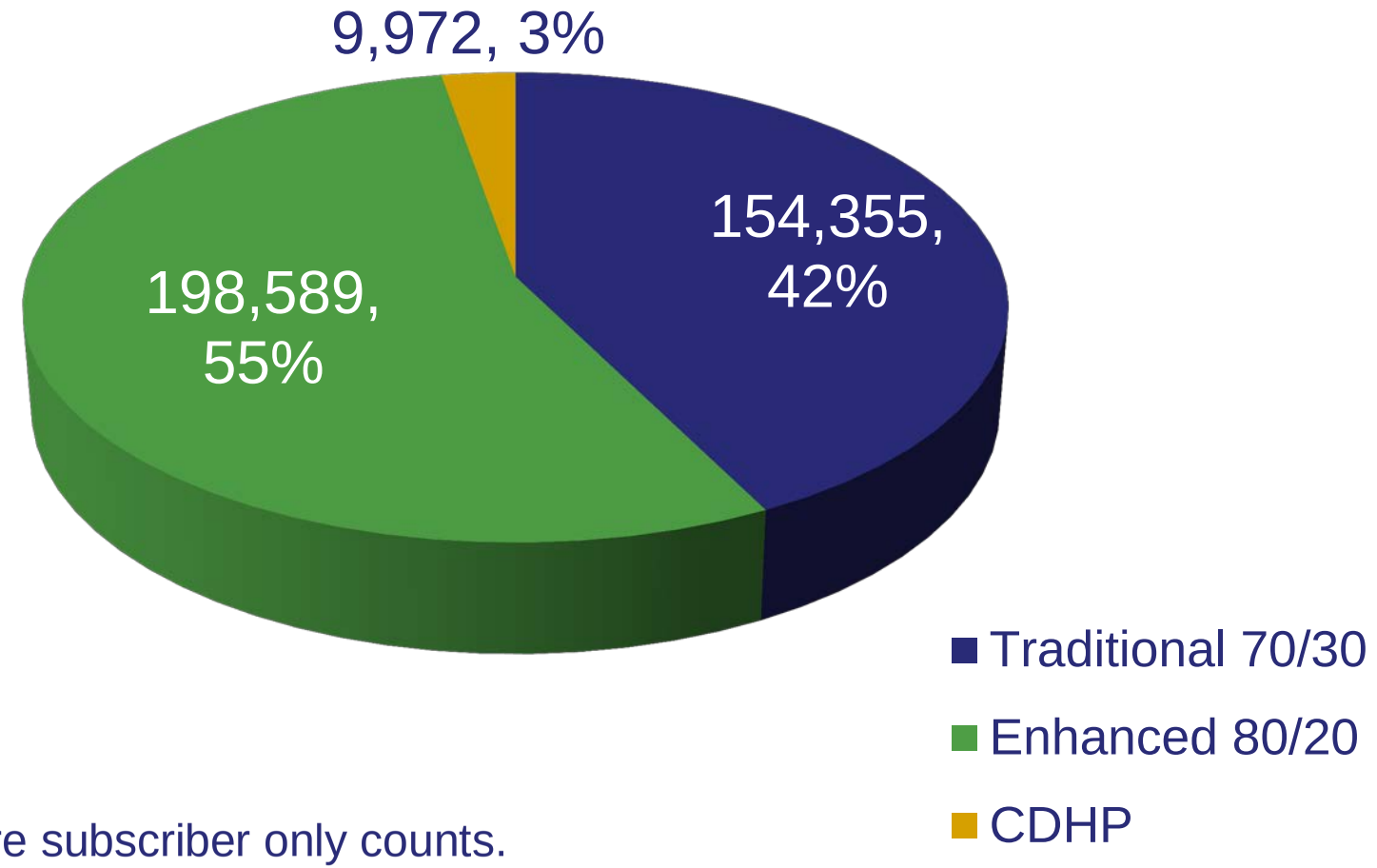


Active/Non-Medicare Retirees **Net** Subscriber Plan Changes by Week

	Week 1	Week 2	Week 3	Week 4	Week 5	Total
CDHP	47	80	91	76	51	**345**
Enhanced 80/20	928	1,526	1,380	1,866	4,034	**9,734**
Traditional 70/30	(643)	(1,268)	(1,179)	(1,369)	(3,600)	**(8,059)**

We will not know the total membership shift until the January membership reports are available in early February 2015.

Plan Distribution Post Enrollment-Active/Non-Medicare Retirees



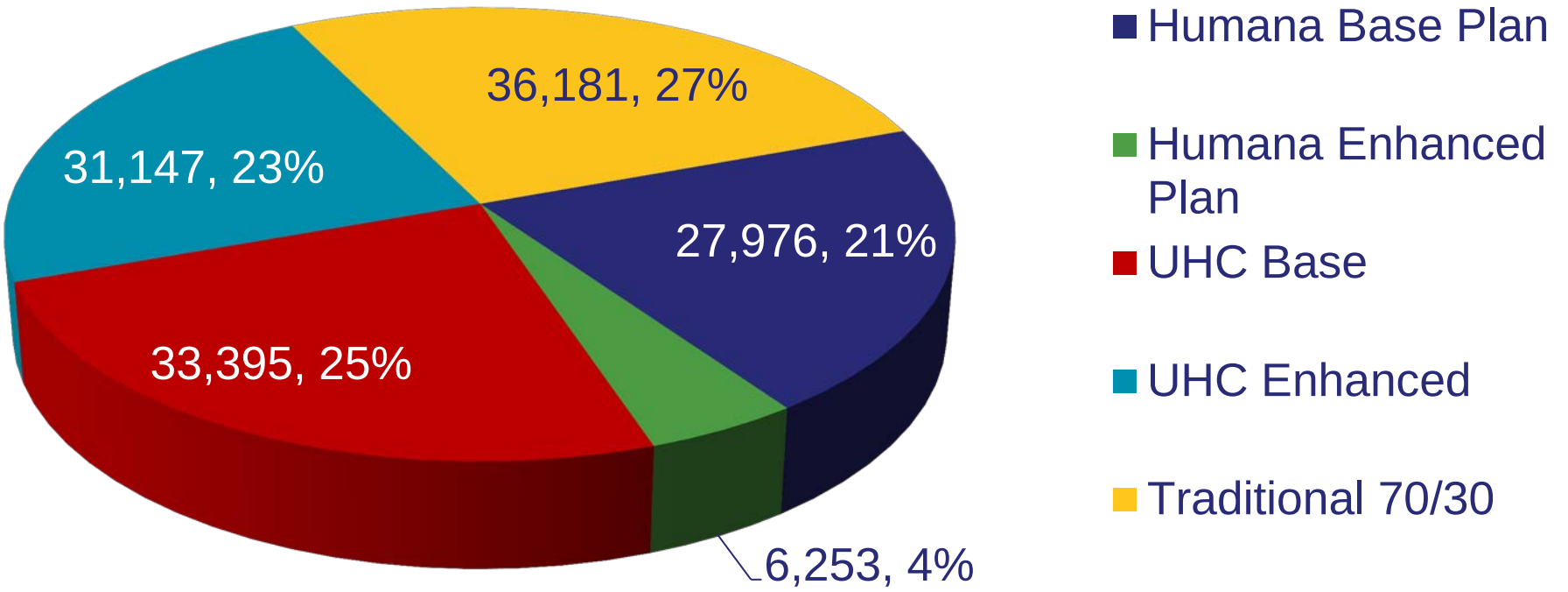
These are subscriber only counts.

Medicare Primary Retirees **Net** Subscriber Plan Changes by Week

	Week 1	Week 2	Week 3	Week 4	Week 5	Total
Humana Base	(309)	(355)	(351)	(401)	(225)	**(1,641)**
Humana Enhanced	49	63	60	121	191	**484**
UHC Base	(230)	(283)	(290)	(329)	(201)	**(1,333)**
UHC Enhanced	303	439	491	712	1,014	**2,959**
Traditional 70/30	82	99	(10)	(176)	(361)	**(366)**

We will not know the total membership shift until the January membership reports are available in early February 2015

Plan Distribution Post Enrollment-Medicare Primary Retirees



Traditional 70/30 results do not include dependent counts. Dependents are included in the MAPDP results.

Premium Wellness Credits

- The BOT approved the following Premium Wellness Credits at the May 30, 2014, Board meeting.

2015 Premium Wellness Credits		
Traditional 70/30 PPO	Enhanced 80/20 PPO	Consumer Directed Health Plan
NA	Smoker Surcharge Applies to Subscriber & Spouse $20	Smoker Surcharge Applies to Subscriber & Spouse $20
NA	PCP Election Each family member must elect a PCP $15	PCP Election Each family member must elect a PCP $10
NA	Health Assessment (HA) Subscriber must complete HA $15	Health Assessment (HA) Subscriber must complete HA $10

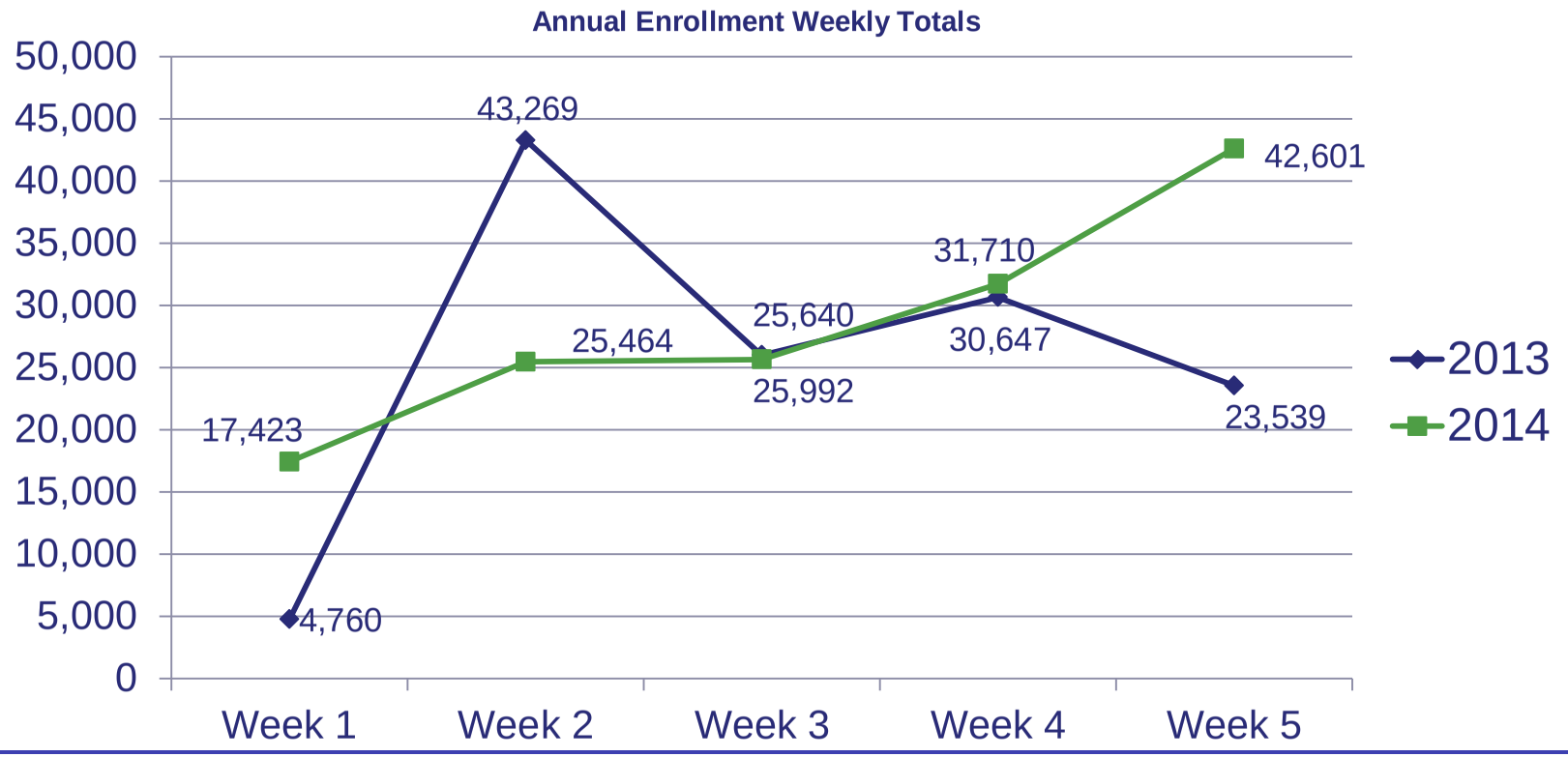
- Smoker Attestation had to be completed during Annual Enrollment
- PCPs could be elected prior to or during Annual Enrollment
- HA had to be completed between November 1, 2013, and the end of Annual Enrollment

Premium Wellness Credits – Health Assessments

- **Health Assessment Credit –** Similar to last year**,** members had a full year to complete the Health Assessment (HA). Anyone who had been hired since last year's Open Enrollment and had completed the HA as part of their initial enrollment or anyone who had just chosen to take it during the year did not have to complete it again during annual enrollment. As a result, a much smaller number of members had to complete the Health Assessment during Annual Enrollment. While there were no true technical barriers to successfully completing the HA, some members attempting to complete the HA online experienced some frustrations:
  - **Browser Compatibility –** Some members, primarily on the BEACON platform, experienced browser compatibility issues which made it difficult to connect via the enrollment site to ActiveHeath. Workaround instructions were posted. Active Health's call center was available to assist with telephonic health assessments.
  - **Member Matching –** Some members who transferred from a BEACON agency to a Benefitfocus agency (or to the Retirement Systems) were not able to connect to the HA online. ActiveHealth's call center was available to assist with telephonic health assessments.
- An audit was conducted at the end of Annual Enrollment to ensure that all members who successfully completed the HA in the appropriate timeframe were given credit.

Total Health Assessments

Health Assessment Completions	2014	2013
During Annual Enrollment	142,838	174,219
Carry Over from Previous Completions	90,530	40,208
TOTAL	**233,368**	**214,427**



Premium Wellness Credits – Non-Smoker Attestation

- **Non-Smoker Attestation Credit –** Subscribers had to attest to being a non-smoker or commit to a smoking cessation program by January 1, 2015, during Annual Enrollment. This is the one premium wellness activity that had to be completed during Annual Enrollment. Therefore, anyone who had attested to being a non-smoker last year, had to re-attest this year to get the credit.

2014	• Approximately 5,000 Members did not earn the non-smoker credit
2015	• Approximately 51,000 members did not earn the non-smoker credit • 45,479, or 22%, took no action

Premium Wellness Credits – Non-Smoker Attestation

- Primary reasons given for not completing the attestation:
  - **Did not complete AE** – The primary reason given for not completing the attestation is that they either forgot or did not understand the need to re-attest.
  - **Health Assessment** – Some members believed that by answering the smoker question within the Health Assessment, they had completed the smoker attestation.
  - **Navigation** – Although the non-smoker attestation was in the same place as last year, we heard that some members had trouble finding it.

All of our Annual Enrollment materials had the following section **Bolded**:

"Even if you attested during last year's Annual Enrollment, you will need to re-attest. The smoker attestation can be completed only during Annual Enrollment."

We also reminded members to print their confirmation statements because those statements not only confirmed enrollment but highlighted the premium wellness credits earned.

163,223 Subscribers enrolled in the Enhanced 80/20 and CDHP successfully attested to being a Non-Smoker.

Premium Wellness Credits – PCP Elections

While we do not have the final counts on the PCP elections, going into Annual Enrollment, 92% of our members in the CDHP and Enhanced 80/20 had elected a PCP. Members were not required to re-elect a PCP during Annual Enrollment.

Annual Enrollment – Next Steps

Exception Requests –

- Exceptions from members are starting to roll in but not at the volume we experienced last year.
    - Requests mainly revolve around the premium credits

ID Cards –

- Based on the current schedule, members who took action during Annual Enrollment should have ID cards by January 1.

Medicare Advantage Disenrollment Period –

- **Medicare Advantage members** have the option to disenroll from a Medicare Advantage Plan and enroll in the Traditional 70/30 Plan from Jan. 1 until Feb. 14, 2015.

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

Communication and Open Enrollment Update
High Deductible Health Plan

Board of Trustees Meeting

November 20, 2014

Statutory Requirement to Offer Alternative Benefit

- Section 35.16 of SL 2014-100 (SB 744 Appropriations Act) establishes a new health benefit eligibility category for full-time employees not otherwise covered by the Plan to comply with the Affordable Care Act (ACA).
  - The ACA and section 4980H of the Internal Revenue Code (the Code) prescribe updated definitions of full-time employees and requirements to determine which employees are required to be offered employer-sponsored health care.
  - Employees are determined to be full-time, and thus required to be offered employer-sponsored health care, if they are reasonably expected to work 30 hours per week.
- G.S. 135-48.40(e) requires the Treasurer and Board to offer a health benefit coverage option for these "newly eligible" employees that provides minimum essential coverage at no greater than the ACA "Bronze" level and that minimizes the employer contribution in an administratively feasible manner.

Benefit Development Recap

- The Plan formed an informal workgroup to build consensus on an administrative approach to providing coverage for newly eligibles
- The workgroup consisted of representatives from:
  - Office of State Human Resources (OSHR)
  - Department of Public Instruction (DPI)
  - University of North Carolina General Administration (UNC-GA)
  - NC Community College System Office
  - Local Education Agencies
    - Charlotte-Mecklenburg Schools
    - Guildford County Schools
    - Orange County Schools
    - Wake County Public School System

The work group's recommendations formed the basis for the billing process and rate structure of the High Deductible Health Plan (HDHP) design presented and approved by the BOT in August 2014.

HDHP Communications Recap

The State Health Plan began communicating the new offering to all Non-BEACON employing units.

August 20, 2014 – HBR Alert

- ACA Requirements
- Impacts of new state legislation
- Plan Design
- Proposed rate structure (final rates had not been approved by BOT)
- Administration

September 8, 2014 – HBR Alert

- BOT approved
  - Rates
  - Plan Design
  - Administration
- Proposed Open Enrollment timeframes
- HBR Training Schedule

September 23, 2014 – HBR Alert

- Requested employing units confirm Open Enrollment schedule selected

September 30, 2014 – HBR Alert

- Provided additional Open Enrollment information

Employing Unit Presentations

Conference/Meeting Presentations:

- June 4, Large NC District ACA Work Group, Greensboro, NC (Public Schools)
- October 5, PANC Conference, Asheville, NC (Public Schools)
- October 28, NCACCBO Fall Conference, Asheville, NC (Community Colleges)
- November 6, State School Board Meeting, Raleigh, NC (Public Schools)
- November 7, Regional PANC Meeting, Mocksville, NC (Public Schools)
- November 18, Regional PANC Meeting, Williamston, NC (Public Schools)

- The Plan has attended several meetings in response to questions regarding eligibility, especially regarding retirees. We have also issued an HBR Alert dedicated to this topic.
- The Alert included a Referenced Guide addressing the most frequently asked questions around HDHP eligibility and specific instructions about processing and reporting retirees who qualify for HDHP coverage.

Potential Impact of Requirement on Retirees

- While there is general confusion about who should be offered the HDHP, there has been particular concern about the impact of the legislations on re-hired retirees.
- Section 35.16A of SL 2014-100 (SB 744 Appropriations Act) requires employing units to cover re-hired State retirees as active employees, if they are determined to meet definition of full-time employee.
- G.S. 135-48.41(j) specifies that during the time of their full-time employment, re-hired State retirees are not eligible for retiree health benefit coverage.
- This provision is consistent with prior law requiring employing units to cover re-hired retirees employed in permanent positions on a recurring basis and working 30 or more hours per week for nine or more months in a calendar year.

Retiree Termination Process

- If a re-hired retiree meets the eligibility requirements, employing units must offer the retiree coverage.
- While the retiree is not required to enroll in the HDHP, the retiree is no longer eligible for the State Health Plan retiree group coverage under the Retirement Systems as required by state law.
- Therefore, the Plan will terminate the retiree from the State Health Plan retiree group coverage under the Retirement Systems.

Additional resources and information can be found on the State Health Plan's website under the Health Benefits Representative tab.

Retiree Re-enrollment Process

- Any re-hired retiree who enrolled in the HDHP will be offered COBRA, if the individual is no longer eligible for the HDHP.
- Loss of eligibility is a qualifying life event under the State Health Plan enrollment rules and retirees will have 30 days to re-enroll in their State Health Plan coverage under the Retirement Systems.
- If the retiree fails to re-enroll within the 30 days, they will be unable to come back on the Plan until the next enrollment period.

Open Enrollment Update-HDHP

- At the employing units' request, the Plan established three different Open Enrollment periods:
  - **October 1 – 31**
    - Designed to coincide with the traditional Annual Enrollment
    - While 20 employing units signed up for this OE, no eligible employees were loaded
  - **November 1 – 30**
    - Requested by University System, but open to any employing unit
    - To date, 19 employing units have loaded 513 eligible employees into the portal, but no one has enrolled.
  - **November 20 – December 19**
    - Requested by OSHR. It is the last option available to complete enrollment prior to January 1.

Appendix

ACA Requirements – Coverage of Full-time Employees

Shared Employer Responsibility Provisions

- To avoid tax penalties under section 4980H of the Internal Revenue Code large employers must offer health coverage that is affordable and at least “minimal value” to all full-time employees.
- Employees are considered full-time, and thus required to be offered employer-sponsored health care, if they are reasonably expected to work 30 hours per week.
- The requirement extends health benefit eligibility to non-permanent full-time employees, who traditionally have not been eligible for coverage under the State Health Plan.

ACA Requirements – Benefit Coverage Rules

To avoid Employer Shared Responsibility penalties, large employers must offer full-time employees health benefit coverage that meets the definition of Minimum Essential Coverage:

- **Minimum Actuarial Value:** Provides at least a value of 60% of the cost of services (Bronze level on the Exchange)
- **Affordable:** Costs an employee no more than 9.5% of gross taxable wages for employee-only coverage
  - An employer contribution is needed for low-wage employees to maintain affordability and ensure the avoidance of penalties

ACA Requirements - Penalties for Non-Compliance

"Sledge Hammer" Penalty	"Tack Hammer" Penalty
If employing units do not offer "minimum essential coverage" to at least 70% of full-time employees (and dependent children under age 26) and if one full-time employee receives subsidized coverage on the Exchange: • Penalty is $2,000 (annualized) times the **total # of full-time employees** (minus first 30 workers)	If employing units do offer coverage to 95% of full-time employees (and their dependent children under 26), but the coverage is either not affordable or not of minimum value and one full-time employee receives federally subsidized coverage in the Exchange • Penalty is $3,000 (annualized) times the # of full-time employees getting a tax credit in an Exchange (subject to a penalty maximum)

High Deductible Health Plan Option (HDHP)

Monthly Contributions: Employer = $117.62, Employee = $92.38

Benefit Design	Individual Coverage	Family Coverage
Deductible	$5,000	$10,000
Out-of-Pocket Maximum	$6,450	$12,900
Coinsurance	50%	50%
ACA Preventive Medical	Covered at 100% in-network	
ACA Preventive Pharmacy	Covered at 100% in-network	

- *Non-network benefits will be paid at 40%.*
- *The non-network deductible and out-of-pocket maximum will be 2 times the in-network amounts.*

Meets ACA minimum value standard
Eligible for a Health Savings Account (HSA), which will allow the employee to make 2015 tax-exempt contributions of up to $3,350 ($6,650 for family coverage) to an account that can be used to pay eligible medical expenses

HDHP Monthly Premium Rates

Coverage Type	Employer Share	Employee Monthly Premium	Dependent Monthly Premium	Total Monthly Employee Premium
Employee-only	$117.62	$92.38	N/A	$92.38
Employee + Child(ren)	$117.62	$92.38	$169.78	$262.16
Employee + Spouse	$117.62	$92.38	$376.56	$468.94
Employee + Family	$117.62	$92.38	$470.56	$562.94

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

Same Sex Marriage Qualifying Event Update

Board of Trustees Meeting

November 20, 2014

Eligibility Update Regarding Ruling on Same Sex Marriages

- On October 10, 2014, a federal court overturned North Carolina's law regarding same sex marriage, recognizing same sex marriages as legal in North Carolina.
- This ruling makes same sex spouses of State Health Plan subscribers eligible for State Health Plan coverage.

  - **Qualifying Life Event –** This ruling is considered a qualifying life event and same sex spouses of covered subscribers were immediately eligible for Plan coverage. Because the ruling was made in October, November 1, 2014, was the effective date for anyone who enrolled using this qualifying life event. Any future same sex marriages will also be a qualifying life event and the spouse will be eligible the first of the month following the marriage. As with all qualifying life events, members have 30 days to take action.

Eligibility Update Regarding Ruling on Same Sex Marriages

Notifications

- **Employing Units –** The Plan issued an HBR Alert advising groups of the steps required to add these members.
- **Members** – The Plan immediately updated the State Health Plan website with the impacts of the ruling and enrollment instructions.

Enrollments

- **54** same sex spouses have been added with an 11/1/14 effective date.

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

Communication Update – Health Literacy

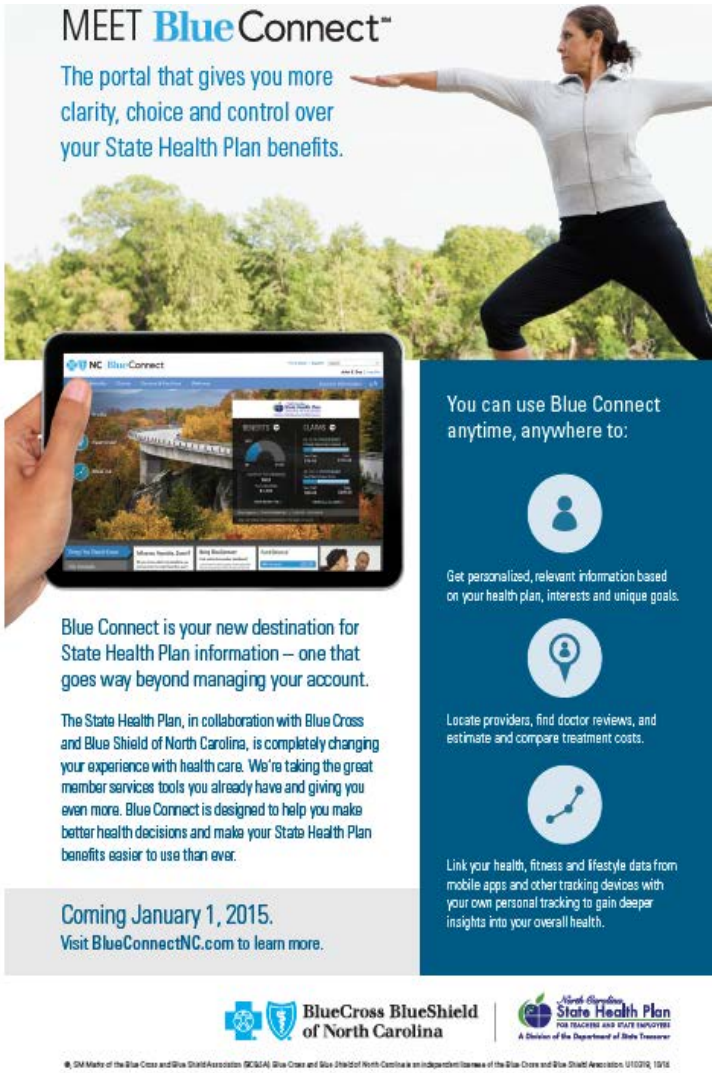
Board of Trustees Meeting

November 20, 2014

Health Literacy: Blue Connect

BCBSNC is rolling out an enhanced member website in January. In addition to providing new features and tools, the site will have a new name: Blue Connect

We plan to promote the site throughout 2015 as part of our health literacy campaign. While our health literacy strategy is still in development, we are taking advantage of the issuance of the 2015 AE ID cards to insert a "buck slip" promoting the site.



Health Literacy: Bundled Payment

Coming Soon

- Promotion of Bundled Knee Replacement Surgery at the following practices:
  - OrthoCarolina
  - Triangle Orthopaedics

- Working on plans to communicate these services through direct mail and other avenues

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

September 2014 Financial Report

Board of Trustees Meeting

November 20, 2014

A Division of the Department of State Treasurer

Financial Results: Actual v. Budgeted
Calendar Year to Date September 2014

Calendar Year 2014	Actual thru Sep 2014	Certified Budget (per Segal 8-19-13)	Variance Over/(Under) Budget
Beginning Cash Balance	**$838.5 m**	**$695.0 m**	**$143.5 m**
Plan Revenue	**$2.241 b**	**$2.216 b**	**$25.3 m**
Net Claims Payments	$1.878 b	$1.924 b	($46.1 m)
Medicare Advantage Premiums	$117.7 m	$130.4 m	($12.7 m)
Net Administrative Expenses	$114.2 m	$135.5 m	($21.3 m)
Total Plan Expenses	**$2.110 b**	**$2.190 b**	**($80.1 m)**
Net Income/(Loss)	**$131.4 m**	**$26.0 m**	**$105.4 m**
Ending Cash Balance	**$969.9 m**	**$721.0 m**	**$248.9 m**

Adjusted Variance Report
Calendar Year to Date September 2014

Calendar Year 2014	Actual thru Sep 2014, As Adjusted	Certified Budget (per Segal 8-19-13)	Variance Over/(Under) Budget
Plan Revenue *	**$2.260 b**	**$2.216 b**	**$43.4 m**
Net Claims Payments ^	$1.888 b	$1.924 b	($36.6 m)
Medicare Advantage Premiums	$117.7 m	$130.4 m	($12.7 m)
Net Administrative Expenses †	$105.7 m	$135.5 m	($29.8 m)
Total Plan Expenses	**$2.111 b**	**$2.190 b**	**($79.1 m)**
Net Income/(Loss)	**$148.5 m**	**$26.0 m**	**$122.5 m**

Note: Numbers might not sum to totals due to rounding

* Adjusted for timing issues and to exclude non-budgeted revenue.
^ Adjusted for timing issues and to remove the impact of unanticipated pharmacy rebate true-up payments.
† Adjusted for timing issues.

Financial Results Actual v. Budgeted
Calendar Year to Date September 2014

Per Member Per Month (PMPM) Analysis

Calendar Year 2014	Actual thru Sep 2014	Certified Budget (per Segal 8-19-13)	Variance Over/(Under) Budget
Plan Revenue	**$367.59**	**$370.05**	**($2.46)**
Net Claims Payments	$308.28	$321.08	($12.80)
Medicare Advantage Premiums	$19.32	$21.77	($2.45)
Net Administrative Expenses	$18.75	$22.61	($3.86)
Total Plan Expenses	**$346.35**	**$365.46**	**($19.11)**
Net Income/(Loss)	**$21.24**	**$4.59**	**$16.65**

Comparing actual results to the budget projection on a PMPM basis helps correct for changes in membership that occurred during the year.

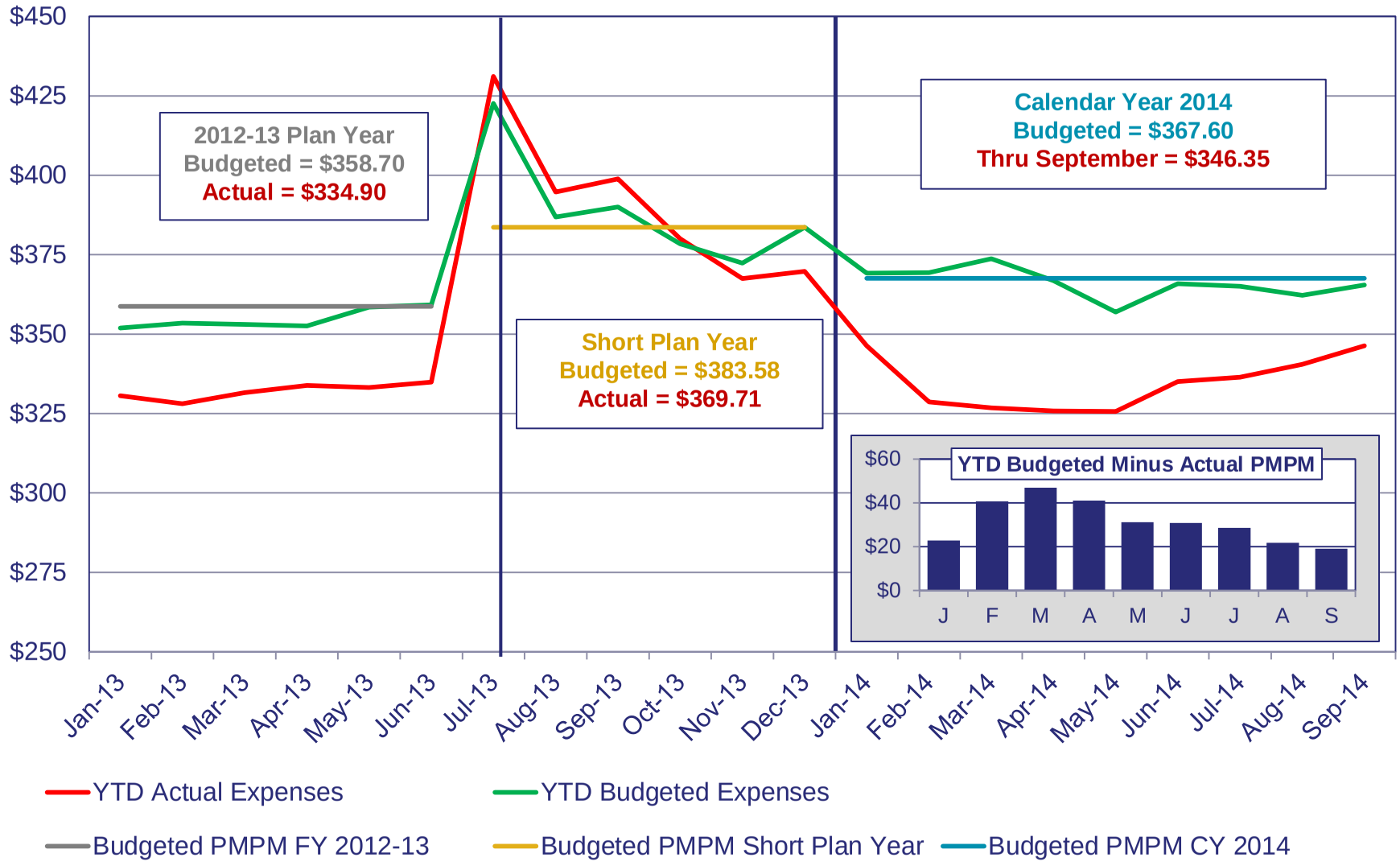
Adjusted Variance Report
Calendar Year to Date September 2014

Per Member Per Month (PMPM) Analysis

Calendar Year 2014	Actual thru Sep 2014, as Adjusted	Certified Budget (per Segal 8-19-13)	Variance Over/(Under) Budget
Plan Revenue *	**$370.57**	**$370.05**	**$0.52**
Net Claims Payments ^	$309.85	$321.08	($11.23)
Medicare Advantage Premiums	$19.32	$21.77	($2.45)
Net Administrative Expenses †	$17.35	$22.61	($5.26)
Total Plan Expenses	**$346.52**	**$365.46**	**($18.94)**
Net Income/(Loss)	**$24.05**	**$4.59**	**$19.46**

* Adjusted for timing issues and to exclude non-budgeted revenue.
^ Adjusted for timing issues and to remove the impact of a larger-than-expected pharmacy rebate true-up payment.
† Adjusted for timing issues.

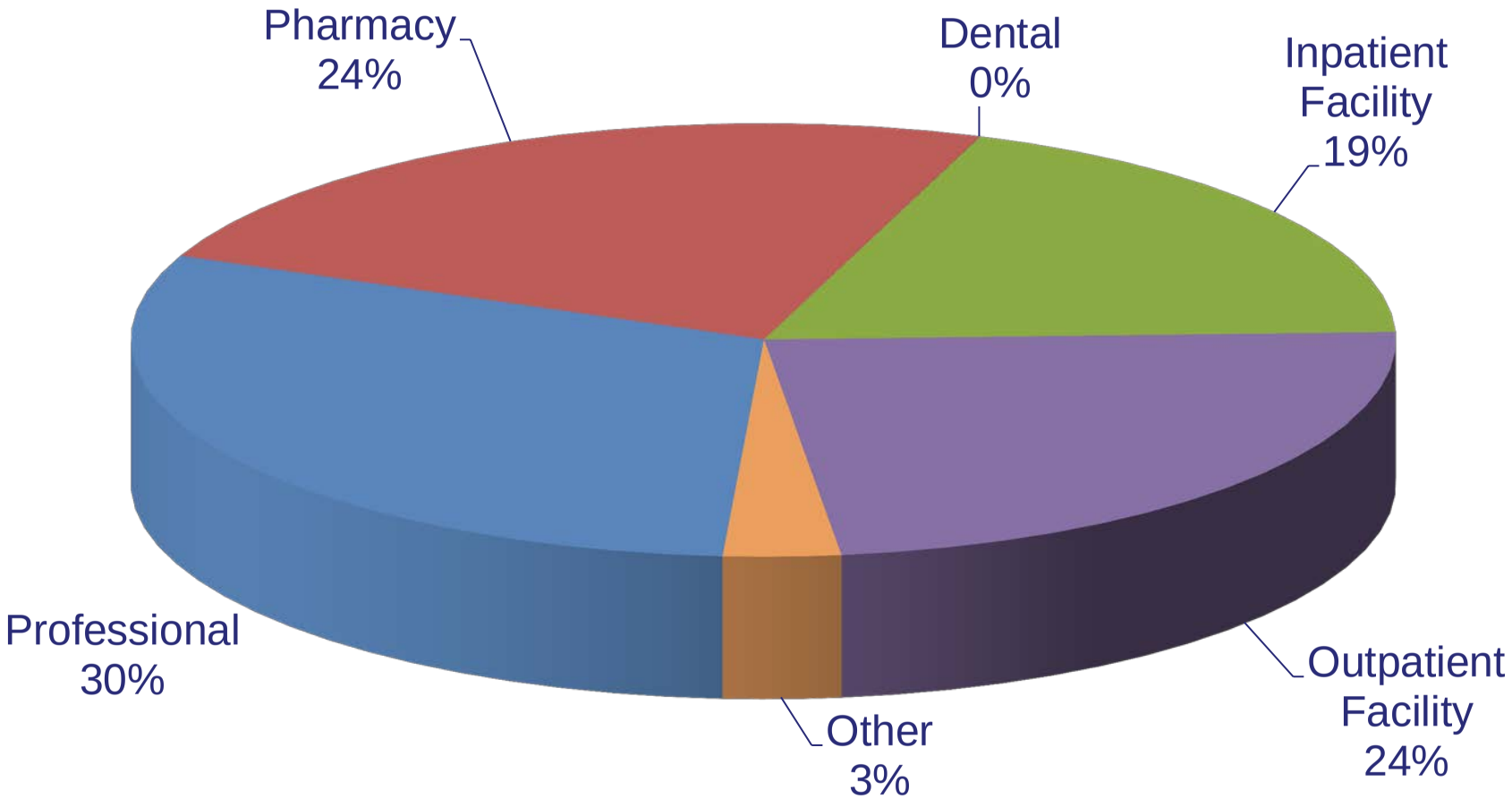
Plan Year to Date (YTD) Expenditure Trend Per Member Per Month



Allocation of Claims Expenditures

Calendar Year to Date: September 2014

Includes Medical, Blue Card & Pharmacy Payments



Source: BCBSNC Summary of Billed Charges

North Carolina State Health Plan for Teachers and State Employees
Summary of Operations (Cash Basis)
Consolidated Report, Actual vs. Certified Budget
For the Month Ended September 2014
Calendar Year 2014

		A	B	C	D	E	F	G	H
		Actual September 2014	Certified Budget September 2014	Monthly Variance Over/(Under) Certified Budget	Actual 2014 Calendar Year To Date	Certified Budget 2014 Calendar Year to Date	Calendar Year to Date Variance Over/(Under) Certified Budget	Calendar Year Certified Budget (Jan- Dec 2014)	Calendar Year to Date Variance Over/(Under) Certified Budget
1	**Plan Revenue:**								
2									
3	Member Premiums	$ 257,532,521	243,274,345	$ 14,258,176	$ 2,191,544,860	$ 2,192,567,897	$ (1,023,037)	$ 2,921,878,532	$ (730,333,672)
4	Premium Refunds/Retroactive Disenrollments	-	(124,010)	124,010	(28,401)	(1,117,634)	1,089,233	(1,489,408)	1,461,007
5	Medicare Part D (RDS) Subsidy	2,369,310	381,280	1,988,030	18,004,435	4,768,956	13,235,479	6,344,076	11,660,359
6	Medicare PDP (EGWP + Wrap) Subsidy	-	-	-	28,378,401	17,999,101	10,379,300	31,047,005	(2,668,604)
7	Medicare Advantage (MA) Subsidy	38,742	-	38,742	536,077	-	536,077	-	536,077
8	Federal Early Retiree Reinsurance Program (ERRP)	-	-	-	-	-	-	-	-
9	**Net Premium & Other Contributions**	259,940,573	243,531,615	16,408,958	2,238,435,372	2,214,218,320	24,217,052	2,957,780,205	(719,344,833)
10									
11	Investment Earnings	353,651	243,779	109,872	3,232,497	2,148,114	1,084,383	2,892,005	340,492
12	Miscellaneous Revenue	-	-	-	-	-	-	-	-
13	**Other Revenue**	353,651	243,779	109,872	3,232,497	2,148,114	1,084,383	2,892,005	340,492
14									
15	**Total Plan Revenue (excludes internal transfers)**	260,294,224	243,775,394	16,518,830	2,241,667,869	2,216,366,434	25,301,435	2,960,672,210	(719,004,341)
16									
17	**Plan Expenses:**								
18									
19	Medical Claim Payments	189,082,882	190,257,347	(1,174,465)	1,478,419,240	1,560,780,719	(82,361,479)	2,062,826,346	(584,407,106)
20	Medical Claim Refunds/Recoveries	(1,861,670)	(2,213,070)	351,400	(17,050,328)	(19,230,764)	2,180,436	(25,469,051)	8,418,723
21	**Net Medical Claims**	187,221,212	188,044,277	(823,065)	1,461,368,912	1,541,549,955	(80,181,043)	2,037,357,295	(575,988,383)
22									
23	Pharmacy Claim Payments	53,062,418	42,854,219	10,208,199	504,763,477	426,075,554	78,687,923	599,541,594	(94,778,117)
24	Pharmacy Claim Rebates	-		-	(88,001,925)	(43,238,232)	(44,763,693)	(54,794,623)	(33,207,302)
25	Pharmacy Claim Refunds/Recoveries	(32,318)	-	(32,318)	110,669	-	110,669	-	110,669
26	**Net Pharmacy Claims**	53,030,100	42,854,219	10,175,881	416,872,221	382,837,322	34,034,899	544,746,971	(127,874,750)
27									
28	**Net Claim Payments**	240,251,312	230,898,496	9,352,816	1,878,241,133	1,924,387,277	(46,146,144)	2,582,104,266	(703,863,133)
29									
30	**Medicare Advantage Premium Payments**	13,163,912	14,543,619	(1,379,707)	117,713,027	130,459,448	(12,746,421)	174,162,733	(56,449,706)
31									
32	**Net Administrative Expenses**	12,345,540	14,780,307	(2,434,767)	114,223,530	135,504,535	(21,281,005)	179,815,010	(65,591,480)
33									
34	**Total Plan Expenses (excludes internal transfers)**	265,760,764	260,222,422	5,538,342	2,110,177,690	2,190,351,260	(80,173,570)	2,936,082,009	(825,904,319)
35									
36	Plan Income/(Loss)	(5,466,540)	(16,447,028)	10,980,488	131,490,179	26,015,174	105,475,005	24,590,201	106,899,978
37									
38	**Cash Availability:**								
39									
40	Beginning Cash Balance/(Deficit)	975,403,856	737,437,335	237,966,521	838,447,137	694,975,133	143,472,004	694,975,133	143,472,004
41	**Ending Cash Balance/(Deficit)**	969,937,316	720,990,307	248,947,009	969,937,316	720,990,307	248,947,009	719,565,334	250,371,982
42									
43	Target Stabilization Reserve @ 12/31/14	234,282,695	234,282,695	-	234,282,695	234,282,695	-	234,282,695	-
44									
45	**Cash Balance Over/(Under) Reserve Target**	$ 735,654,621	$ 486,707,612	$ 248,947,009	$ 735,654,621	$ 486,707,612	$ 248,947,009	$ 485,282,639	$ 250,371,982

Comments:
a. Premium receivables totaled $756,360.81 as of September 30, 2014.
b. The average weekly medical claims cost net of claims refunds was $37,444,242.40 for the five scheduled weekly claim cycles.
c. Total pharmacy claims, before rebates and refunds, included two bi-weekly invoice cycles averaging $26,531,209.00 per cycle.
d. The target stabilization reserve is 8.5% of the projected net claims and Medicare Advantage premiums for Calendar Year 2014.
e. Minor differences compared to other reports are due to rounding.

Actual vs Certified Budget (i.e. ***Original Budget*** per SL 2013-360 and Board Approved Design)
September - 2014 Calendar Year

North Carolina State Health Plan for Teachers and State Employees
Summary of Operations (Cash Basis)
Consolidated Report, Actual vs. Authorized Budget
For the Month Ended September 2014
Fiscal Year 2014- 2015

		A	B	C	D	E	F	G	H
		Actual September 2014	Authorized Budget September 2014	Monthly Variance Over/(Under) Authorized Budget	Actual Year to Date FY 2014-15	Authorized Budget Year to Date FY 2014-15	Year to Date Variance Over/(Under) Authorized Budget	Annual Authorized Budget FY 2014-15	Year to Date Variance Over/(Under) Annual Authorized Budget
1	**Plan Revenue:**								
2									
3	Member Premiums	$ 257,532,521	$ 245,187,848	$ 12,344,673	$ 753,025,182	$ 735,811,289	$ 17,213,893	$ 2,937,906,736	$ (2,184,881,554)
4	Premium Refunds/Retroactive Disenrollments	-	(123,367)	123,367	(6,016)	(370,226)	364,210	(1,478,664)	1,472,648
5	Medicare Part D (RDS) Subsidy	2,369,310	364,216	2,005,094	5,096,895	1,343,825	3,753,070	6,276,386	(1,179,491)
6	Medicare PDP (EGWP + Wrap) Subsidy	-	-	-	1,680,417	1,680,417	-	33,414,689	(31,734,272)
7	Medicare Advantage (MA) Subsidy	38,742	-	38,742	118,512	-	118,512	-	118,512
8	Federal Early Retiree Reinsurance Program (ERRP)	-	-	-	-	-	-	-	-
9	**Net Premium & Other Contributions**	259,940,573	245,428,697	14,511,876	759,914,990	738,465,305	21,449,685	2,976,119,147	(2,216,204,157)
10									
11	Investment Earnings	353,651	324,117	29,534	1,157,349	971,239	186,110	3,933,340	(2,775,991)
12	Miscellaneous Revenue	-	-	-	-	-	-	-	-
13	**Other Revenue**	353,651	324,117	29,534	1,157,349	971,239	186,110	3,933,340	(2,775,991)
14									
15	**Total Plan Revenue (excludes internal transfers)**	260,294,224	245,752,814	14,541,410	761,072,339	739,436,544	21,635,795	2,980,052,487	(2,218,980,148)
16									
17	**Plan Expenses:**								
18									
19	Medical Claim Payments	189,082,882	187,306,152	1,776,730	522,002,307	504,097,563	17,904,744	1,995,716,227	(1,473,713,920)
20	Medical Claim Refunds/Recoveries	(1,861,670)	(1,991,119)	129,449	(5,433,940)	(5,961,502)	527,562	(23,520,519)	18,086,579
21	**Net Medical Claims**	187,221,212	185,315,033	1,906,179	516,568,367	498,136,061	18,432,306	1,972,195,708	(1,455,627,341)
22									
23	Pharmacy Claim Payments	53,062,418	51,170,645	1,891,773	186,898,832	179,370,004	7,528,828	686,943,428	(500,044,596)
24	Pharmacy Claim Rebates	-	-	-	(28,537,461)	(28,537,461)	-	(74,166,940)	45,629,479
25	Pharmacy Claim Refunds/Recoveries	(32,318)	-	(32,318)	(48,209)	-	(48,209)	-	(48,209)
26	**Net Pharmacy Claims**	53,030,100	51,170,645	1,859,455	158,313,162	150,832,543	7,480,619	612,776,488	(454,463,326)
27									
28	**Net Claim Payments**	240,251,312	236,485,678	3,765,634	674,881,529	648,968,604	25,912,925	2,584,972,196	(1,910,090,667)
29									
30	**Medicare Advantage Premium Payments**	13,163,912	13,171,149	(7,237)	39,174,180	39,480,705	(306,525)	163,281,044	(124,106,864)
31									
32	**Net Administrative Expenses**	12,345,540	15,847,897	(3,502,357)	35,637,354	47,559,778	(11,922,424)	223,971,245	(188,333,891)
33									
34	**Total Plan Expenses (excludes internal transfers)**	265,760,764	265,504,724	256,040	749,693,063	736,009,087	13,683,976	2,972,224,485	(2,222,531,422)
35									
36	**Plan Income/(Loss)**	(5,466,540)	(19,751,910)	14,285,370	11,379,276	3,427,457	7,951,819	7,828,002	3,551,274
37									
38	**Cash Availability:**								
39									
40	Beginning Cash Balance/(Deficit)	975,403,856	981,737,407	(6,333,551)	958,558,040	958,558,040	-	958,558,040	-
41	**Ending Cash Balance/(Deficit)**	969,937,316	961,985,497	7,951,819	969,937,316	961,985,497	7,951,819	966,386,042	3,551,274
42									
43	Target Stabilization Reserve @ 6/30/15	232,647,498	232,647,498	-	232,647,498	232,647,498	-	232,647,498	-
44									
45	**Cash Balance Over/(Under) Reserve Target**	$ 737,289,818	$ 729,337,999	$ 7,951,819	$ 737,289,818	$ 729,337,999	$ 7,951,819	$ 733,738,544	$ 3,551,274

Comments:
a. Premium receivables totaled $756,360.81 as of September 30, 2014.
b. The average weekly medical claims cost net of claims refunds was $37,444,242.40 for the five scheduled weekly claim cycles.
c. Total pharmacy claims, before rebates and refunds, included two bi-weekly invoice cycles averaging $26,531,209.00 per cycle.
d. The target stabilization reserve is 9% of the projected net claims and Medicare Advantage premiums for Fiscal Year 2014-15.
e. Minor differences compared to other reports are due to rounding.

North Carolina State Health Plan for Teachers and State Employees

Summary of Operations (Cash Basis)
Current Year Actual vs. Prior Year Actual
For the Month Ended September 2014
Fiscal Year 2014-2015

		A	B	C	D	E	F	G
		Current Year Actual September 2014	Prior Year Actual September 2013	Current Year to Date Actual FY 2014-15 thru September	Prior Year to Date Actual FY 2013-14 thru September	Current Year Authorized Annual Budget FY 2014-15	Prior Year Annual Budget FY 2013-14	Prior Year Actual Results FY 2013-14
1	**Plan Revenue:**							
2								
3	Member Premiums	$ 257,532,521	$ 208,817,225	$ 753,025,182	$ 731,105,957	$ 2,937,906,736	$ 2,902,567,015	$ 2,941,097,678
4	Premium Refunds/Retroactive Disenrollments	-	(225,532)	(6,016)	(251,461)	(1,478,664)	(1,466,766)	(299,923)
5	Medicare Part D (RDS) Subsidy	2,369,310	307,743	5,096,895	1,510,296	6,276,386	6,218,762	11,583,652
6	Medicare PDP (EGWP + Wrap) Subsidy	-	4,094,352	1,680,417	16,106,284	33,414,689	50,346,402	63,780,569
7	Medicare Advantage (MA) Subsidy	38,742	-	118,512	-	-	-	417,565
8	Federal Early Retiree Reinsurance Program (ERRP)	-	-	-	-	-	-	-
9	**Net Premium & Other Contributions**	259,940,573	212,993,788	759,914,990	748,471,076	2,976,119,147	2,957,665,413	3,016,579,541
10								
11	Investment Earnings	353,651	303,960	1,157,349	858,605	3,933,340	2,868,131	3,861,263
12	Miscellaneous Revenue	-	54,972	-	54,972	-	-	54,972
13	**Other Revenue**	353,651	358,932	1,157,349	913,577	3,933,340	2,868,131	3,916,235
14								
15	**Total Plan Revenue (excludes internal transfers)**	260,294,224	213,352,720	761,072,339	749,384,653	2,980,052,487	2,960,533,544	3,020,495,776
16								
17	**Plan Expenses:**							
18								
19	Medical Claim Payments	189,082,882	193,560,030	522,002,307	545,279,555	1,995,716,227	2,107,493,114	1,989,574,333
20	Medical Claim Refunds/Recoveries	(1,861,670)	(1,494,252)	(5,433,940)	(5,764,072)	(23,520,519)	(24,643,884)	(22,450,766)
21	**Net Medical Claims**	187,221,212	192,065,778	516,568,367	539,515,483	1,972,195,708	2,082,849,230	1,967,123,567
22								
23	Pharmacy Claim Payments	53,062,418	65,501,226	186,898,832	226,538,700	686,943,428	699,653,578	743,680,114
24	Pharmacy Claim Rebates	-	-	(28,537,461)	(6,882,250)	(74,166,940)	(52,353,361)	(91,653,105)
25	Pharmacy Claim Refunds/Recoveries	(32,318)	(9,866)	(48,209)	(144,644)	-	-	(398,652)
26	**Net Pharmacy Claims**	53,030,100	65,491,360	158,313,162	219,511,806	612,776,488	647,300,217	651,628,357
27								
28	**Net Claim Payments**	240,251,312	257,557,138	674,881,529	759,027,289	2,584,972,196	2,730,149,447	2,618,751,924
29								
30	**Medicare Advantage Premium Payments**	13,163,912	-	39,174,180	-	163,281,044	86,864,744	78,538,847
31								
32	**Net Administrative Expenses**	12,345,540	14,443,126	35,637,354	41,046,132	223,971,245	182,446,628	148,134,913
33								
34	**Total Plan Expenses (excludes internal transfers)**	265,760,764	272,000,264	749,693,063	800,073,421	2,972,224,485	2,999,460,819	2,845,425,684
35								
36	**Plan Income/(Loss)**	(5,466,540)	(58,647,544)	11,379,276	(50,688,768)	7,828,002	(38,927,275)	175,070,092
37								
38	**Cash Availability:**							
39								
40	Beginning Cash Balance/(Deficit)	975,403,856	791,446,724	958,558,040	783,487,948	958,558,040	755,749,494	783,487,948
41	**Ending Cash Balance/(Deficit)**	969,937,316	732,799,180	969,937,316	732,799,180	966,386,042	716,822,219	958,558,040
42								
43	Target Stabilization Reserve @ 6/30/15	232,647,498	239,446,206	232,647,498	239,446,206	232,647,498	239,446,206	229,269,716
44								
45	**Cash Balance Over/(Under) Reserve Target**	$ 737,289,818	$ 493,352,974	$ 737,289,818	$ 493,352,974	$ 733,738,544	$ 477,376,013	$ 729,288,324

Comments:
a. Minor differences compared to other reports are due to rounding

North Carolina State Health Plan for Teachers and State Employees
Summary of Operations (Cash Basis, as adjusted)
Consolidated Report, Actual vs. Budgeted
For the Month Ended September 2014
Calendar Year 2014

		A	B	C	D	E	F
		Actual Year to Date Calendar Year thru September	Adjustments for Timing, Unusual & Onetime Events	*Adjusted Actual Year to Date*	Certified Budget Calendar Year to Date thru September	*Year to Date Adjusted Variance Over/(Under) Budget*	Adjusted Variance as Percentage of Budget
1	**Plan Revenue:**						
2							
3	Member Premiums (Notes 1 and 2)	$ 2,191,544,860	$ 27,214,757	$ 2,218,759,617	$ 2,192,567,897	$ 26,191,720	1.19%
4	Premium Refunds/Retroactive Disenrollments	(28,401)		(28,401)	(1,117,634)	1,089,233	-97.46%
5	Medicare Part D (RDS) Subsidy (Note 3)	18,004,435	(6,855,182)	11,149,253	4,768,956	6,380,297	133.79%
6	Medicare PDP (EGWP + Wrap) Subsidy (Note 4)	28,378,401	(1,680,417)	26,697,984	17,999,101	8,698,883	48.33%
7	Medicare Advantage (MA) Subsidy (Note 5)	536,077	(536,077)	-	-	-	
8	Federal Early Retiree Reinsurance Program (ERRP)	-		-	-	-	
9	**Net Premium & Other Contributions**	**2,238,435,372**	**18,143,081**	**2,256,578,453**	**2,214,218,320**	**42,360,133**	**1.91%**
10							
11	**Other Revenue**	**3,232,497**		**3,232,497**	**2,148,114**	**1,084,383**	**50.48%**
12							
13	**Total Plan Revenue (excludes internal transfers)**	**2,241,667,869**	**18,143,081**	**2,259,810,950**	**2,216,366,434**	**43,444,516**	**1.96%**
14							
15	**Plan Expenses:**						
16							
17	Net Medical Claims	1,461,368,912		1,461,368,912	1,541,549,955	(80,181,043)	-5.20%
18	Net Pharmacy Claims (Notes 6 and 7)	416,872,221	9,575,016	426,447,237	382,837,322	43,609,915	11.39%
19	**Net Claim Payments**	**1,878,241,133**	**9,575,016**	**1,887,816,149**	**1,924,387,277**	**(36,571,128)**	**-1.90%**
20							
21	**Medicare Advantage Premiums**	**117,713,027**		**117,713,027**	**130,459,448**	**(12,746,421)**	**-9.77%**
22							
23	**Net Administrative Expenses (Note 8)**	**114,223,530**	**(8,491,208)**	**105,732,322**	**135,504,535**	**(29,772,213)**	**-21.97%**
24							
25	**Total Plan Expenses (excludes internal transfers)**	**2,110,177,690**	**1,083,809**	**2,111,261,499**	**2,190,351,260**	**(79,089,762)**	**-3.61%**
26							
27	**Plan Income/(Loss)**	**131,490,179**	**17,059,273**	**148,549,452**	**26,015,174**	**122,534,278**	**471.01%**
28							
29	**Cash Availability:**						
30							
31	Beginning Cash Balance/(Deficit)	838,447,137		838,447,137	694,975,133	143,472,004	20.64%
32	**Ending Cash Balance/(Deficit)**	969,937,316	17,059,273	986,996,589	720,990,307	266,006,282	36.89%
33							
34	Target Stabilization Reserve @ 12/31/2014	234,282,695		234,282,695	234,282,695	-	
35							
36	**Cash Balance Over/(Under) Reserve Target**	**$ 735,654,621**	**$ 17,059,273**	**$ 752,713,894**	**$ 486,707,612**	**$ 266,006,282**	**54.65%**

Adjustment Notes:
1. Member premiums adjusted to include $60.8 million in prepaid January premiums received in December 2013.
2. Member premiums adjusted to exclude $33.6 million in prepaid October premiums received in September.
3. Medicare Part D subsidy adjusted to exclude an unbudgeted subsidy refund related to prior plan years.
4. EGWP subsidy adjusted to exclude unbudgeted subsidy payments received in July.
5. Medicare Advantage low income premium subsidies were not budgeted and therefore are excluded.
6. Pharmacy claims adjusted to exclude a $33.1 million claims payment that was budgeted for payment in December 2013 but was not paid until January 2014.
7. Pharmacy claims adjusted to remove unbudgeted rebate true-ups totaling $42.7 million.
8. Administrative expenses adjusted to reflect normal vendor payment schedules.

North Carolina State Health Plan for Teachers and State Employees
Summary of Operations (Cash Basis, as adjusted)
Consolidated Report, Actual vs. Budgeted
For the Month Ended September 2014
Fiscal Year 2014-2015

		A	B	C	D	E	F
		Actual Year to Date Fiscal Year thru September	Adjustments for Timing, Unusual & Onetime Events	*Adjusted Actual Year to Date*	Authorized Budget Fiscal Year to Date thru September	*Year to Date Adjusted Variance Over/(Under) Budget*	Adjusted Variance as Percentage of Budget
1	**Plan Revenue:**						
2							
3	Member Premiums (Notes 1 and 2)	$ 753,025,182	$ (17,599,058)	$ 735,426,124	$ 735,811,289	$ (385,165)	-0.05%
4	Premium Refunds/Retroactive Disenrollments	(6,016)		(6,016)	(370,226)	364,210	-98.38%
5	Medicare Part D (RDS) Subsidy	5,096,895		5,096,895	1,343,825	3,753,070	279.28%
6	Medicare PDP (EGWP + Wrap) Subsidy	1,680,417		1,680,417	1,680,417	-	
7	Medicare Advantage (MA) Subsidy (Note 3)	118,512	(118,512)	-	-	-	
8	Federal Early Retiree Reinsurance Program (ERRP)	-		-	-	-	
9	**Net Premium & Other Contributions**	**759,914,990**	**(17,717,570)**	**742,197,420**	**738,465,305**	**3,732,115**	**0.51%**
10							
11	**Other Revenue**	**1,157,349**		**1,157,349**	**971,239**	**186,110**	**19.16%**
12							
13	**Total Plan Revenue (excludes internal transfers)**	**761,072,339**	**(17,717,570)**	**743,354,769**	**739,436,544**	**3,918,225**	**0.53%**
14							
15	**Plan Expenses:**						
16							
17	Net Medical Claims	516,568,367		516,568,367	498,136,061	18,432,306	3.70%
18	Net Pharmacy Claims	158,313,162		158,313,162	150,832,543	7,480,619	4.96%
19	**Net Claim Payments**	**674,881,529**	-	**674,881,529**	**648,968,604**	**25,912,925**	**3.99%**
20							
21	**Medicare Advantage Premiums**	**39,174,180**		**39,174,180**	**39,480,705**	**(306,525)**	**-0.78%**
22							
23	**Net Administrative Expenses**	**35,637,354**		**35,637,354**	**47,559,778**	**(11,922,424)**	**-25.07%**
24							
25	**Total Plan Expenses (excludes internal transfers)**	**749,693,063**	-	**749,693,063**	**736,009,087**	**13,683,976**	**1.86%**
26							
27	Plan Income/(Loss)	**11,379,276**	**(17,717,570)**	**(6,338,294)**	**3,427,457**	**(9,765,751)**	**-284.93%**
28							
29	**Cash Availability:**						
30							
31	Beginning Cash Balance/(Deficit)	958,558,040		958,558,040	958,558,040	-	
32	**Ending Cash Balance/(Deficit)**	**969,937,316**	**(17,717,570)**	**952,219,746**	**961,985,497**	**(9,765,751)**	**-1.02%**
33							
34	Target Stabilization Reserve @ 6/30/15	232,647,498		232,647,498	232,647,498	-	
35							
36	**Cash Balance Over/(Under) Reserve Target**	**$ 737,289,818**	**$ (17,717,570)**	**$ 719,572,248**	**$ 729,337,999**	**$ (9,765,751)**	**-1.34%**

Adjustment Notes:
1. Member premiums adjusted to include $16.0 million in prepaid July premiums received in June.
2. Member premiums adjusted to exclude $33.6 million in prepaid October premiums received in September.
3. Medicare Advantage low income premium subsidies were not budgeted and therefore are excluded.

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

Actuarial Valuation of Retired Employees' Health Benefits

Other Postemployment Benefits as of December 31, 2014

Based on report prepared by
The Segal Company
for the
Committee on Actuarial Valuation of Retired Employees' Health Benefits

Board of Trustees Meeting

November 20, 2014

A Division of the Department of State Treasurer

Presentation Overview

- Background
- Committee on Actuarial Valuation of Retired Employees' Health Benefits
- Valuation Process
- Results
- Other Postemployment Benefits Exposure Draft

Background

- The Governmental Accounting Standards Board (GASB) sets accounting standards for public and governmental entities to provide uniformity in financial reporting

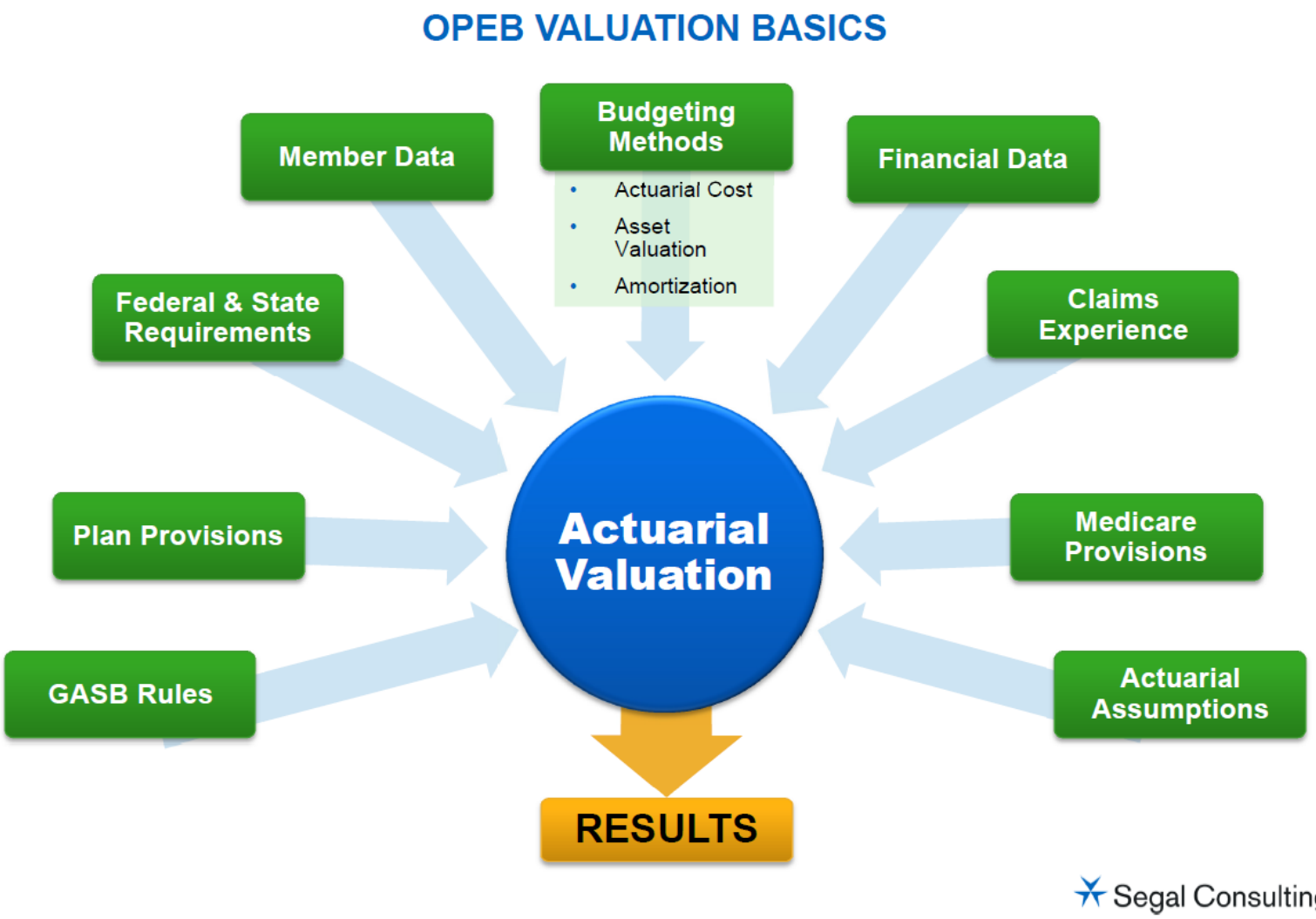
- GASB statements 43 and 45 require governmental entities to disclose information on liabilities associated with Other Postemployment Benefits (OPEB), notably retiree health benefits

- Objective: To report in today's dollars the State's liability associated with retiree health benefits

Committee on Actuarial Valuation of Retired Employees' Health Benefits

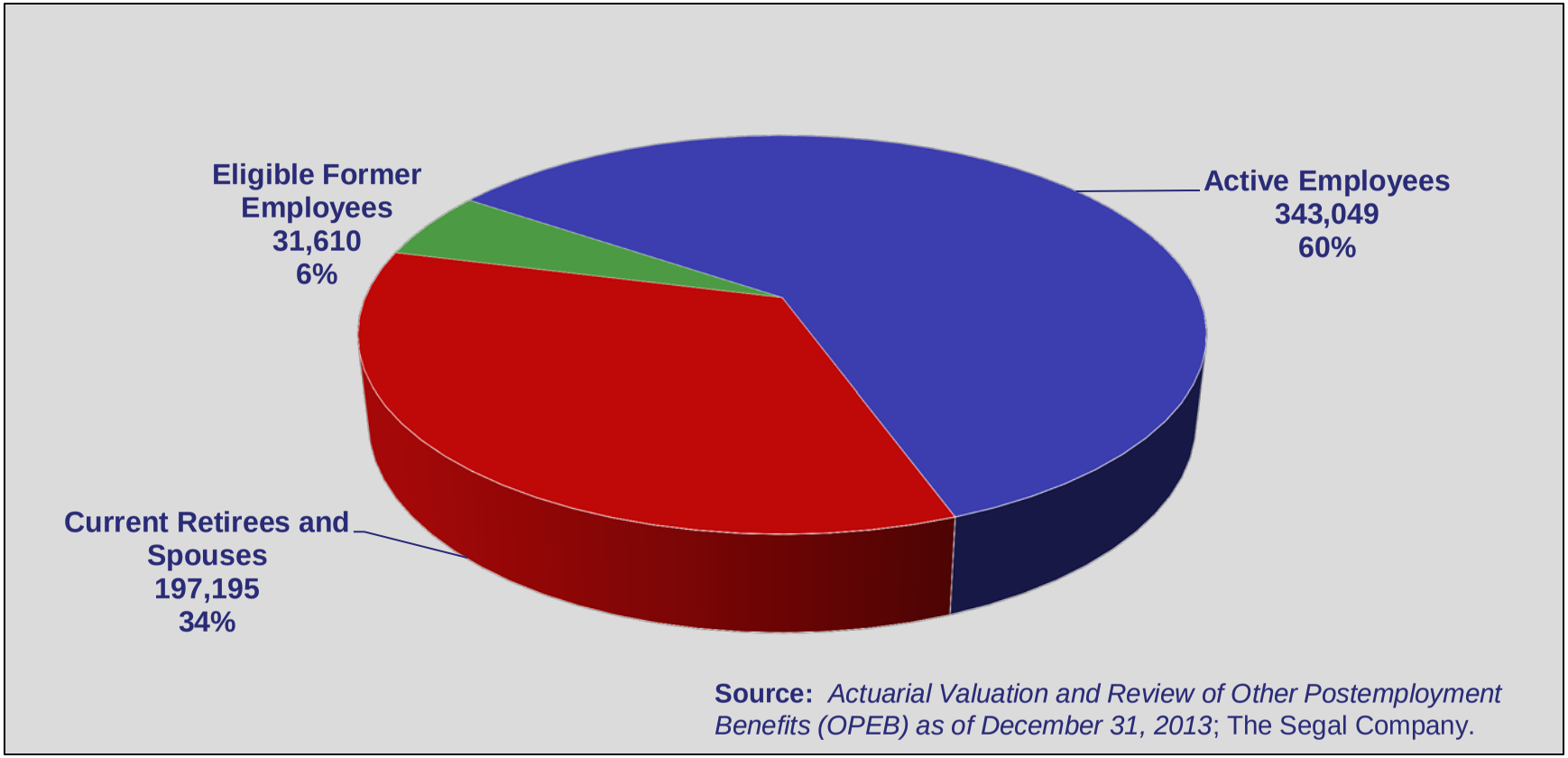
- Established to conduct the annual OPEB valuation
- Committee consists of:
  - State Budget Officer (as Chair)
  - State Controller
  - State Treasurer
  - Executive Administrator of the State Health Plan
- Committee's responsibilities:
  - Select actuary (can choose the Plan's actuary or Retirement's actuary)
  - Collect data
  - Review actuarial assumptions to be used in the valuation
  - Report results

Valuation Process



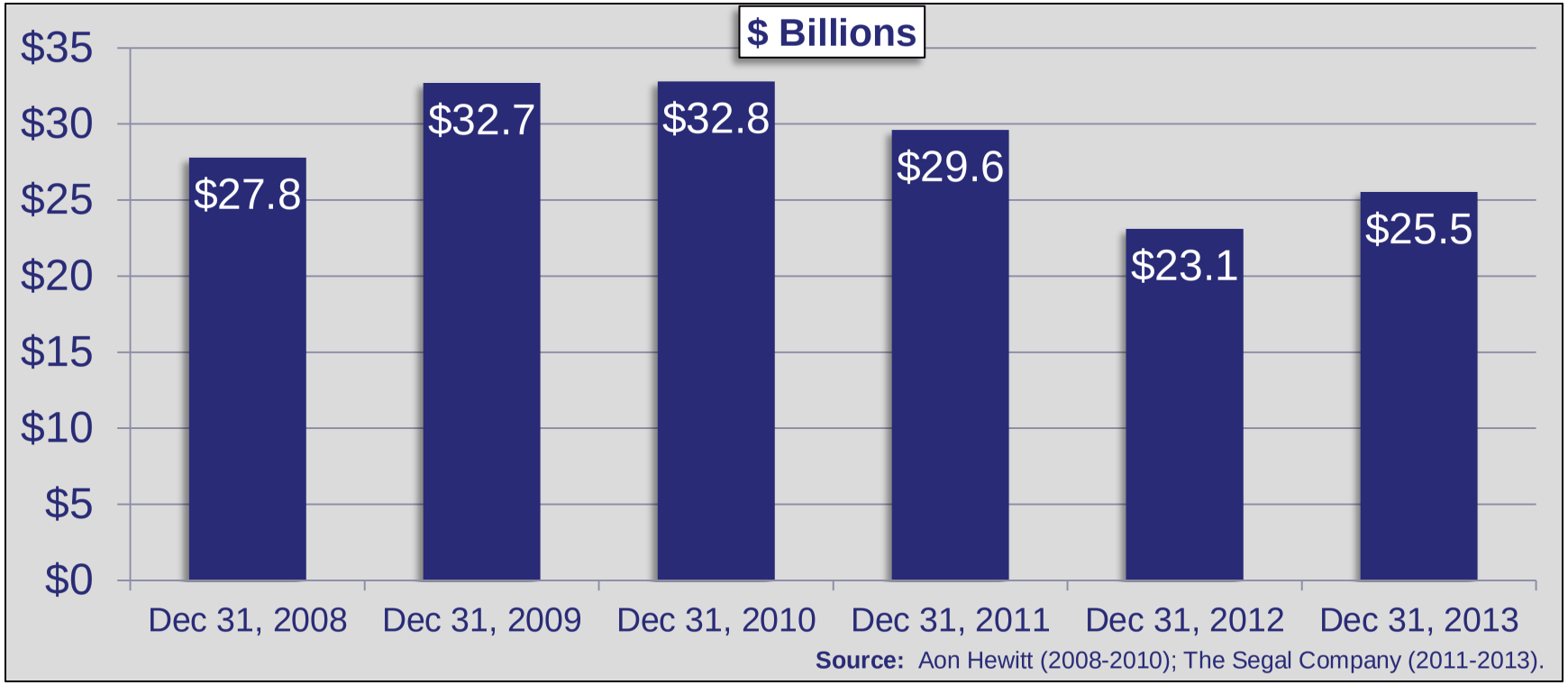
Valuation Census

- As of December 31, 2013, there were 571,854 employees and retirees eligible for retiree health benefits



Source: *Actuarial Valuation and Review of Other Postemployment Benefits (OPEB) as of December 31, 2013*; The Segal Company.

Results: Unfunded Actuarial Accrued Liability (UAAL)



- UAAL increased $2.4 billion from December 31, 2012 to December 31, 2013
- 2013 UAAL was $1.0 billion more than projected last year due to:
  - **Assumption changes** (*e.g.*, per capita healthcare costs, long-term trends) increased UAAL by $2.4 billion
  - **Actuarial experience** (*e.g.*, demographics, investment performance, contributions) decreased UAAL by $1.4 billion

Results: Annual Required Contribution (ARC)

- ARC = Amortization of unfunded liability + normal costs
  - If the State were to amortize the UAAL over a 30-year period, the annual payment would be $943 million
  - Liability associated with future benefits earned in the current (valuation) year is the “normal cost.” Normal cost for 2013 UAAL is $1.281 billion

	12/31/2008	12/31/2009	12/31/2010	12/31/2011	12/31/2012	12/31/2013
Amortization of Unfunded Liability	$1.0 b	$1.2 b	$1.2 b	$1.1 b	$0.8 b	$0.9 b
Normal Cost	$1.7 b	$1.8 b	1.7 b	$1.4 b	$1.2 b	$1.3 b
ARC	**$2.7 b**	**$3.0 b**	**$2.9 b**	**$2.5 b**	**$2.0 b**	**$2.2 b**
As % of Payroll	17.5%	19.9%	19.3%	16.7%	13.5%	14.8%

Future Changes to OPEB Reporting

- GASB released “Exposure Drafts” relating to OPEB in June 2014
- The drafts would require OPEB liabilities to be listed as a balance sheet item rather than a note beginning with fiscal years starting after December 15, 2016 (State Fiscal Year 2017-18 for NC)
- The drafts would also make changes to the calculation of total OPEB liabilities and require additional disclosures and supplementary information
- OPEB liabilities are not the responsibility of the Plan or the Board of Trustees, but once the proposed changes are implemented, there may be pressure on the Board and the State to reexamine retiree health benefits

North Carolina State Health Plan

Actuarial Valuation and Review of Other Postemployment Benefits (OPEB) as of December 31, 2013 in Accordance with GASB Statements No. 43 and No. 45

Segal Consulting

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September 12, 2014

Committee on Actuarial Valuation
of Retired Employees' Health Benefits (OPEB)
State of North Carolina
4901 Glenwood Avenue Suite 300
Raleigh, North Carolina 27612

Dear Committee members:

We are pleased to submit this Actuarial Valuation and Review of Other Postemployment Benefits (OPEB) as of December 31, 2013 under Governmental Accounting Standards Board Statements 43 and 45. The report summarizes the actuarial data used in the valuation, discloses the Net OPEB obligation (NOO) as of June 30, 2014, establishes the Annual Required Contribution (ARC) for the coming year, and analyzes the preceding year's experience. This report was based on the census data provided by the Teachers' and State Employees' Retirement Systems (TSERS), the financial information provided by the Department of State Treasurer, and the terms of the Plan. Claims and enrollment data was received from the State Health Plan. The actuarial calculations were completed under the supervision of K. Eric Fredén, FSA, MAAA, FCA, Vice President & Actuary.

This actuarial valuation has been completed in accordance with generally accepted actuarial principles and practices. To the best of our knowledge, the information supplied in this actuarial valuation is complete and accurate. Further, in our opinion, the assumptions used in this valuation and described in Exhibit II are reasonably related to the experience of and the expectations for the Plan. The actuarial projections are based on these assumptions and the plan of benefits as summarized in Exhibit III.

Sincerely,

Segal Consulting, a Member of the Segal Group, Inc.

By:

J. Richard Johnson
Senior Vice President

K. Eric Fredén, FSA, MAAA, FCA
Vice President & Actuary

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SECTION 2

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PURPOSE

This report presents the results of our actuarial valuation of State of North Carolina (the "Employer") OPEB plan as of December 31, 2013. The results are in accordance with the Governmental Accounting Standards, which prescribe an accrual methodology for accumulating the value of other postemployment benefits (OPEB) over participants' active working lifetimes.

HIGHLIGHTS OF THE VALUATION

- The **unfunded actuarial accrued liability (UAAL)** as of December 31, 2013 is $25,529,412,173 an increase of $2,412,133,157, from the prior valuation UAAL of $23,117,279,016. Net unfunded plan obligations had been expected to increase to $24,501,242,962, due to normal plan operations. The difference between actual and expected unfunded actuarial accrued liabilities was the net effect of several factors:
  - An **actuarial experience gain** decreased the UAAL by $1,396,547,365. This was the net result of gains and losses due to fund investment performance, demographic changes and actual 2014 contributions and benefit payments that were different from expected. We have taken these actuarial gains and losses into account in reviewing our assumptions for the current valuation.
  - **Valuation assumption changes** increased the UAAL by $2,424,716,576. This was the result of a decrease in obligations due to lowering the valuation-year per capita health costs and adjusting the future trend on these costs.
  - **There were no Plan changes since last valuation.**
- As of December 31, 2013, the ratio of assets to the AAL (the funded ratio) is 3.37%.
- The **Net OPEB Obligation (NOO)** increased to $14,314,298,263 for the year ending June 30, 2014. The NOO generally increases if the contributions in relation to the ARC are less than the ARC. The contributions in relation to the ARC during the year ending June 30, 2014 were $798,401,569 compared to the ARC of $2,223,900,337. Contributions in relation to the ARC totaled 35.90% of the ARC in the year ending June 30, 2014. Chart 6 shows the detailed derivation of the NOO as of June 30, 2014.
- The **Annual Required Contribution (ARC)** increased to $2,223,900,337 for the year ending June 30, 2014. The ARC was $2,021,026,309 for the last year. As a percentage of payroll, the ARC increased from 13.51% last year to 14.75% this year.
- The **Annual OPEB Cost (AOC)** increased to $2,223,900,337 for the year ending June 30, 2014. The AOC was $2,085,390,268 last year.

The key valuation results for the current and prior years are shown.

SUMMARY OF VALUATION RESULTS

	December 31, 2013	December 31, 2012
Actuarial Accrued Liability (AAL)	$26,420,167,735	$23,883,106,962
Actuarial Value of Assets	890,755,562	765,827,946
Unfunded Actuarial Accrued Liability	25,529,412,173	23,117,279,016
Funded Ratio	3.37%	3.21%
Market Value of Assets	$890,755,562	$765,827,946
Annual Required Contribution (ARC) for Fiscal Year Ending:	**June 30, 2014**	**June 30, 2013**
Normal cost	$1,280,839,603	$1,167,070,175
Amortization of the unfunded actuarial accrued liability	943,060,734	853,956,134
Total Annual Required Contribution, including adjustment for timing	$2,223,900,337	$2,021,026,309
Covered payroll	$15,080,626,734	$14,957,178,663
ARC as a percentage of pay	14.75%	13.51%
Total Participants	571,854	560,625
Annual OPEB Cost (AOC) for Fiscal Year Ending:	**June 30, 2014**	**June 30, 2013**
Annual Required Contributions	$2,223,900,337	$2,021,026,309
Interest on Net OPEB Obligations	544,745,285	492,005,421
ARC Adjustments	-473,481,917	-427,641,462
Total Annual OPEB Cost	$2,295,163,705	$2,085,390,268
AOC as a percent of pay	15.22%	13.94%

September 12, 2014

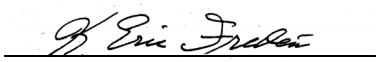
ACTUARIAL CERTIFICATION

This is to certify that Segal Consulting, a Member of the Segal Group, Inc. has conducted an actuarial valuation of certain benefit obligations of North Carolina State Health Plan's other postemployment benefit programs as of December 31, 2013, in accordance with generally accepted actuarial principles and practices. The actuarial calculations presented in this report have been made on a basis consistent with our understanding of GASB Statements 43 and 45 for the determination of the liability for postemployment benefits other than pensions.

The actuarial valuation is based on the plan of benefits verified by the Employer and reliance on participant, premium, claims and expense data provided by the Employer or from vendors employed by the Employer. Segal Consulting does not audit the data provided. The accuracy and comprehensiveness of the data is the responsibility of those supplying the data. Segal, however, does review the data for reasonableness and consistency.

The actuarial computations made are for purposes of fulfilling plan accounting requirements. Determinations for purposes other than meeting financial accounting requirements may be significantly different from the results reported here. Accordingly, additional determinations may be needed for other purposes, such as judging benefit security at termination of the plan, or determining short-term cash flow requirements.

To the best of my knowledge, this report is complete and accurate and in my opinion presents the information necessary to comply with GASB Statements 43 and 45 with respect to the benefit obligations addressed. The signing actuary is a member of the Society of Actuaries, the American Academy of Actuaries, and other professional actuarial organizations and meets their "General Qualification Standards for Statements of Actuarial Opinions" to render the actuarial opinion contained herein.



K. Eric Fredén, FSA, MAAA, FCA
Vice President & Actuary

The actuarial present value of total projected benefits uses the actuarial assumptions disclosed in Section 4 to calculate the value today of all benefits expected to be paid to current actives and retired plan members. The actuarial balance sheet shows the expected breakdown of how these benefits will be financed.

CHART 1

Actuarial Present Value of Total Projected Benefits (APB) and Actuarial Balance Sheet

	Actuarial Present Value of Total Projected Benefits (APB)	
	December 31, 2013	**December 31, 2012**
Participant Category		
Current retirees, beneficiaries, and dependents	$9,810,405,584	$8,165,950,545
Current active members	32,406,097,969	29,886,993,329
Terminated members entitled but not yet eligible	2,425,418,463	2,255,068,465
Total	$44,641,922,016	$40,308,012,340

		December 31, 2013	**December 31, 2012**
Actuarial Balance Sheet			
The actuarial balance sheet as of the valuation date is as follows:			
	Assets		
1.	Actuarial value of assets	$890,755,562	$765,827,946
2.	Present value of future normal costs	18,221,754,281	16,424,905,378
3.	Unfunded actuarial accrued liability	25,529,412,173	23,117,279,016
4.	Present value of current and future assets	$44,641,922,016	$40,308,012,340
	Liabilities		
5.	Actuarial present value of total projected benefits	$44,641,922,016	$40,308,012,340

The actuarial accrued liability shows that portion of the APB (Chart 1) allocated to periods prior to the valuation date by the actuarial cost method. The chart below shows the portion covered by retiree contributions, the portion covered by accumulated plan assets, and reconciles the unfunded actuarial liability from last year to this year.

CHART 2

Actuarial Accrued Liability (AAL) and Unfunded AAL (UAAL)

	December 31, 2013	December 31, 2012
Participant Category		
Current retirees, beneficiaries, and dependents	$9,810,405,584	$8,165,950,545
Current active members	14,184,343,688	13,462,087,951
Terminated members entitled but not yet eligible	2,425,418,463	2,255,068,465
Total	$26,420,167,735	$23,883,106,962
Effect of Retiree Contributions		
Actuarial accrued liability before reduction for retiree contributions	$30,210,097,630	$26,680,709,258
Less projected retiree contributions	3,789,929,895	2,797,602,296
Net employer actuarial accrued liability	26,420,167,735	23,883,106,962
Actuarial value of assets	890,755,562	765,827,946
Unfunded actuarial accrued liability	$25,529,412,173	$23,117,279,016
Development of Unfunded Actuarial Accrued Liability		
1. Unfunded actuarial accrued liability as of December 31, 2012		$23,117,279,016
2. Employer normal cost at beginning of year		1,167,070,175
3. Total employer contributions at beginning of year		-781,957,861
4. Interest		998,851,632
5. Expected unfunded actuarial accrued liability		$24,501,242,962
6. Change due to the combined effect of experience gains, updated assumptions and methods and plan changes		1,028,169,211
7. Unfunded actuarial accrued liability as of December 31, 2013		$25,529,412,173

The Annual Required Contribution (ARC) is the amount calculated to determine the annual cost of the OPEB plan for accounting purposes *as if* the plan were being funded through contributions to a trust fund. The GASB standards cannot require the contributions actually be made to a trust fund. The ARC is simply a device used to measure annual plan costs on an accrual basis. The calculation consists of adding the Normal Cost of the plan to an amortization payment. The resulting sum is then adjusted to the start of the accounting period and adjusted as if the annual cost were to be contributed in the middle of the year.

The amortization payment is based on a 30-year amortization of the Unfunded Actuarial Accrued Liability on an increasing payment basis at 3.50%.

CHART 3

Determination of Annual Required Contribution (ARC) – Payable Throughout Fiscal Year

	Cost Element	Fiscal Year Beginning July 1, 2013 and Ending June 30, 2014		Fiscal Year Beginning July 1, 2012 and Ending June 30, 2013	
		Amount	Percentage of Compensation	Amount	Percentage of Compensation
1	Normal cost	$1,280,839,603	8.49%	$1,167,070,175	7.80%
2	Amortization of the unfunded actuarial accrued liability (30 years)	943,060,734	6.25%	853,956,134	5.71%
3	Total Annual Required Contribution (ARC)	$2,223,900,337	14.75%	$2,021,026,309	13.51%
4	Total Compensation	$15,080,626,734		$14,957,178,663	

The Annual OPEB Cost (AOC) adjusts the ARC for timing differences between the ARC and contributions in relation to the ARC. The AOC is the cost of OPEB actually booked as an expense for the Fiscal Year under GASB 45.

CHART 3 (continued)

Determination of Annual OPEB Cost (AOC) – Payable Throughout Fiscal Year

	Cost Element	Fiscal Year Beginning July 1, 2013 and Ending June 30, 2014		Fiscal Year Beginning July 1, 2012 and Ending June 30, 2013	
		Amount	Percentage of Compensation	Amount	Percentage of Compensation
1	Annual Require Contribution	$2,223,900,337	14.75%	$2,021,026,309	13.51%
2	Interest on Beginning of Year Net OPEB Obligation (NOO)	544,745,285	3.61%	492,005,421	3.29%
3	ARC adjustment	-473,481,917	-3.14%	-427,641,462	-2.86%
4	Annual OPEB Cost	$2,295,163,705	15.22%	$2,085,390,268	13.94%

For GASB 43 (plan reporting) purposes, the schedule of employer contributions compares actual contributions to the ARC. For GASB 45 (employer reporting) purposes, the schedule of employer contributions compares actual contributions to the AOC.

CHART 4

Required Supplementary Information – Schedule of Employer Contributions GASB 43

Fiscal Year Ended June 30	Annual Required Contributions	Actual Contributions	Percentage Contributed
2007	$2,389,583,000	$550,942,204	23.06%
2008	2,714,184,000	825,081,155	30.40%
2009	2,674,416,000	635,675,084	23.77%
2010	3,018,959,000	677,827,218	22.45%
2011	2,910,615,707	868,263,454	29.83%
2012	2,480,159,722	852,358,729	34.37%
2013	2,021,026,309	844,452,283	41.78%
2014	2,223,900,337	798,401,569	35.90%

Required Supplementary Information – Schedule of Employer Contributions GASB 45

Fiscal Year Ended June 30	Annual OPEB Cost	Actual Contributions	Percentage Contributed
2007	$2,389,582,938	$550,942,204	23.06%
2008	2,399,416,597	825,081,155	34.39%
2009	2,699,430,651	635,675,084	23.55%
2010	3,049,870,032	677,827,218	22.22%
2011	2,954,027,031	868,263,454	29.39%
2012	2,535,167,544	852,358,729	33.62%
2013	2,085,390,268	844,452,283	40.49%
2014	2,295,163,705	798,401,569	34.79%

This schedule of funding progress presents multi-year trend information about whether the actuarial value of plan assets is increasing or decreasing over time relative to the actuarial accrued liability for benefits.

CHART 5

Required Supplementary Information – Schedule of Funding Progress

Actuarial Valuation Date	Actuarial Value of Assets (a)	Actuarial Accrued Liability (AAL) (b)	Unfunded AAL (UAAL) (b) – (a)	Funded Ratio (a) / (b)	Covered Payroll (c)	UAAL as a Percentage of Covered Payroll [((b) – (a)) / (c)]
12/31/2005	139,174,878	23,925,138,742	23,785,963,864	0.58%	12,359,975,359	192.44%
12/31/2007	296,500,252	28,890,229,747	28,593,729,495	1.03%	14,810,270,168	193.07%
12/31/2008	434,768,521	28,288,439,376	27,853,670,855	1.54%	15,295,559,646	182.10%
12/31/2009	556,303,039	33,321,783,854	32,765,480,815	1.67%	15,131,145,834	216.54%
12/31/2010	655,445,062	33,494,640,678	32,839,195,616	1.96%	15,098,336,130	217.50%
12/31/2011	729,094,584	30,339,346,481	29,610,251,897	2.40%	14,851,954,027	199.37%
12/31/2012	765,827,946	23,883,106,962	23,117,279,016	3.21%	14,957,178,663	154.56%
13/31/2013	890,755,562	26,420,167,735	25,529,412,173	3.37%	15,080,626,734	169.29%

The Net OPEB obligation measures the accumulated differences between the annual OPEB cost and the actual contributions in relation to the ARC.

CHART 6

Required Supplementary Information – Net OPEB Obligation (NOO)

Actuarial Valuation Date	Fiscal Year End	Annual Required Contribution (a)	Interest on Existing NOO (b)	ARC Adjustment (c)	Annual OPEB Cost (a) + (b) + (c) (d)	Actual Contribution Amount (e)	Net Increase in NOO (d) – (e) (f)	NOO as of Fiscal Year (g)
12/31/2010	06/30/2011	$2,910,615,707	331,841,094	(288,429,771)	$2,954,027,031	868,263,454	2,085,763,576	$9,893,789,327
12/31/2011	06/30/2012	2,480,159,722	420,486,046	(365,478,224)	2,535,167,544	852,358,729	1,682,808,815	11,576,598,142
12/31/2012	06/30/2013	2,021,026,309	492,005,421	(427,641,462)	2,085,390,268	844,452,283	1,240,937,985	12,817,536,127
12/31/2013	06/30/2014	2,223,900,337	544,745,285	(473,481,917)	2,295,163,705	798,401,569	1,496,762,136	14,314,298,263

Employer contribution in relation to the ARC consist of benefits paid directly to or on behalf of a retiree or beneficiary, premiums paid to an insurer, or assets irrevocably transferred to OPEB trust.

CHART 7

Net Contribution In Relation to the ARC

Transaction	06/30/2014	Source of information	06/30/2013	Source of information
Claims paid net of refunds	$840,259,194	SAS claims database	$853,623,268	SAS claims database
Administrative load	43,866,132	Segal FYE 2014 Q4 financial updates	46,671,747	Segal FYE 2013 Q4 financial updates
Retiree/Dependent premiums	(104,030,070)	Enrollment & retiree contribution rates	(116,948,276)	Enrollment & retiree contribution rates
Net benefits paid	780,095,256	Sum of above	783,346,739	Sum of above
Employer contribution to trust	813,956,238	Retiree health reserve statement 06/30/2014	813,222,689	Retiree health reserve statement 06/30/2013
Transfer to SHP from trust	(795,649,925)	Retiree health reserve statement 06/30/2014	(752,117,145)	Retiree health reserve statement 06/30/2013
Net contribution in relation to the ARC	798,401,569	P. 16 Exh D Col [e]	844,452,283	P. 16 Exh D Col [e]

This exhibit summarizes the participant data used for the current and prior valuations.

EXHIBIT A

Summary of Participant Data

	December 31, 2013	December 31, 2012
Retirees		
Number of retirees	182,146	170,070
Average age of retirees	69.3	69.3
Number of spouses	12,690	12,745
Average age of spouses	68.4	66.6
Surviving Spouses		
Number	2,359	2,566
Average age	80.6	80.4
Inactive Vesteds		
Number of inactive vested	31,610	32,511
Average age of inactive vested	48.0	48.0
Average expected retirement age	63.03	62.97
Active Participants		
Number	343,049	342,733
Average age	44.8	44.9
Average years of service	9.9	11.3
Average expected retirement age	59.0	58.5

EXHIBIT B

Members in Active Service as of December 31, 2013 By Age and Service

	Service									
Age	**Total**	**0-4**	**5-9**	**10-14**	**15-19**	**20-24**	**25 – 29**	**30 – 34**	**35 – 39**	**40 & Over**
Under 25	11,689	11,656	32	1	- -	- -	- -	- -	- -	- -
25 - 29	31,815	24,945	6,857	13	- -	- -	- -	- -	- -	- -
30 - 34	37,862	15,880	17,052	4,700	230	- -	- -	- -	- -	- -
35 - 39	40,178	13,418	11,569	11,423	3,747	21	- -	- -	- -	- -
40 - 44	49,060	13,579	12,051	9,613	10,575	3,196	46	- -	- -	- -
45 - 49	48,437	11,515	11,040	8,757	7,228	7,289	2,589	19	- -	- -
50 - 54	48,405	9,868	10,183	8,749	7,326	5,350	5,932	986	11	- -
55 - 59	42,694	7,766	8,609	7,788	6,760	5,264	4,371	1,654	479	3
60 - 64	24,263	4,710	5,183	4,336	3,721	3,049	1,843	768	541	112
65 - 69	6,629	1,607	1,535	1,218	821	563	392	226	159	108
70 & over	2,017	573	404	358	228	154	107	59	47	87
Total	343,049	115,256	84,515	56,956	40,897	24,886	15,280	3,712	1,237	310

EXHIBIT C

Cash Flow Projections

The ARC generally exceeds the current pay-as-you-go ("paygo") cost of an OPEB plan. Over time the paygo cost will tend to grow and may even eventually exceed the ARC in a well funded plan. The following table projects the paygo cost as the projected net fund payment over the next ten years.

Year Ending December 31	Projected Number of Retirees*			Projected Benefit Payments			Projected Retiree Contributions	Projected Net Fund Payment	Contribution Ratio
	Current	Future	Total	Current	Future	Total			
2014	197,195	15,977	213,172	$782,672,377	$58,220,424	$840,892,801	$84,181,320	$756,711,481	10.01%
2015	191,822	29,380	221,202	763,160,033	159,590,251	922,750,284	96,480,909	826,269,375	10.46%
2016	186,357	42,491	228,848	740,479,300	264,021,341	1,004,500,641	110,174,623	894,326,018	10.97%
2017	180,812	55,376	236,188	718,038,648	369,579,771	1,087,618,419	125,281,907	962,336,512	11.52%
2018	175,181	68,424	243,605	696,343,624	475,546,267	1,171,889,891	141,927,910	1,029,961,981	12.11%
2019	169,480	82,510	251,990	680,480,894	585,008,292	1,265,489,186	160,535,930	1,104,953,256	12.69%
2020	163,713	95,614	259,327	670,112,293	697,340,494	1,367,452,787	179,875,495	1,187,577,292	13.15%
2021	157,874	108,186	266,060	660,418,801	810,509,947	1,470,928,748	199,043,402	1,271,885,346	13.53%
2022	151,971	120,410	272,381	647,643,554	923,835,077	1,571,478,631	217,389,586	1,354,089,045	13.83%
2023	146,013	131,998	278,011	634,824,713	1,034,432,195	1,669,256,908	234,623,911	1,434,632,997	14.06%

* *Includes spouses of retirees.*

EXHIBIT D

ARC and NOO Projection

The following charts project the ARC and NOO through June 30, 2014 assuming a stable active population and that State contributions to the trust fund follow the current percent of pay methodology through the 2014 fiscal year and remain at 5.3% of pay thereafter. These contributions are expected to exceed transfers to the SHP by amounts similar to recent experience.

Actuarial Valuation Date	Actuarial Value of Assets (a)	Actuarial Accrued Liability (b)	Normal Cost (c)	Unfunded AAL (b) - (a)	30-Year Amortization (d)	Annual Required Contribution (c) + (d)
12/31/2014	$899,575,966	$28,105,675,864	$1,278,211,650	$27,206,099,898	$1,004,997,858	$2,283,209,508
12/31/2015	906,849,176	29,789,057,828	1,284,602,708	28,882,208,652	1,066,913,594	2,351,516,302
12/31/2016	912,524,928	31,481,158,405	1,297,448,735	30,568,633,477	1,129,210,408	2,426,659,143
12/31/2017	916,519,661	33,189,124,561	1,316,910,466	32,272,604,900	1,192,155,395	2,509,065,861
12/31/2018	918,752,808	34,920,920,575	1,343,248,676	34,002,167,767	1,256,045,736	2,599,294,412
12/31/2019	918,976,779	36,677,207,245	1,376,829,893	35,758,230,466	1,320,914,984	2,697,744,877
12/31/2020	916,927,229	38,458,782,988	1,418,134,789	37,541,855,759	1,386,802,399	2,804,937,188
12/31/2021	912,453,027	40,273,055,096	1,467,769,507	39,360,602,069	1,453,987,190	2,921,756,697
12/31/2022	905,475,615	42,132,245,611	1,526,480,287	41,226,769,995	1,522,923,744	3,049,404,031
12/31/2023	895,903,054	44,049,420,007	1,595,171,900	43,153,516,953	1,594,098,097	3,189,269,997

Fiscal Year End	Annual Required Contribution (a)	Interest on Existing NOO (b)	Adjustment (c)	Annual OPEB Cost (a) + (b) + (c) (d)	Projected Contribution Amount (e)	NOO as of Fiscal Year (f)
06/30/2015	$2,283,209,508	$608,357,676	-$528,772,560	$2,362,794,624	$778,366,526	$15,898,726,361
06/30/2016	2,351,516,302	675,695,870	-587,301,597	2,439,910,576	846,714,458	17,491,922,479
06/30/2017	2,426,659,143	743,406,705	-646,154,527	2,523,911,322	914,272,613	19,101,561,188
06/30/2018	2,509,065,861	811,816,350	-705,614,849	2,615,267,363	981,598,542	20,735,230,009
06/30/2019	2,599,294,412	881,247,275	-765,962,847	2,714,578,840	1,052,397,639	22,397,411,210
06/30/2020	2,697,744,877	951,889,976	-827,364,097	2,822,270,756	1,130,678,195	24,089,003,772
06/30/2021	2,804,937,188	1,023,782,660	-889,851,808	2,938,868,041	1,213,598,693	25,814,273,120
06/30/2022	2,921,756,697	1,097,106,608	-953,583,545	3,065,279,760	1,296,289,927	27,583,262,952
06/30/2023	3,049,404,031	1,172,288,675	-1,018,930,324	3,202,762,383	1,377,079,349	29,408,945,986
06/30/2024	3,189,269,997	1,249,880,204	-1,086,371,359	3,352,778,843	1,460,014,814	31,301,710,015

EXHIBIT E

Financial Information

Employers may accumulate assets to pay for future OPEB. In order to be treated as plan assets, the funds must be set aside in a trust fund or equivalent arrangement that has the following characteristics:

a. Employer contributions are irrevocable
b. Plan assets are dedicated to OPEB only
c. Plan assets are legally protected from the creditors of the employer and the plan administrator.

North Carolina State Health Plan has an arrangement that meets those requirements.

Statement of Plan Net Assets

	Year Ended December 31, 2013	Year Ended December 31, 2012
Assets		
Cash equivalents	$121,158,277	$771,261,531
Investments	785,721,085	0
Investment income	45,801	282,486
Contributions receivable	49,722,073	56,922,023
Total assets	$956,647,236	$828,466,040
Liabilities		
Less accounts payable:	-65,891,674	-62,638,094
Net assets held in trust for other postemployment benefits	$890,755,562	$765,827,946

EXHIBIT F

Statement of Changes in Plan Net Assets

	Year Ended December 31, 2013	Year Ended December 31, 2012
Additions		
Employer contributions*	$808,140,588	$756,750,625
Interest credited	86,129,281	3,752,161
Total additions:	$894,269,869	$760,502,786
Deductions		
Benefit Payments	$768,864,551	$723,429,964
Expenses	477,702	339,460
Total deductions	$769,342,253	$723,769,424
Net increase	$124,927,616	$36,733,362
Net assets held in trust for other postemployment benefits		
Beginning of year	$765,827,946	$729,094,584
End of year	$890,755,562	$765,827,946

** Employer contributions include both implicit and explicit subsidies for the retirees' cost of OPEB. These are the contributions in relation to the ARC.*

EXHIBIT G

Detailed Actuarial Gain and Loss Analysis

If all actuarial assumptions had been exactly realized the ARC would have been expected to be $2,072,150,167 this year. The actual ARC for this year is $2,223,900,337, a difference of $151,750,170. The following chart identifies the sources of this difference.

Actuarial Gain and Loss

Item	FY 2014	FY 2013
Expected ARC	$2,072,150,167	$2,548,184,950
Experience gain or loss	-55,795,356	225,043,128
Assumption changes	207,545,526	-421,233,465
Plan changes	0	-330,968,304
Total change	$151,750,170	-$527,158,641
Actual ARC	$2,223,900,337	$2,021,026,309

EXHIBIT I

Summary of Required Supplementary Information

Valuation date	December 31, 2013	
Actuarial cost method	Projected Unit Credit. Service from hire date to full eligibility was used to allocate costs. Full eligibility in this context refers to the date when an employee retires, according to the valuation assumptions.	
Amortization method	Open 30-Year Amortization	
Remaining amortization period	30 years as of December 31, 2013	
Asset valuation method	Market Value	
Actuarial assumptions:		
Investment rate of return	4.25%	
Inflation rate	3.50%	
Projected salary increases	Vary by group and years of service	
Medical cost trend rate	7.50% graded to 5.00% over 8 years	
Plan membership:	December 31, 2013	December 31, 2012
Current retirees, beneficiaries, and dependents	197,195	185,381
Current active participants	343,049	342,733
Terminated participants entitled but not yet eligible	31,610	32,511
Total	571,854	560,625

EXHIBIT II

Actuarial Assumptions and Actuarial Cost Method

Data:	Detailed census data, premium data and/or claim experience, and summary plan descriptions for OPEB were provided by the State.
Actuarial Cost Method:	Projected Unit Credit. Service from hire date to full eligibility was used to allocate costs. Full eligibility in this context refers to the date when an employee retires, according to the valuation assumptions.
Asset Valuation Method:	Market Value
Measurement Date:	December 31, 2013
Discount Rate:	4.25%
Salary Increases:	Vary by group and years of service
Mortality Rates:	RP-2000 Non-Annuitant and Annuitant Mortality Tables, with the following adjustments: Male teachers (healthy): one-year set back Female teachers (healthy): no adjustment Male general employee (healthy): one-year set forward Female general employees (healthy): one-year set forward Male law-enforcement officer (healthy): no adjustment Female law-enforcement officer (healthy): no adjustment Male beneficiaries of deceased members: one-year set forward Female beneficiaries of deceased members: two-year set forward Male retirees (disabled): six-year set back Female retirees (disabled): one-year set forward All mortality rates for employees and healthy annuitants are projected from December 31, 2003 using Scale AA. No mortality improvements are projected for disabled retirees.

Termination before retirement:

General Employees:

	Rate (%)					
	Mortality		Disability		Turnover*	
Age	Male	Female	Male	Female	Male	Female
25	0.0004	0.0002	0.0002	0.0002	0.0650	0.0900
30	0.0005	0.0003	0.0004	0.0004	0.0650	0.0800
35	0.0008	0.0005	0.0010	0.0010	0.0500	0.0600
40	0.0011	0.0008	0.0030	0.0018	0.0400	0.0400
45	0.0016	0.0012	0.0050	0.0032	0.0350	0.0400
50	0.0023	0.0018	0.0084	0.0050	0.0350	0.0400
55	0.0033	0.0028	0.0144	0.0088	0.0350	0.0400
60	0.0054	0.0043	0.0240	0.0138	0.0000	0.0000
65	0.0081	0.0062	0.0000	0.0000	0.0000	0.0000
69	0.0099	0.0076	0.0000	0.0000	0.0000	0.0000

Teachers:

	Rate (%)					
	Mortality		Disability		Turnover*	
Age	Male	Female	Male	Female	Male	Female
25	0.0004	0.0002	0.0001	0.0002	0.0600	0.0700
30	0.0004	0.0003	0.0001	0.0003	0.0550	0.0600
35	0.0007	0.0005	0.0003	0.0006	0.0400	0.0450
40	0.0010	0.0007	0.0007	0.0010	0.0350	0.0300
45	0.0014	0.0011	0.0014	0.0018	0.0350	0.0300
50	0.0020	0.0017	0.0023	0.0032	0.0350	0.0300
55	0.0028	0.0025	0.0047	0.0055	0.0350	0.0300
60	0.0044	0.0039	0.0077	0.0102	0.0000	0.0000
65	0.0070	0.0058	0.0000	0.0000	0.0000	0.0000
69	0.0091	0.0073	0.0000	0.0000	0.0000	0.0000

** Higher rates are used during the first five years of service.*

Law Enforcement Officers:

	Rate (%)			
	Mortality			
	Male	Female	Disability	Turnover
25	0.0004	0.0002	0.0033	0.0400
30	0.0004	0.0003	0.0043	0.0350
35	0.0008	0.0005	0.0060	0.0300
40	0.0011	0.0007	0.0079	0.0300
45	0.0015	0.0011	0.0110	0.0300
50	0.0021	0.0017	0.0176	0.0300
55	0.0030	0.0025	0.0307	0.0000
60	0.0049	0.0039	0.0601	0.0000
65	0.0076	0.0058	0.0000	0.0000
69	0.0095	0.0073	0.0000	0.0000

** Higher rates are used during the first five years of service.*

Actives' Retirement Rates:

	General Employees		Teachers		Law Enforcement Officers
	Rate (%)		Rate (%)		Rate (%)
Age	Male	Female	Male	Female	Male Female
50	0.3500	0.3500	0.3000	0.3000	0.5000
55	0.2000	0.2250	0.3000	0.2750	0.5000
60	0.2250	0.2500	0.3000	0.2750	0.5000
65	0.3500	0.3500	0.3500	0.5000	0.4000
70	0.2250	0.2500	0.2500	0.2750	0.3000
75	1.0000	1.0000	1.0000	1.0000	1.0000

**Special rates are used for early service retirement.*

Inactive Vested Retirement Rates:	Age 55 with 20 or more years of service; age 63 with 5 or more years of service, but less than 20 years of service. Actives and terminated vested who do not have plan code are assumed to be enrolled in plans based on enrollment assumptions. Missing date of birth or invalid date of birth are assumed an average value of the group. Invalid gender codes are replaced with the default of male.
Missing Participant Data:	Any other missing census item for a given participant was assumed to equal the average value of that item over all other participants of the same status for whom the item is known.
Participation and Coverage Election:	100% of employees eligible to retire and receive subsidized postretirement welfare coverage were assumed to elect medical and prescription drug coverage. All participants are assumed to be enrolled in plans based on enrollment assumptions.
Dependents:	Demographic data was available for spouses of current retirees. For future retirees, husbands were assumed to be four years older than their wives. 10% of future retirees who elect to continue their health coverage at retirement were assumed to have an eligible spouse who also opts for health coverage at that time.

Per Capita Cost Development:

Medical and Prescription Drug

Per capita claims costs were based on actual paid claim experience for the periods July 1, 2012 through June 30, 2013. Claims were separated by Medicare and Non-Medicare participants, then adjusted as follows:

- paid claims were multiplied by a factor to yield an estimate of incurred claims,
- total claims were divided by the number of adult members to yield a per capita claim,
- the per capita claim was trended to the midpoint of the valuation year at assumed trend rates, and the per capita claim was adjusted for the effect of any plan changes

Actuarial factors were then applied to the per capita claims to estimate individual retiree and spouse costs by age and by gender.

Medicare Advantage plans were valued by actuarially adjusting the insured premium rates by age and gender.

Administrative Expenses Administrative expenses were based on projection furnished by Segal for the period January 1, 2014 through December 31, 2014.

Per Capita Health Costs: 2014 medical and prescription drug claims costs, excluding assumed expenses, are shown in the table below for retirees and for spouses at selected ages. These costs are net of deductibles and other benefit plan cost sharing provisions.

Non-Medicare

	Medical Basic				Medical CDHP			
	Retiree		Spouse		Retiree		Spouse	
Age	Male	Female	Male	Female	Male	Female	Male	Female
40	$3,038	$3,907	$1,889	$3,139	$3,541	$4,554	$2,202	$3,658
45	3,613	4,532	2,241	3,383	4,211	5,282	2,612	3,943
50	4,288	4,884	2,995	3,922	4,998	5,692	3,491	4,571
55	5,093	5,258	4,008	4,539	5,935	6,128	4,671	5,291
60	6,048	5,667	5,366	5,265	7,049	6,605	6,253	6,136
65	7,183	6,105	7,183	6,105	8,371	7,116	8,371	7,116
70	8,325	6,579	8,325	6,579	9,702	7,668	9,702	7,668
75	8,971	7,082	8,971	7,082	10,456	8,254	10,456	8,254
80	9,661	7,635	9,661	7,635	11,259	8,899	11,259	8,899

	Medical Enhanced				Prescription Drug			
	Retiree		Spouse		Retiree		Spouse	
Age	Male	Female	Male	Female	Male	Female	Male	Female
40	$3,731	$4,798	$2,320	$3,855	$949	$1,220	$590	$980
45	4,437	5,566	2,752	4,154	1,128	1,415	700	1,056
50	5,266	5,998	3,678	4,816	1,339	1,525	935	1,224
55	6,254	6,457	4,922	5,575	1,590	1,642	1,251	1,417
60	7,427	6,959	6,589	6,465	1,888	1,769	1,675	1,644
65	8,821	7,497	8,821	7,497	2,243	1,906	2,243	1,906
70	10,223	8,080	10,223	8,080	2,599	2,054	2,599	2,054
75	11,017	8,697	11,017	8,697	2,801	2,211	2,801	2,211
80	11,864	9,376	11,864	9,376	3,016	2,384	3,016	2,384

Medicare – Non Medicare Advantage

	Medical Basic				Prescription Drug			
	Retiree		Spouse		Retiree		Spouse	
Age	Male	Female	Male	Female	Male	Female	Male	Female
40	$283	$364	$176	$292	$949	$1,220	$590	$980
45	336	422	209	315	1,128	1,415	700	1,056
50	399	455	279	365	1,339	1,525	935	1,224
55	474	489	373	423	1,590	1,642	1,251	1,417
60	563	528	499	490	1,888	1,769	1,675	1,644
65	669	568	669	568	2,243	1,906	2,243	1,906
70	775	612	775	612	2,599	2,054	2,599	2,054
75	835	659	835	659	2,801	2,211	2,801	2,211
80	899	711	899	711	3,016	2,384	3,016	2,384

Medicare – Medicare Advantage

	Medicare Advantage (Base)			
	Retiree		Spouse	
Age	Male	Female	Male	Female
40	$555	$714	$345	$574
45	660	829	410	618
50	784	893	548	717
55	931	961	733	830
60	1,106	1,036	981	962
65	1,313	1,116	1,313	1,116
70	1,522	1,203	1,522	1,203
75	1,640	1,295	1,640	1,295
80	1,766	1,396	1,766	1,396

Health Care Cost Trend Rates: Health care trend measures the anticipated overall rate at which health plan costs are expected to increase in future years. The rates shown below are "net" and are applied to the net per capita costs shown above. The trend shown for a particular plan year is the rate that is applied to that year's cost to yield the next year's projected cost.

	Rate (%)	
Year Ending December 31,	Medical and Prescription Drug	Admin.
2014	7.50%	3.00%
2015	7.25%	3.00%
2016	7.00%	3.00%
2017	6.75%	3.00%
2018	6.50%	3.00%
2019	6.25%	3.00%
2020	6.00%	3.00%
2021	5.50%	3.00%
2022 & later	5.00%	3.00%

Medicare Part D Subsidy Assumption: GASB guidelines prohibit the offset of OPEB obligations by the future value of Medicare Part D subsides. Therefore, these calculations do not include an estimate for retiree prescription drug plan federal subsidies that the North Carolina State Health Plan may be eligible to receive for plan years beginning in 2006.

Retiree Contribution Increase Rate: Retiree contributions for medical and prescription drugs was assumed to increase at the same trend rate as medical and prescription drug cost.

Administrative Expenses: An administrative expense load of $253 per participant increasing at 3.0% per year was added to projected incurred claims cost in developing the benefit obligations.

Plan Design: Development of plan liabilities was based on the substantive plan of benefits in effect as described in Exhibit III.

Annual Maximum Benefits: There are no annual maximum benefits assumed.

Lifetime Maximum Benefits: There are no lifetime maximum benefits assumed.

Plan Enrollment Assumptions:

Non-Medicare

Plan	2014	2015	2016	2017	2018	2019+
Basic	44.3%	43.9%	46.1%	46.0%	48.2%	48.0%
Enhanced	53.9%	53.4%	50.6%	50.1%	47.2%	46.8%
CDHP	1.8%	2.7%	3.3%	3.9%	4.6%	5.2%

Medicare

Plan	Enrollment
Basic	24.7%
MA Base	47.6%
MA Enhanced	27.7%

Assumption Changes since Prior Valuation:

Medical and prescription drug claims cost were changed based on most recent experience.

Medical and prescription drug trend rates were changed to current schedule.

Enrollment assumptions were introduced to model expected migrations among plan options over the next few years.

EXHIBIT III

Summary of Plan

This exhibit summarizes the major benefit provisions as included in the valuation. To the best of our knowledge, the summary represents the substantive plans as of the measurement date. It is not intended to be, nor should it be interpreted as, a complete statement of all benefit provisions.

Eligibility:	Participants in the North Carolina State Health Plan for Teachers and State Employees who retire from the State, the University of North Carolina System, community colleges, local school systems, and certain other component units are eligible to continue to participate in the State Health Plan in retirement if they meet certain criteria. Former employees who are eligible to receive medical benefits are long-term disability beneficiaries of the Disability Income Plan of North Carolina (DIPNC) and retirees of the Teachers' and State Employees' Retirement System (TSERS), the Consolidated Judicial Retirement system (CJRS), the Legislative Retirement System (LRS), the University Employees' Optional Retirement Program (UEORP), and a small number of local governments. General retirement requirements are as follows: **Law Enforcement Officer:** ➢ age 50 and 15 years of service; ➢ age 55 and 5 years of service; or ➢ any age with 30 or more years of service. **All Others:** ➢ age 50 and 20 years of service; ➢ age 60 and 5 years of service; or ➢ any age with 30 or more years of service.
Benefit Types:	Basic, Standard and CDHP are offered to non-Medicare participants, and Basic, MA and MA+ are offered to Medicare eligible participants.
Duration of Coverage:	Lifetime for retirees and dependents
Dependent Benefits:	Same as retirees
Retiree Contributions:	Monthly contributions, effective January 1, 2014, are shown below.

For Retirees hired prior to October 1, 2006 (February 1, 2007 for legislators):

	Non-Medicare			Medicare		
	Basic	Standard	CDHP	Basic	MA	MA+
Retiree	$0.00	$63.56*	$40.00*	$0.00	$0.00	$33.00
Spouse	528.52	628.54	475.68	383.72	114.50	147.50

* Reduced by Wellness incentive credits for those who participate.

For Retirees hired after October 1, 2006 (February 1, 2007 for legislators), contributions are defined as a percentage of the total premium costs based on the following service based schedule:

Years of Service at Retirement	Retiree Contribution Percentage
5 – 9.99	100%
10 – 19.99	50%
20 or more	0%

100% of the total premium costs are show below:

	Non-Medicare			Medicare		
	Basic	Standard	CDHP	Basic	MA	MA+
Retiree	$448.11	$511.67*	$488.11*	$348.25	$114.50	$147.50
Spouse	528.52	628.54	475.68	383.72	114.50	147.50

* Reduced by Wellness incentive credits for those who participate.

Benefit Descriptions:

PPO Basic	In-Network	Out-Of-Network
Medical		
Annual Deductible	$933/$2,799	$1,866/$5,598
Coinsurance	70%	50%
Coinsurance Maximum	$3,793/$11,379	$7,586/$22,758
Lifetime Maximum	Unlimited	Unlimited
Office Visit copay		
Primary Care	$35	Ded. & coins.
Specialist	$81	Ded. & coins.
Urgent Care	$87	$87
Inpatient Hospitalization	$291 + ded. & coins.	Same as in-network
Outpatient Hospitalization	ded. & coins.	ded. & coins.
Emergency Room	$291 + ded. & coins.	Same as in-network
Chiropractic	$64	Ded. & coins.
Physical, Occupational or Speech Therapy	$64	Ded. & coins.
Mental Health, Chemical Dependency	$35	coins.

Prescription Drugs *(up to 30 day supply)*	
Tier 1	$12
Tier 2	$40
Tier 3	$64
Tier 4 (Preferred Specialty)	25% coins., $100 max.
Tier 5 (Non-Preferred Specialty)	25% coins., $125 max.
Brand drug with a generic equivalent	Tier 1 copay plus the difference in the cost to the Plan between the generic and brand name drug, not to exceed $100 per 30-day supply of the brand name medication.
Preferred diabetic testing supplies	$10
Non-Preferred diabetic testing supplies	$25
Out-of-Pocket Maximum	$2500

Coverage becomes secondary when former employees become eligible for Medicare.

PPO Standard	In-Network	Out-Of-Network
Medical		
Annual Deductible	$700/$2,100	$1,400/$4,200
Coinsurance	80%	60%
Coinsurance Maximum	$3,210/$9,630	$6,420/$19,260
Lifetime Maximum	Unlimited	Unlimited
Office Visit copay		
Primary Care	$30	Ded. & coins.
Specialist	$70	Ded. & coins.
Urgent Care	$87	$87
Inpatient Hospitalization	$233 + ded. & coins.	Same as in-network
Outpatient Hospitalization	ded. & coins.	ded. & coins.
Emergency Room	$233 + ded. & coins.	Same as in-network
Chiropractic	$52	Ded. & coins.
Physical, Occupational or Speech Therapy	$52	Ded. & coins.
Mental Health, Chemical Dependency	$30	coins.

Prescription Drugs *(up to 30 day supply)*	
Tier 1	$12
Tier2	$40
Tier 3	$64
Tier 4 (Preferred Specialty)	25% coins., $100 max.
Tier 5 (Non-Specialty)	25% coins., $125 max
Brand drug with a generic equivalent	Tier 1 copay plus the difference in the cost to the Plan between the generic and brand name drug, not to exceed $100 per 30-day supply of the brand name medication.
Preferred diabetic testing supplies	$10
Non-Preferred testing supplies	$25
Out-of-Pocket Maximum	$2500

Coverage becomes secondary when former employees become eligible for Medicare.

CDHP	In-Network	Out-Of-Network
Medical & Prescription Drug		
Annual Deductible	$1,500/4,500	$3,000/9,000
Coinsurance	85%	65%
Lifetime Maximum	Unlimited	Unlimited
HRA	$500/$1,500	$500/$1,500

MA	MA-PDP Basic	Humana MA-PDP Enhanced	UHC MA-PDP Enhanced
Medical			
Annual Deductible	$0	$0	$0
Coinsurance	80%	80%	80%
Coinsurance Maximum	$4,000	$2,600	$2,600
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Office Visit copay			
Primary Care	$20	$10	$10
Specialist	$40	$30	$35
Preventive Care	$0	$0	$0
Emergency Room	$65	$50	$50

Prescription Drugs			
Retail (up to 31 day supply)			
Tier 1	$10	$7	$5
Tier 2	$40	$35	$30
Tier 3	$64	$50	$40
Tier 4	25% coins., $100 max.	25% coins., $95 max.	25% coins., $95 max.
Out-of-Pocket Maximum	$2,500	$2,500	$2,500
Mail Order (up to 90 day supply)			
Tier 1	*$24*	*$14*	*$10*
Tier 2	*$80*	*$70*	*$60*
Tier3	*$128*	*$100*	*$80*
Tier 4	*25% coins., $300 max.*	*25% coins., $190 max.*	*25% coins., $200 max.*
Out-of-Pocket Maximum	*$2,500*	*$2,500*	*$2,500*

Plan Changes: None.

EXHIBIT IV

Definitions of Terms

The following list defines certain technical terms for the convenience of the reader:

Assumptions or Actuarial Assumptions: The estimates on which the cost of the Plan is calculated including:

(a) Investment return — the rate of investment yield that the Plan will earn over the long-term future;

(b) Mortality rates — the death rates of employees and pensioners; life expectancy is based on these rates;

(c) Retirement rates — the rate or probability of retirement at a given age;

(d) Turnover rates — the rates at which employees of various ages are expected to leave employment for reasons other than death, disability, or retirement.

Actuarial Present Value of Total Projected Benefits (APB): Present value of all future benefit payments for current retirees and active employees taking into account assumptions about demographics, turnover, mortality, disability, retirement, health care trends, and other actuarial assumptions.

Normal Cost: The amount of contributions required to fund the benefit allocated to the current year of service.

Actuarial Accrued Liability For Actives: The equivalent of the accumulated normal costs allocated to the years before the valuation date.

Actuarial Accrued Liability For Retirees: The single sum value of lifetime benefits to existing retirees. This sum takes account of life expectancies appropriate to the ages of the retirees and of the interest which the sum is expected to earn before it is entirely paid out in benefits.

Actuarial Value of Assets (AVA):	The value of assets used by the actuary in the valuation. These may be at market value or some other method used to smooth variations in market value from one valuation to the next.
Funded Ratio:	The ratio AVA/AAL.
Unfunded Actuarial Accrued Liability (UAAL):	The extent to which the actuarial accrued liability of the Plan exceeds the assets of the Plan. There is a wide range of approaches to paying off the unfunded actuarial accrued liability, from meeting the interest accrual only to amortizing it over a specific period of time.
Amortization of the Unfunded Actuarial Accrued Liability:	Payments made over a period of years equal in value to the Plan's unfunded actuarial accrued liability.
Investment Return (discount rate):	The rate of earnings of the Plan from its investments, including interest, dividends and capital gain and loss adjustments, computed as a percentage of the average value of the fund. For actuarial purposes, the investment return often reflects a smoothing of the capital gains and losses to avoid significant swings in the value of assets from one year to the next. If the plan is funded on a pay-as-you-go basis, the discount rate is tied to the expected rate of return on day-to-day employer funds.
Covered Payroll:	Annual reported salaries for all active participants on the valuation date.
ARC as a Percentage of Covered Payroll:	The ratio of the annual required contribution to covered payroll.
Health Care Cost Trend Rates:	The annual rate of increase in net claims costs per individual benefiting from the Plan.
Annual Required Contribution (ARC):	The ARC is equal to the sum of the normal cost and the amortization of the unfunded actuarial accrued liability.

Net OPEB Obligation (NOO): The NOO is the cumulative difference between the ARC and actual contributions made. If the plan is not pre-funded, the actual contribution would be equal to the annual benefit payments less retiree contributions. There are additional adjustments in the NOO calculations to adjust for timing differences between cash and accrual accounting, and to prevent double counting of OPEB plan costs.

EXHIBIT V

Accounting Requirements

The Governmental Accounting Standards Board (GASB) issued Statement Number 43 – *Financial Reporting for Postemployment Benefit Plans Other Than Pension Plans*, and Statement Number 45 – *Accounting and Financial Reporting by Employers for Postemployment Benefits Other Than Pensions*. Under these statements, all state and local government entities that provide other post employment benefits (OPEB) are required to report the cost of these benefits on their financial statements. The accounting standards supplement cash accounting, under which the expense for postemployment benefits is equal to benefit and administrative costs paid on behalf of retirees and their dependents (*i.e.*, a pay-as-you-go basis).

The statements cover postemployment benefits of health, prescription drug, dental, vision and life insurance coverage for retirees; long-term care coverage, life insurance and death benefits that are *not* offered as part of a pension plan; and long-term disability insurance for employees. The benefits valued in this report are limited to those described in Exhibit III of Section 4, which are based on those provided under the terms of the substantive plan in effect at the time of the valuation and on the pattern of sharing costs between the employer and plan members. The projection of benefits is not limited by legal or contractual limits on funding the plan unless those limits clearly translate into benefit limits on the substantive plan being valued.

The new standards introduce an accrual-basis accounting requirement, thereby recognizing the employer cost of postemployment benefits over an employee's career. The standards also introduce a consistent accounting requirement for both pension and non-pension benefits.

The total cost of providing postemployment benefits is projected, taking into account assumptions about demographics, turnover, mortality, disability, retirement, health care trends, and other actuarial assumptions. These assumptions are summarized in Exhibit II of Section 4. This amount is then discounted to determine the actuarial present value of the total projected benefits (APB). The actuarial accrued liability (AAL) is the portion of the present value of the total projected benefits allocated to years of employment prior to the measurement date. The unfunded actuarial accrued liability (UAAL) is the difference between the AAL and actuarial value of assets in the Plan.

Once the UAAL is determined, the Annual Required Contribution (ARC) is determined as the normal cost (the APB allocated to the current year of service) and the amortization of the UAAL. This ARC is compared to actual contributions made and any difference is reported as the Net OPEB Obligation (NOO). In addition, Required Supplementary Information (RSI) must be reported, including historical information about the UAAL and the progress in funding the Plan. Exhibits IV and VI of Section

4 contain a definition of terms as well as more information about GASB 43/45 concepts.

The calculation of an accounting obligation does not, in and of itself, imply that there is any legal liability to provide the benefits valued, nor is there any implication that the Employer is required to implement a funding policy to satisfy the projected expense.

Actuarial calculations reflect a long-term perspective, and the methods and assumptions use techniques designed to reduce short term volatility in accrued liabilities and the actuarial value of assets, if any.

Actuarial valuations involve estimates of the value of reported amounts and assumptions about the probability of events far into the future, and the actuarially determined amounts are subject to continual revision as actual results are compared to past expectations and new estimates are made about the future.

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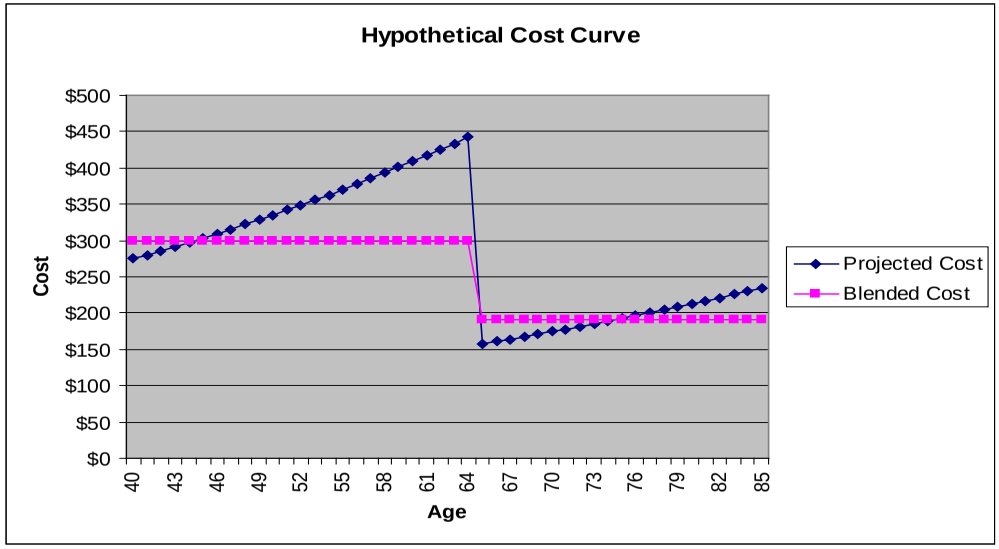
EXHIBIT VI

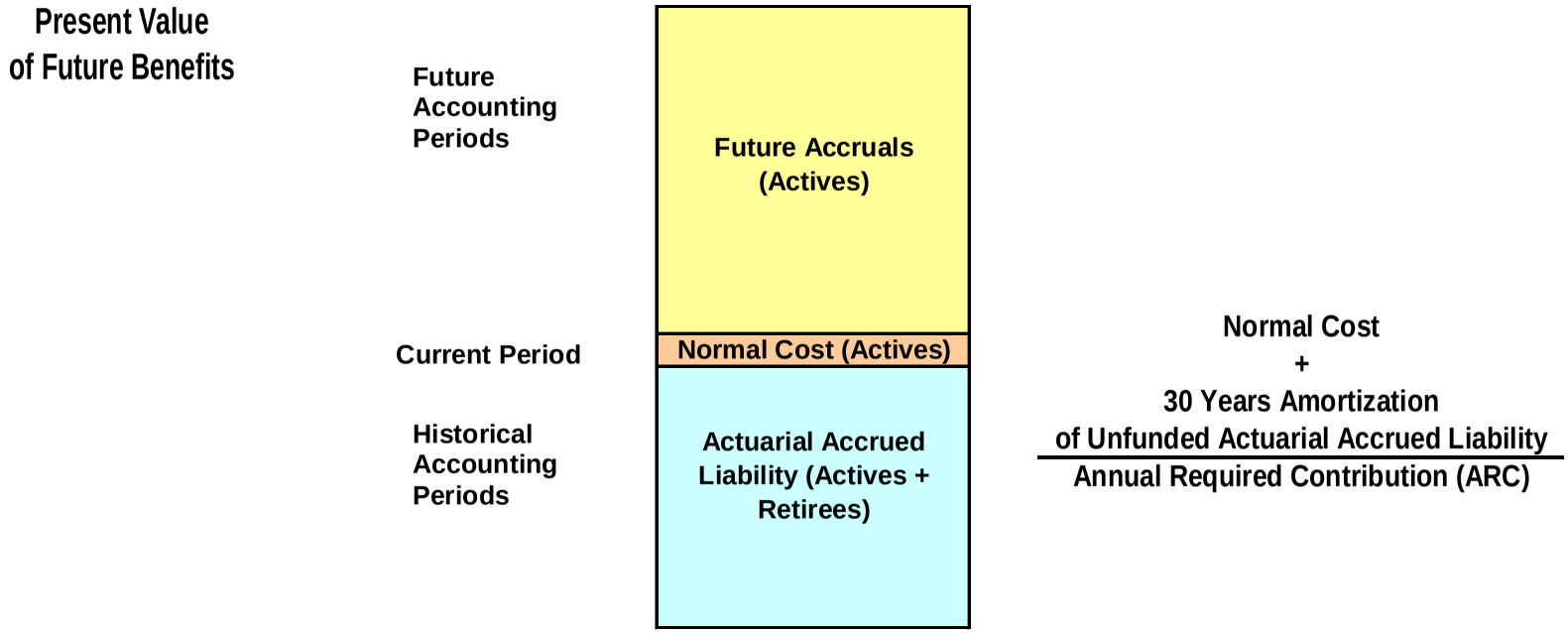
GASB 43/45 Concepts

The following graph illustrates why a significant accounting obligation may exist even though the retiree contributes most or all of the blended premium cost of the plan. The average cost for retirees is likely to exceed the average cost for the whole group, leading to an implicit subsidy for these retirees. The accounting standard requires the employer to identify and account for this implicit subsidy as well as any explicit subsidies the employer may provide.



This graph shows how the actuarial present value of the total projected benefits (APB) is broken down and allocated to various accounting periods. The exact breakdown depends on the actuarial cost method and amortization methods selected by the employer.

GASB 43/45 Measurement Elements Using Actuarial Cost Methods



Net OPEB Obligation = $ARC_1 + ARC_2 + ARC_3 + \ldots\ldots$

$- Contribution_1 - Contribution_2 - Contribution_3 - \ldots\ldots$

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

Summary of Audit Results

Board of Trustees Meeting

November 20, 2014

Presentation Overview

- Audit Process
- Medical Claims Audits
- BCBSNC Administrative Costs
- Pharmacy Audits
- ERRP Audit

Why Do We Conduct Audits?

- To ensure contractual compliance
- To identify pricing errors
- To assess vendors' internal controls
- To validate benefit design is administered correctly
- To validate vendor performance guarantees
- To comply with State laws/regulations

Audit Process

Audit Workflow

Audit Plan

- Determine objective and scope
- Assessment of data needs
- Establish timeframes

Conduct Audit

- Review data
- Onsite fieldwork

Findings

- Document findings
- Root cause analysis
- Establish corrective action plan

Finalized Audit Report

- Review
- Recommend changes or improvements
- Sign off

Follow Up

- Monitor correction plan
- Collect funds for missed performance guarantees

Medical Claims Audits

Medical Claims Audit Overview

- **Objectives:**
  - To determine if claims are processed and paid by the Third Party Administrator (TPA) in accordance with the contract
  - To determine whether the TPA met claims accuracy performance guarantees (an annual medical claims processing financial accuracy rate of 99%, payment accuracy rate of 99% and a process accuracy rate of 97% for the contract ended June 30, 2014)
- **Auditor**:
  - Thomas & Gibbs CPAs, PLLC
- **Frequency**:
  - Quarterly, with an annual report delivered at the end of each fiscal year
- **Methodology**:
  - "Standard" and "focused" audits of statistically valid, random samples of medical claims are audited for processing and pricing accuracy
- **Status**:
  - Thomas & Gibbs has completed the FY 2013-14 reports

Medical Claims Audit Findings and Follow-up

July 2013 - June 2014						
	Performance Guarantee	QE 9/30/13	QE 12/31/13	QE 3/31/14	QE 6/30/14	Fiscal Year 2013-14
Standard Medical Claims Audit						
Processing Accuracy Rate	97%	98.00%	97%	100.00%	100.00%	98.67%
Payment Accuracy Rate	99%	99.00%	99%	100.00%	100.00%	99.33%
Financial Accuracy Rate	99%	99.93%	99.76%	100.00%	100.00%	99.89%
"Focused Audit" Duplicate Claims						
Processing Accuracy Rate	N/A	92.00%	98.67%	100.00%	100.00%	N/A
Payment Accuracy Rate	N/A	93.33%	100.00%	100.00%	100.00%	
Financial Accuracy Rate	N/A	99.79%	100.00%	100.00%	100.00%	
"Focused Audit" Coordination of Benefits						
Processing Accuracy Rate	N/A	93.33%	96.48%	99.29%	98.59%	N/A
Payment Accuracy Rate	N/A	93.33%	96.48%	100.00%	98.59%	
Financial Accuracy Rate	N/A	99.85%	99.84%	100.00%	99.99%	

Processing Accuracy Rate is the number of claims processed with no procedural errors divided by the total number of claims processed.

Payment Accuracy Rate is the number of claims with the correct benefit dollars paid divided by the total number of claims paid in the audit sample.

Financial accuracy is the total dollar amount in the audit sample processed accurately divided by the total dollar amount processed in the audit sample. Absolute dollar amounts are used so underpayments do not offset overpayments.

Follow-up: Some audit errors uncover more systematic or process issues that need further review. When necessary, the Plan works with the TPA to develop a corrective action plan. Once developed, the Plan does three-month, six-month and annual follow-up reviews with BCBSNC to monitor action plan results.

Medical Claims Audit - Quality Management Reviews

- The Plan's Quality Team performs additional TPA process quality checks throughout the year. Here is a list of TPA processes that were reviewed:
  - Duplicate Claims
  - Debt Set Off
  - Medicare Claims Processing Accuracy
  - Retro-Termination Processing

BCBSNC Administrative Costs

BCBSNC Administrative Costs

- **Purpose**:
  - To determine the validity of BCBSNC's administrative charges, including both direct and indirect charges under the former Administrative Services Agreement (ASA)
  - To ensure the Plan did not reimburse BCBSNC for un-allowed costs
  - To ensure the Plan was not charged implementation costs associated with the new TPA contract that began July 1, 2013
- **Auditor**:
  - Thomas & Gibbs CPAs, PLLC
- **Frequency:**
  - Annual, following the end of each fiscal year under the "cost plus" ASA
- **Methodology:**
  - For the Fiscal Year 2012-2013 audit, auditors reviewed supporting documentation for 128 transactions totaling approximately $21 million in costs
- **Status:**
  - The Fiscal Year 2012-2013 audit was the final annual audit of the BCBSNC cost plus contract; no further BCBSNC administrative audits are planned at this time

BCBSNC Administrative Costs Findings

- **Findings (FY 2012-13 report)**
  - Administrative costs billed to the Plan totaled $108.3 million and were less than:
    - BCBSNC administrative fees in the prior fiscal year; and
    - The cost plus cap established for the fiscal year
  - None of the 128 audited transactions were found to be invalid
  - BCBSNC's methodology for excluding implementation costs provided "reasonable assurance" that implementation costs for the new TPA contract were not billed to the Plan under the cost plus ASA
    - The methodology was not applied to the costs for some of the BCBSNC staff whose time is dedicated exclusively to the Plan (BCBSNC Dedicated Unit)

BCBSNC Administrative Costs Follow-up

- **Follow-up/Outcome:**
  - In its response to the audit findings, BCBSNC stated they were working under the impression there was an understanding with the Plan that dedicated resources would not track their time relative to new contract implementation.
  - The Plan disagrees with BCBSNC and maintains there was no preexisting agreement on how to account for costs associated with BCBSNC staff specifically dedicated to administration of the Plan.
  - Because BCBSNC employees in the Dedicated Unit did not identify and record time associated with the new contract implementation, there is no way to attach a dollar amount to this finding.

Pharmacy Audits

Pharmacy Audits

Audits Conducted on the Pharmacy Benefit Manager:

- Pharmacy Financial Audit
- Pharmacy Claims Audit
- Pharmacy Benefit Manager Rebate Audit

Pharmacy Financial Audit Overview

- **Objectives:**
  - To verify the Pharmacy Benefit Manager (PBM) (Express Scripts/ESI) has adjudicated pharmacy claims consistent with the pricing terms indicated in the contract
  - To determine whether the PBM met the financial performance guarantees
- **Auditor:**
  - The Segal Company
- **Frequency:**
  - Quarterly with an annual report delivered after the contract year
- **Methodology:**
  - Detailed biweekly pharmacy claims files are analyzed for pricing and invoicing accuracy
- **Status:**
  - Contract year October 1, 2012- September 30, 2013 completed

Pharmacy Audit Components

- **Invoice reconciliation:** A claims data file covering the period of review is received from ESI and compared to invoice records obtained from ESI and also matched to the SHP's paid PBM invoice report.

- **Claims Average Wholesale Price (AWP):** The AWP reported for each claim by ESI is examined and compared to the AWP independently obtained from Medi-Span, using an 11-digit national drug code (NDC) and actual dispensing date for each claim.

- **Dispensing Fees:** Test of dispensing fee guarantees involves aggregating total dispensing fees paid for all non-member resubmitted claims filled at mail and retail pharmacies and comparing the actual dispensing fee changed to the amount expected based on the contractual guarantee.

- **Discount guarantees:** Claims are aggregated according to terms of the agreement. Claims excluded from discount guarantees are identified and separated from all other claims. The contract terms state that the discount and dispensing fee guarantees are guaranteed on a dollar-for-dollar basis. ESI may not offset a shortfall generated in one guarantee category (retail/mail, brand/generic) with a surplus generated in another.

- **Duplicate Claims:** Criteria is applied to identify duplicate claims, including same member ID, same date of service, and same national drug code (NDC).

Pharmacy Audit Components Results

	QE 12/31/12	QE 3/31/13	QE 6/30/13	QE 9/30/13	Contract Year
Invoice Reconciliation	No issues noted	No issues noted	No issues noted	No issues noted	No issues noted
AWP	No issues noted	No issues noted	No issues noted	No issues noted	No issues noted
Dispensing fee	Shortfall in aggregate dispensing fee noted	Shortfall in aggregate dispensing fee noted	Shortfall in aggregate dispensing fee noted	Shortfall in aggregate dispensing fee noted	Shortfall in aggregate dispensing fee noted
Aggregate achieved discount	Shortfall in aggregate discount noted	Shortfall in aggregate discount noted	Shortfall in aggregate discount noted	Shortfall in aggregate discount noted	Shortfall in aggregate discount noted
Specialty drug discount	No issues noted	No issues noted	No issues noted	No issues noted	No issues noted
Duplicate Claims	No issues noted	No issues noted	No issues noted	No issues noted	No issues noted

At the end of the contract year, the PBM is required to reconcile with the Plan any shortfall of financial guarantees. For contract year ending September 30, 2013 Segal identified a $4.5 million shortfall in financial discounts for achieved discounts and dispensing fees.

Pharmacy Claims Audit Overview

- **Objectives:**
  - To determine if claims are processed and paid by the PBM in accordance with the contract
  - To determine whether the PBM met the claims accuracy performance guarantee (an annual pharmacy claims processing error rate of no more than 1.5%)
- **Auditor:**
  - Thomas & Gibbs CPAs, PLLC
- **Frequency:**
  - Quarterly, with an annual report delivered at the end of each fiscal year
- **Methodology:**
  - Statistically valid, random samples of pharmacy claims are audited for processing and pricing accuracy
- **Status:**
  - Thomas & Gibbs has completed the FY 2013-14 reports

Pharmacy Claims Audit Findings

July 2013 - June 2014					
	Performance Guarantee	QE 9/30/13	QE 12/31/13	QE 3/31/14	QE 6/30/14
Processing error rate	1.5% or less	0.00%	0.00%	0.00%	0.00%
Payment error rate	1.5% or less	0.00%	0.00%	0.00%	0.00%
Financial accuracy	99% or higher	100.00%	100.00%	100.00%	100.00%

Processing error rate is the total number of claims noted with claim payment errors divided by the total number of claims in the sample.

Payment error rate is the total absolute dollar amount of overpayments or underpayments resulting from errors in the claims tested divided by the total dollar amount of claims in the sample.

Financial accuracy is the total dollar amount in the audit sample processed accurately divided by the total dollar amount processed in the audit sample. Absolute dollar amounts are used so underpayments do not offset overpayments.

Pharmacy Rebate Audit

- **Objective:**
  - To verify that contractual requirements between the Plan and PBM have been met and that payments provided under the Plan's rebate payment agreement validate rebate history
- **Auditor:**
  - The Segal Company
- **Frequency:**
  - Annual
- **Methodology:**
  - Auditor will select six to ten major pharmaceutical manufacturers working with the PBM and review PBM's contracts with the manufacturers to ensure that all manufacturer rebates are passed back to the Plan as required by the contract
- **Status:**
  - Completed June 30, 2014
- **Results:**
  - The Plan received rebate payments as contracted for the 4th Quarter 2011 through the 3rd Quarter 2012 for the top eight manufactures audited

Early Retiree Reinsurance Program (ERRP) Audit

Early Retiree Reinsurance Program Audit

- **Background**:
  - ERRP was one of the components of health care reform. The program offered an incentive for employers to continue coverage for early retirees.
  - The Plan received $87 million in ERRP reimbursements for early retirees with incurred claims between $15,000 and $90,000 in a plan year between June 2010 and December 2011.
- **Objective:**
  - To ensure the Plan met ERRP program requirements and reimbursements received were for claims incurred by early retirees
- **Auditor:**
  - Centers for Medicare and Medicaid Services (CMS)
- **Frequency:**
  - One time audit
- **Status:**
  - Program requirements portion was completed in 2012
  - Claims audit (both medical and pharmacy) was conducted in February 2014

ERRP Audit Findings and Follow-Up

Validity of Claims and Eligibility of Early Retirees, Spouses, and Dependents

- **Finding*:*** Based on a paid claims universe of 552,359 items representing $86,901,860 in ERRP reimbursement, a stratified random sample of 255 items were selected to review the validity of claims submitted for ERRP reimbursement. Two (2) claims of the 255 items in the sample were identified as overstated.
- **Plan Response**: The Plan agrees that the appropriate adjustments were not submitted for these claims. While other adjustments from this period were submitted, the adjustments identified in the audit sample were processed by the Plan's Third Party Administrator after the final ERRP reimbursement for that plan year was submitted.
  - The Plan promptly reimbursed the overpayment in the amount of $1,949.29 upon receipt of payment instructions from CMS.

Completeness and Timeliness of Delivery

- **Finding:** The envelope used for the 2011 Annual Enrollment package, which included the plan participant notice (PPN), only included the plan participant's name and was not addressed to the spouse/dependents or "and family" as required by the ERRP guidance.
- **Finding:** The Plan sponsor sent out PPNs in a reasonable amount of time after the first reimbursement from the ERRP, but failed to send additional PPNs to the new participants after the initial mailing in April, 2011.
- **Plan Response**: The Plan agrees with both of these findings. The mail file should have been updated to include the appropriate information, and additional mailings should have been processed to address newly eligible members.

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

Diabetes and Chronic Disease Legislative Reports

Board of Trustees

November 20, 2014

2013 Legislation

Session Law 2013-192, Senate Bill 336

An Act requiring the Divisions of Medical Assistance (DMA) and Public Health (DPH) within the Department of Health and Human Services and the State Health Plan Division within the Department of State Treasurer to coordinate the diabetes programs they each administer; To develop plans to reduce the incidence of diabetes, to improve care, and to control complications; and to report to the Joint Legislative Oversight Committee on Health and Human services and the Fiscal Research Division.

Session Law 2013-207, House Bill 459

An Act requiring the Department of Health and Human Services to coordinate chronic disease care; the Department's Division of Public Health, Medical Assistance and the State Health Plan Division within the Department of State Treasurer shall collaborate to reduce the incidence of chronic disease and improve chronic disease care coordination within the State.

Reports due to legislature on or before January 1, 2015 , and then progress to be reported on January 1st of each odd numbered year (2017).

Required Components in Reports

- Financial impact and magnitude of chronic conditions
- An assessment of benefits derived from wellness and prevention programs implemented within the State
- A description of the level of coordination among the Divisions of Public Health, Medical Assistance and the State Health Plan
- Action plans for care coordination of multiple chronic conditions, with specific focus on the following:
  - Adjustment of hospital readmission rates
  - Development of transition of care programs
  - Implementation of comprehensive Medication Therapy Management (MTM)
  - Adoption of standards related to quality and expected outcomes

Current Coordination in Diabetes Prevention and Control

- Development of a business case to provide Diabetes Self-Management Education (DSME) and access to Certified Diabetes Educators (CDE) as covered benefits
- Collaboration with DPH and BCBSNC to distribute hypertension and diabetes clinical guidelines to the State Health Plan's network of providers.
- Collaboration in the development of a campaign to raise awareness on pre-diabetes among Plan members and increase early identification and treatment.
- Potential collaboration with DPH on assessment of worksite wellness and the development of sustainable and replicable models of worksite wellness programs.
- Some Diabetes Education Recognition Program (DERP) sites coordinate with DMA's vendor, Community Care of North Carolina to teach classes and to refer patients to DSME.

Increasing Coordination for Diabetes Management

Action Items

- Develop a combined campaign to increase awareness of pre-diabetes and diabetes, and promote evidence-based diabetes self-management education among North Carolinians.
- Evaluate and enhance the benefit design of the State Health Plan and DMA covered plans to impact the identification, and improved management of diabetes and prediabetes.
- Promote third party coverage of Diabetes Prevention Lifestyle Change Programs for persons with pre-diabetes.
- Support and foster a statewide network of recognized DSME providers through training and certification.
- Establish common quality metrics that will monitor the prevalence, impact and complications associated with prediabetes and diabetes across the State.

Current Coordination in Chronic Disease Management

- Tobacco Prevention and Control- Utilization of QuitlineNC resources and Nicotine Replacement Therapy (NRT) products
- Plan members have access to Eat Smart, Move More, Weigh Less, a 15-week adult weight management program
- Participation in Justus-Warren Heart Disease and Stroke Prevention Task Force and development of Comprehensive Plan for Management of Heart Disease and Stroke
- Working with Asthma Alliance of North Carolina and the implementation of evidence-based asthma management strategies
- All diabetes related coordination , as detailed on slide 4

Increasing Coordination in Chronic Disease Management

Action Items

- Continue to manage QuitlineNC to Plan and Medicaid eligible tobacco users who want to quit in order for them to have access to evidence-based tobacco cessation services and provide technical assistance to improve the quality of those services.

- Work together with Plan and Medicaid to promote QuitlineNC (1-800-QuitNow) to ensure all Plan and Medicaid eligible tobacco users who want to quit are aware of this service, through clinic referrals, earned media, social media and other communication channels to Plan and Medicaid members.

- Support the continued development and dissemination of a comprehensive statewide “Know your Numbers” campaign for providers, beneficiaries of Medicaid and Plan members.

Increasing Coordination for Chronic Disease Management

Action Items

- Continue to promote and deliver evidence-based weight management programs such as Eat Smart, Move More, Weigh Less among Medicaid beneficiaries, Plan members, and other North Carolinians who are at-risk for chronic conditions due to weight maintenance issues.

- Expand and refine the current transition of care programs offered to members to address inpatient admission, readmission and emergency department admission rates among Plan members.

- Explore continued opportunities for Pharmacists to work in conjunction with Physician practices to support the management of chronic conditions.

Increasing Coordination for Chronic Disease Management

State Health Plan Specific Action Items

- **Value Based Benefit Design Review**–Evaluate opportunities to redesign pharmacy and medical benefits to incentivize effective chronic disease management.

- **Medication Therapy Management (MTM) Vendor Resource Evaluation**–Identify MTM resources and evaluate the capabilities of each to coordinate care within the Patient Centered Medical Home (PCMH) and integrate care across the spectrum of the Plan's services.

- **Financial Analysis**–Evaluate the MTM services identified by the Plan as essential to offer including transitional care support and PCMH coordination, to propose a reimbursement methodology to pay pharmacists and/or vendors based on clinical outcomes and performance.

Expected Outcomes

- Increased early detection and screening (breast, cervical cancer, CVD risk factors, renal disease)
- Increased cost savings from reduced hospital and Emergency Department (ED) utilization
- Improved adherence to medication regimens
- Increased referrals to and participation of members in smoking cessation and Active Life Coaching (ALC) programs provided by the Plan's partners and Population Health Management vendor
- Expanded and refined transitional care programs to reduce inpatient readmissions and emergency department admissions among high priority Plan members

Expected Outcomes

- Completed environmental scan for medication therapy management (MTM) services and identification of potential value based pharmacy benefit design for chronic disease care among Plan members
- Defined plan for MTM services and initiation of contract procurement for the State Health Plan, if current vendor resources do not support the Plan
- Availability of evidence-based strategies including home assessments for high risk members with Asthma
- Availability of evidence-based strategies for Diabetes Self-Management Education, such as Diabetes Prevention Program, and access to Certified Diabetes Educators for members with diabetes

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

Comparative Analysis of State Health Plans

Board of Trustees Meeting

November 21, 2014

Presentation Overview

- Executive Summary
- Selected States for Comparison
  - Original List
  - Value Based State Comparison
- Comparative Analysis Methodology
- Comparative Analysis
  - Comparator States
- States Incorporating Value Based and other Innovative Strategies
- Emerging Conclusions

Executive Summary

Purpose

As part of the Strategic Planning process, the Strategic Planning Workgroup and Board of Trustees requested an environmental scan of state health plans in other states to compare the North Carolina State Health Plan

- This has been updated to provide guidance to the 2016 Benefit planning process

Approach

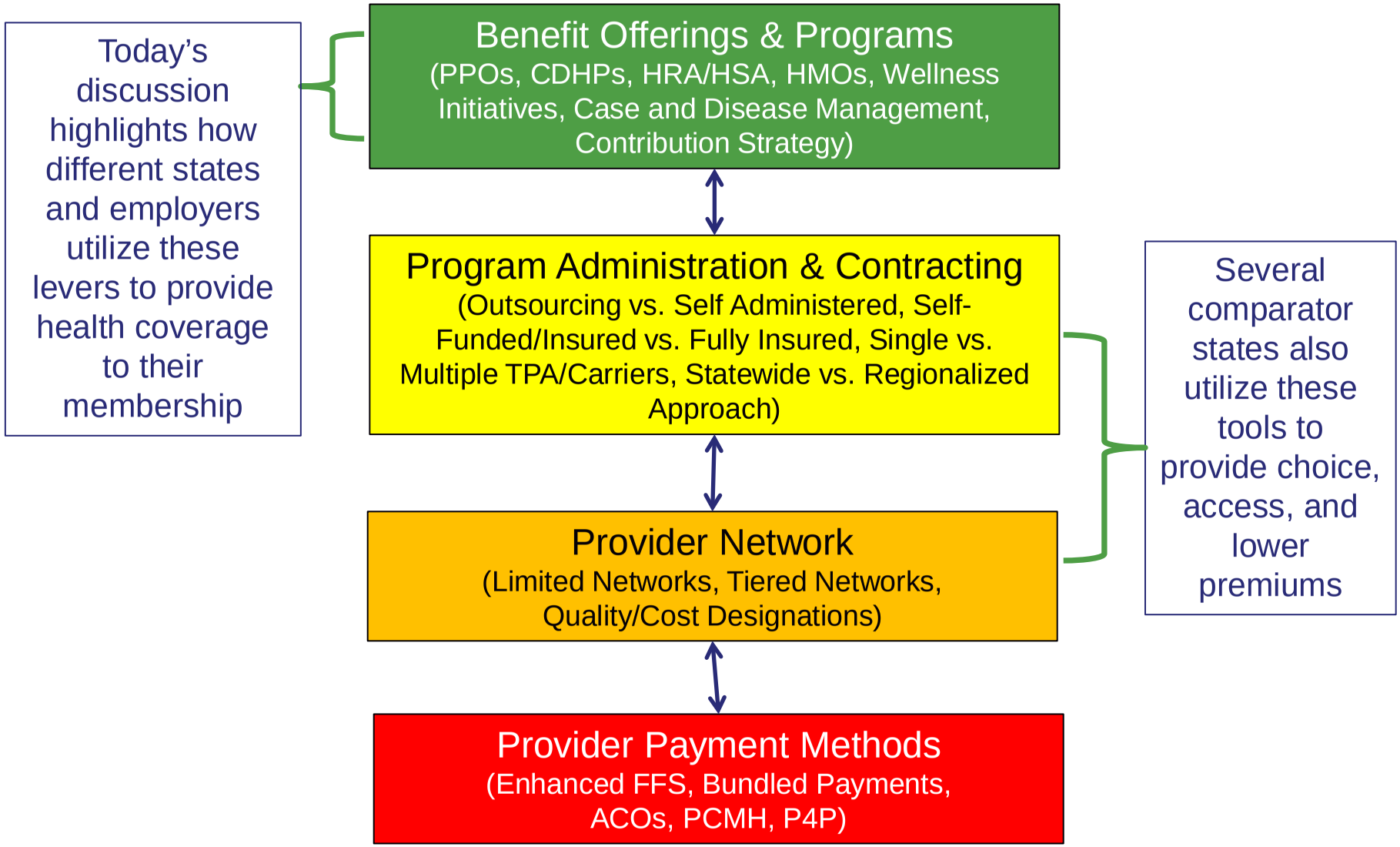
The Plan investigated the following factors:

- Plan richness (analysis by Segal)
- Premium cost sharing (analysis by Segal)
- Healthy lifestyle benefits
- Number of coverage choices

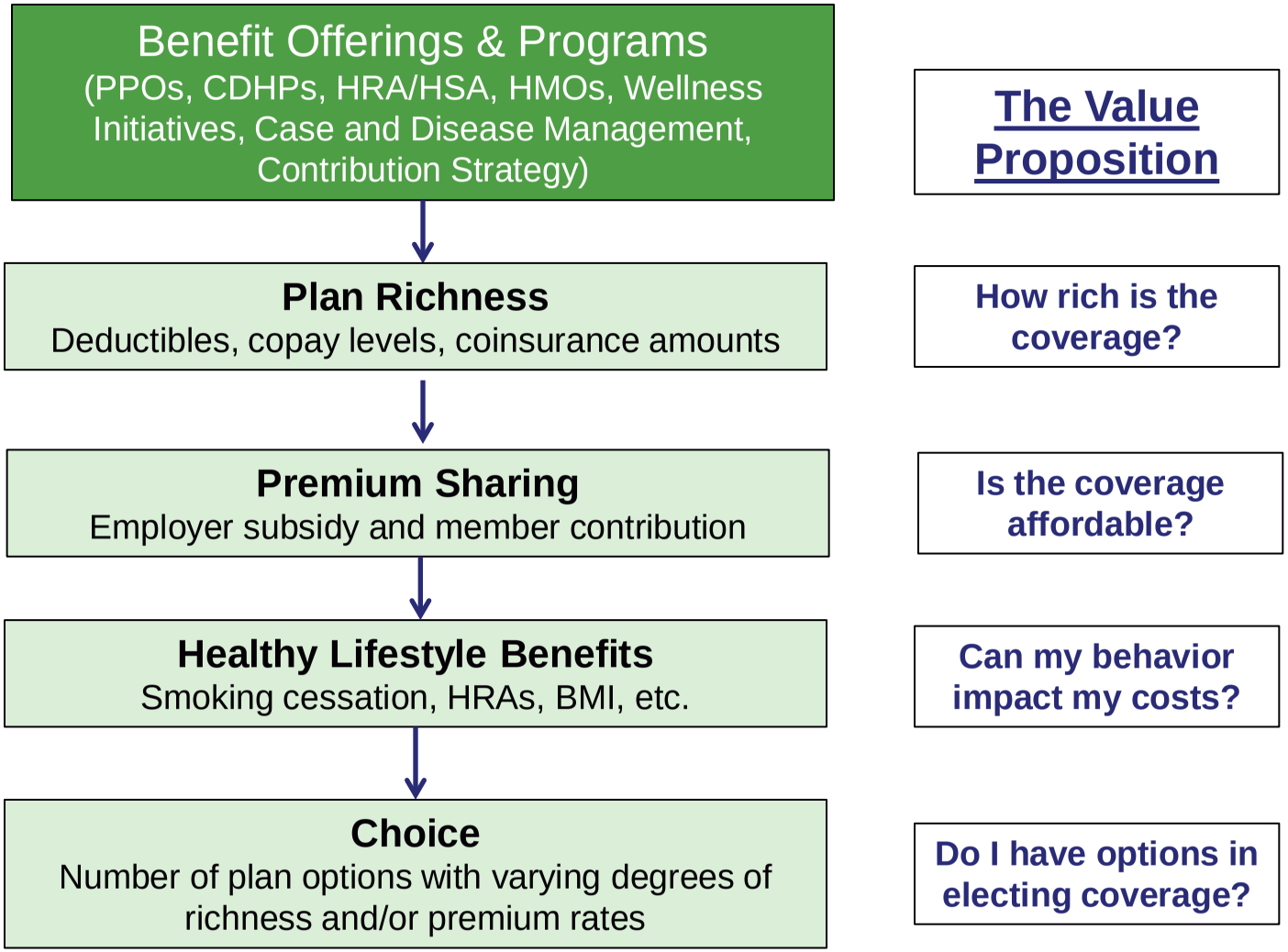
Key Findings (*related to other state health plans*)

- Comparatively, the Plan provides employees/retirees generous and affordable health benefits. However, coverage for dependents does not compare favorably
- Healthy lifestyle benefits continue to expand in states with many providing detail on how these plans will grow each year
  - States are requiring more participation to receive credits
- States are incorporating Value Based Insurance Design (VBID) -like components into their designs. SHP is near the top of the curve
- Low premium increases across the country

Methods to Address the Triple Aim & the Cost of Health Benefits



Value Proposition to Members and Points of Comparison



Selected Comparator States

Comparator States

(lowest and highest premium offerings)

Based on proximity to NC

- Georgia
- Kentucky
- Tennessee
- South Carolina
- Virginia

Based on size of state population and other factors

- Arizona
- Maryland
- Michigan
- Ohio
- Wisconsin

States with Value Based Initiatives

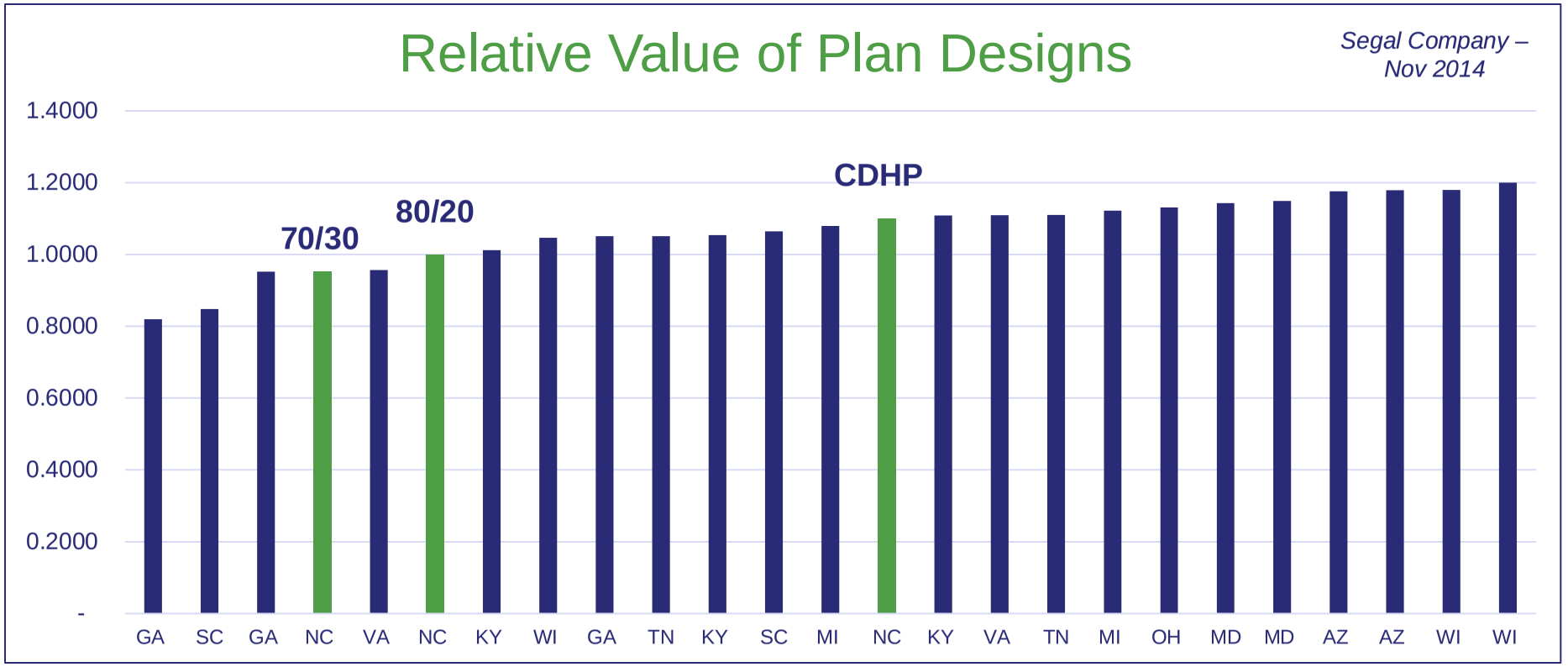
- Connecticut
- Kentucky
- Minnesota
- Oregon
- Tennessee
- West Virginia

Comparing Health Benefits – Plan Richness

How much does the average person pay out-of-pocket when they utilize their benefit?

- Comparing the actuarial value, or plan value, of each state's offerings provides a method to understand the average portion of claims costs a benefit design would pay for:
  - deductible,
  - coinsurance,
  - out-of-pocket maximums,
  - copays, and
  - out-of-network benefits (some states offer closed network plans)
- As many individuals make their benefit design election based on premium cost, we looked at the highest and lowest premium offerings available in the comparison states and benchmarked them against the 80/20 plan
- For NC the CDHP and 70/30 plans were included in the analysis
- No set methodology for incorporating value-based designs

Relative Plan Richness



- The relative value of NC's options is increasing as some States scale back or offer less rich options/plan designs. The relative value of the CDHP has improved most significantly compared to the previous analysis.
- Although the CDHP offers a relatively rich benefit, approximately 97% of Plan members are enrolled in the 70/30 or 80/20.

Are the 70/30 and 80/20 plans too similar? Should members be offered more significant choice?

Financing Health Benefits

- Each state government finances health coverage for their membership differently
  - Most states provide direct subsidies for dependent coverage
    - Fixed subsidy by tier or dependent
    - Percentage of premium
  - Some states have collective bargaining that impacts decision making

- NC's contribution strategy differs from most other states
  - Significant subsidies for employee and retiree only coverage
  - Employees and retirees pay full premium cost for dependents, but the State's contribution does provide an indirect subsidy
  - Changes to the State's contribution approach could impact expected Plan costs and the long-term sustainability of the Plan
    - Positively or negatively

Comparing Health Benefits – Premium Sharing

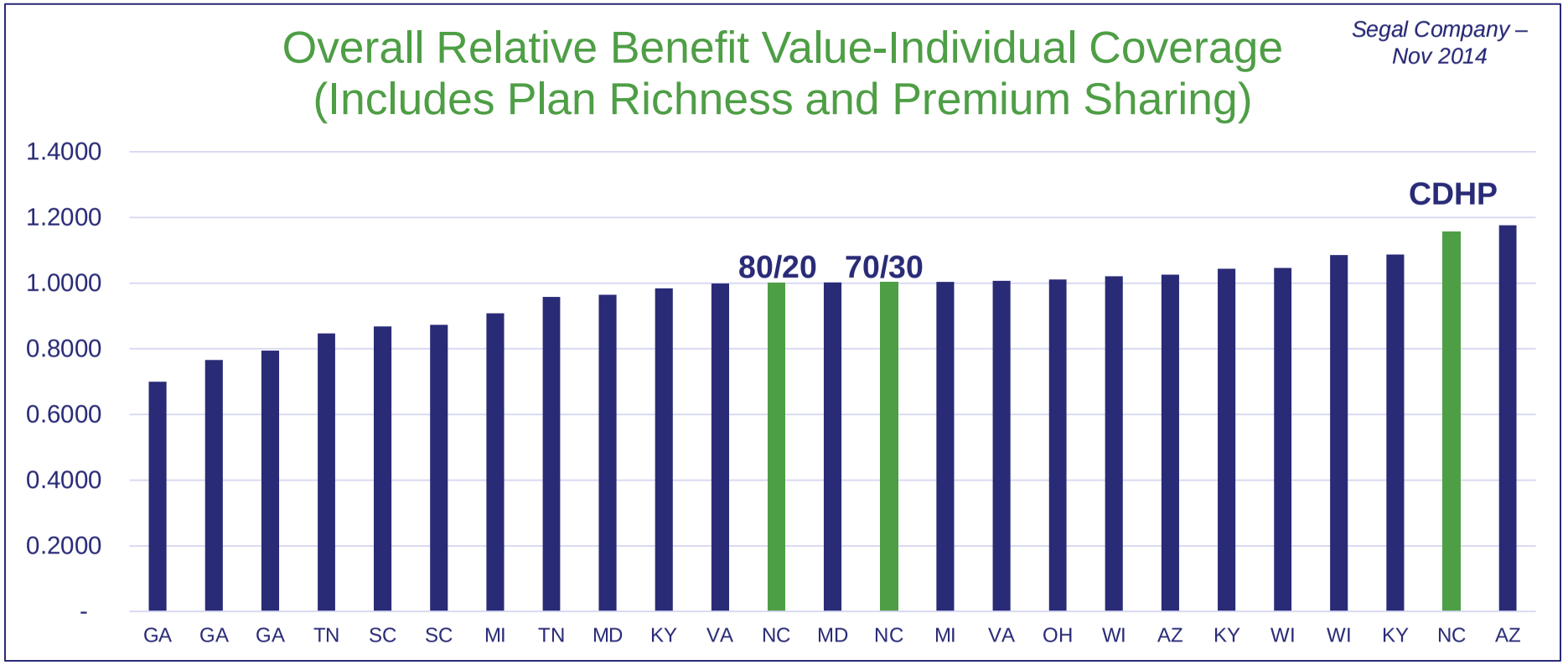
How can employer subsidies and member premiums be incorporated?

- In addition to determining the value of the plan design, which represents the out-of-pocket exposure, the analysis included the individual's premium share to reflect average person's total cost exposure
  - The percentage of premium paid by each state for each plan combined with relative plan value determines the *Overall Relative Benefit Value* of the benefit offering

Caveat:

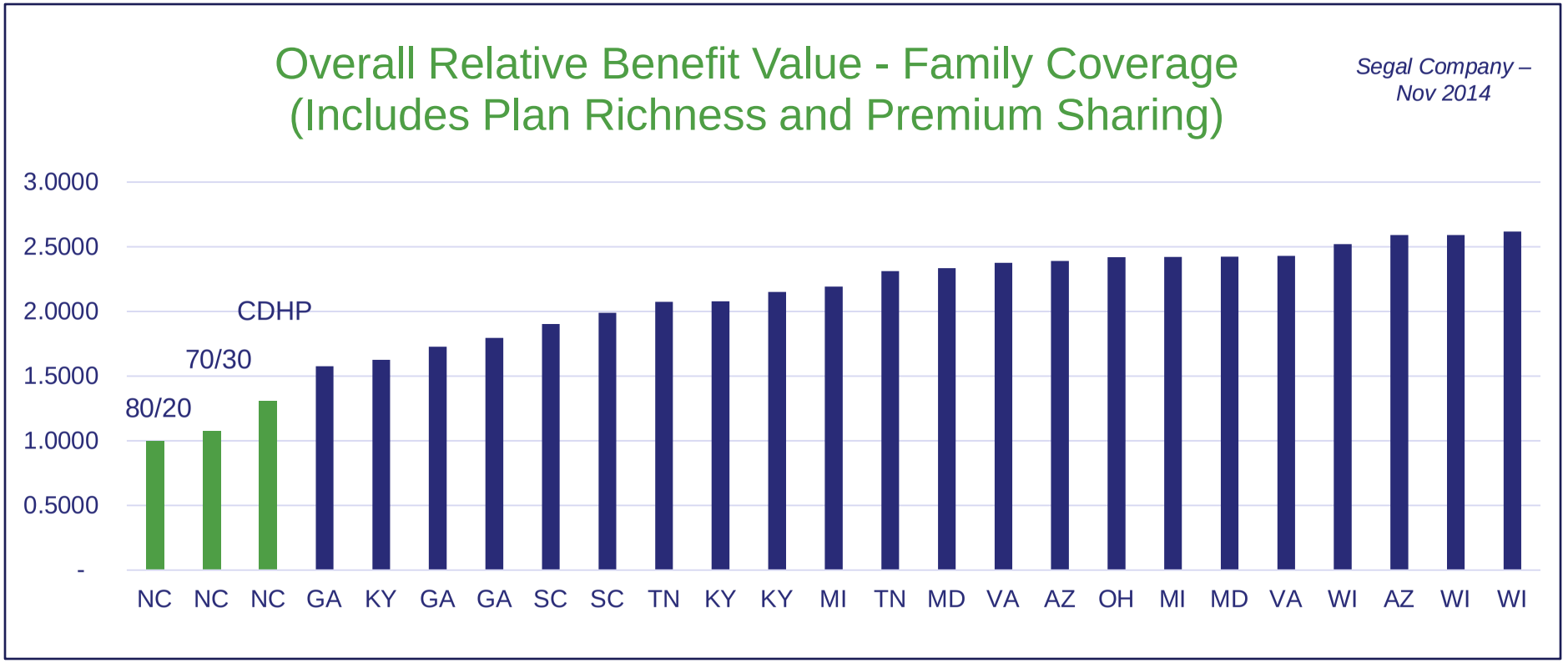
- Plan values are proxies for the anticipated average portion of claims cost covered by the benefit; the actual experience of low and high utilizers will vary

Relative Overall Benefit Value – Individual Coverage



- When premiums are considered, NC's options continue to provide high relative overall value, with the CDHP among the most generous benefit offerings, prior to factoring in value-based incentives such HRA credits for PCP visits.

Relative Overall Benefit Value – Family Coverage



- Historically, NC has not provided direct subsidies for dependent coverage while the median family subsidy of benchmarked states was 83% of total family premium (up from 81%)
- NC contributes between 39% and 47% of the cost of family premiums (through the State's employer contribution)

Trends in Comparative Analysis

Coverage Level	States ranked less favorable	States ranked more favorable
Individual	• Lower employer subsidy • Higher out-of-pocket costs • Higher coinsurance percentage for employees	• Lower deductibles • Use of closed networks • Out-of-pocket maximum versus coinsurance maximums • More favorable mail order differential in Rx (2x copay versus 3x copay)
Family	• Higher premiums • Less generous coverage	• **Dependent subsidies** • Lower deductibles • Use of closed networks • Out-of-pocket maximum versus coinsurance maximums • More favorable mail order differential in Rx (2x copay versus 3x copay)

Healthy Lifestyle Benefits Comparison

- State health plans continue to incorporate healthy life benefits into their plan design to address the growing cost of health care and to increase member engagement
- 80% of comparator states had at least one healthy living benefit in place; those that do not, do offer multiple TPAs/carriers
  - Two states (KY and TN) require healthy action steps to enroll in the most generous benefit offerings
  - 70% of states utilize Health Assessments (HA) or Well Being Assessments (WBA) as part of their healthy lifestyle benefit; this is up from last year
  - Healthy lifestyle benefits range from $17 to $80 per month
  - Georgia provides up to $480 in Health Reimbursement Account (HRA) contributions for completing all healthy action steps

Healthy Lifestyle Benefit Grid *(Updated Oct 2014)*

	NC	GA	SC	KY	TN	VA	AZ	MD	MI	OH	WI
Smoking Credit	**$20 monthly**	**$80**	**$40 monthly**	**$40 monthly**	**Yes**	No	No	No	No	No	No
HA/WBA	**$10 monthly**	**Incentive ($)**	No	**Yes**	**Yes**	**$17 monthly**	**Yes**	**Yes**	No	**$50**	No
PCP	**$10 monthly**	No	No	No	No	No	No	**Yes**	No	No	No
Biometric screening	**No**	**Incentive ($)**	No	**Yes**	**Yes**	**$17 monthly**	**Yes**	No	No	**$75**	No
Activities/ Coaching	**No**	**Incentive ($)**	No	**Yes**	**Yes**	No	**Yes**	No	No	**$200**	No
Enrollment	**No**	No	No	**Yes**	**Yes**	No	No	No	No	No	No

Providing Meaningful Member Choice

States take unique approaches to designing their health offerings.

Approaches include:

- Multiple vendors
  - Statewide or regional
    - 73% of comparator states utilize more than one TPA/carrier in their active population with many providing different rates based on the TPA/carrier provider network
      - This is an increase from last year's analysis

- Number of offerings
  - The average state had three offerings for actives, with Georgia having the most with seven and Ohio having the least with one
  - Three states reduced their number of plan offerings and two increased their number of plan offerings

- Differentiation in offerings
  - Members have unique coverage and price sensitivities

Employee Choice by State *(Updated Oct 2014)*

State	Number of Offerings	Multiple TPA/Carriers	Regional Offerings or Rates
NC	3	No	No
GA	**7** ***(up from 3)***	**Yes***	**Yes***
SC	**2** ***(down from 3)***	No	No
KY	4	No	No
TN	**2** ***(down from 3)***	Yes	Yes
VA	4	Yes	Yes
AZ	3	Yes	No
MD	**5** ***(down from 8)***	Yes	Yes
MI	2	Yes	Yes
OH	1	Yes	No
WI	**3** ***(up from 2)***	Yes	Yes

** indicates change from previous analysis*

Value-Based Initiatives in State Health Plans

- As a follow-up to the Value-Based Insurance Design (VBID) presentation, staff examined three states that are incorporating different components of VBID into their benefit offerings
  - There are several ways a plan can incent value
  - There does not appear to be a consistent model or approach for implementing value based design

- Value-driven design components include:
  - Tiered networks and benefits by network
  - Tying enrollment to participation in programs
  - Reducing or removing copays
  - Emphasizing Patient Centered Medical Home (PCMH)
  - End of life care

Value-Based Incentives: Connecticut

- Connecticut's Health Enhancement Program (HEP) allows members the opportunity to:
  - Waive deductibles for the year
  - Reduce monthly premiums
  - Receive lower/no cost care for select drugs and office visits
  - $100 payment for complying with all HEP requirements

- Participation Requirements:
  - Multi-year stair step approach
  - All age appropriate screenings and wellness exams
  - One dental cleaning
  - If a member has a chronic condition they must participate in education and counseling programs

Value-Based Incentives: Oregon

- Oregon's Health Engagement Model (HEM) and 2015 Open Enrollment model allow members to:
  - Save on premiums
  - Earn gym credits
  - Reduction in deductible
  - Utilize PCMH model

- Participation requirements:
  - Health Assessment
  - Completion of two healthy activities:
    - Weight Watchers
    - Gym participation
    - Team training
    - MoodHelper
    - Tobacco Cessation
- PCMH model includes PCP visits that are not subject to deductible or copay; further PCP visits have reduced copays

Value-Based Incentives: Minnesota

- Fund Health Savings Account for:
  - Signing up for HDHP
  - Biometric screening
  - Health Assessment (and agreeing to accept a coaching call)
    - PCP copay reduction for completing HA in other plan

- Provider groups are broken out by price and cost sharing varies by each tier
  - Deductible range: $75 to $1,000
  - PCP copay range: $18 to $55
  - MRI/CT coinsurance range: 5% to 25%
  - Inpatient copay range: $0 to 25% coinsurance

Value-Based Incentives: West Virginia

- West Virginia's employee benefit program has sliding cost sharing and premiums based on employee salary
- In addition to smoker wellness premiums, West Virginia includes a premium reduction for completing a Living Will and/or Advance Directive Planning
  - There is no specific answer or response on the living will to earn the premium reduction, however, members must complete the information

Innovative Plan Design Solutions: Tennessee and Kentucky

Tennessee

- Offers employees two plan offerings through two TPAs/carriers with regional rates
- To enroll in the lower premium, more comprehensive offering members must complete Well Being Assessment (WBA) and a biometric screening
  - In coming years members will have additional action steps in place

Kentucky

- Offers employees four plan offerings
- To enroll in the two most generous offerings members must complete a Health Assessment, keep contact information current, and complete healthy activities
- Separate smoker credit for all four plans

Emerging Conclusions

- If you've seen one state health plan, you've seen one state health plan
- SHP benefits are more generous now than in CY2012
- SHP is near the front of the curve in terms of integrating value based components which provide members the opportunity for richer benefits
- Plans are developing programs that give members broad choice in the type of plans they can select
- Plans are looking to incent certain behaviors and members can generate more value within benefit offerings by engaging
- Several states utilize multiple TPA/carriers to offer coverage; this trend is growing in the selected states

Emerging Conclusions (*continued*)

- Based on relatively fixed funding, changing any aspect of a health plan will have a direct impact on other levers
  - Increasing benefit richness would increase member premiums
  - Reducing dependent premiums would increase individual premiums
- Legislative mandate to reduce premiums limits flexibility around improving all benefits

Next Steps/Questions

- Where should the Plan offerings be positioned in 2016?
- Where do we have opportunities in the market?
- Where should changes be considered to demonstrate different value proposition to members?
- Would changing the vendor arrangement provide the opportunity for greater flexibility?

Appendix

Out-of-Pocket Comparison

In-network Plan Benefits[1]	NC	GA	KY	SC	TN	VA
Deductible • Single • Family	$700 to 1,500 $2,100 to 4,500	$1,300 to 3,500 $2,600 to 6,450	$500 to 1,750 $1,000 to 3,500	$445 to 3,600 $890 to 7,200	$450 to 800 $1,150 to 2,050	$0 to 1,750 $0 to 3,500
Co-insurance	70% to 85%	70% to 85%	70% to 85%	80% to 85%	80% to 90%	80% to $100
Maximum[2] • Single • Family • Rx	$3,000 to 3,793 $9,000 to 11,379 Separate/Include	$4,000 to 6,450 $8,000 to 12,900 Include	$2,500 to 3,500 $5,000 to 7,000 Separate/Include	$2,540 to 6,000 $5,080 to 12,000 Included	$2,300 to 2,600 $4,600 to 5,200 Separate	$1,500 to 5,000 $3,000 to 10,000 Separate/Include
Office • PCP • SCP	$30 to ded/coin $70 to ded/coin	$35 to ded/coin $45 to ded/coin	$25 to ded/coin $45 to ded/coin	$12 to ded/coin $12 to ded/coin	$25 to 30 $45 to 50	$25 to ded/coin $40 to ded/coin
Inpatient Surgery	$233, ded/coin to ded/coin	$250 to ded/coin	Ded/coin	Ded/coin	Ded/coin	$300 to ded/coins
Rx • Tier 1 • Tier 2 • Tier 3	$12 to ded/coin $40 to ded/coin $64 to ded/coin	$20 to ded/coin $50 to ded/coin $90 to ded/coin	$10 to ded/coin $35 to ded/coin $55 to ded/coin	$9 to ded/coin $38 to ded/coin $63 to ded/coin	$5 to 10 $35 to 45 $85 to 95	$15 to ded/coin $25 to ded/coin $40 to ded/coin

1. Ded/coin = subject to deductible and coinsurance
2. NC uses coinsurance maximums on two plans, most other plans are out-of-pocket maximums

Out-of-Pocket Comparison (continued)

In-network Plan Benefits[1]	NC	AZ	MD	MI	OH	WI
Deductible • Single • Family	 $700 to 1,500 $2,100 to 4,500	 $0 to 1,300 $1,000 to 2,500	 $0 $0	 $400 $800	 $200 $400	 $200 to 1,700 $400 to 3,400
Co-insurance	70% to 85%	90% to 100%	90% to100%	90% to 100%	80%	90%
Maximum[2] • Single • Family • Rx	 $3,000 to 3,793 $9,000 to 11,379 Separate/Include	 N/A to $2,000 N/A to $4,000 Include	 $1,500 to $2,000 $2,000 to $3,000 Separate	 N/A to $2,000 N/A to $4,000 Include	 $1,500 $3,000 Include	 $800 to 3,500 $1,600 to 7,000 Separate/Include
Office • PCP • SCP	 $30 to ded/coin $70 to ded/coin	 $15 to ded/coin $15 to ded/coin	 $15 $15 to $30	 $20 $20	 $20 $20	 Ded/coin Ded/coin
Inpatient Surgery	$233, ded/coin to ded/coin	$150 to ded/coin	$0 to ded/coin	$0 to ded/coin	Ded/coin	Ded/coin
Rx • Tier 1 • Tier 2 • Tier 3	 $12 to ded/coin $40 to ded/coin $64 to ded/coin	 $10 $20 $40	 $10 $15 $25	 $10 $30 $60	 $10 $25 $50	 $5 to ded/coin $15 to ded/coin $35to ded/coin

1. Ded/coin = subject to deductible and coinsurance
2. SHP uses coinsurance maximums on two plans, most other plans are out-of-pocket maximums

Comparative Analysis Methodology

Step one

- Plan staff and Segal discussed relevant states to use in comparative analysis
- Plan staff compiled benefit design components such as deductibles, copays, coinsurance for both individual/family coverage and in-network/out-of-network benefits
  - Premium contributions were also collected

Step two

- Segal ran the data inputs through their rate manual to develop expected costs of the benefit on PMPM basis
  - A rate manual is a tool that actuaries use to assign PMPMs based on underwriting guidelines and projected utilization
  - The expected costs are purely meant to compare benefit design values only and do not reflect expected utilization changes of different plan designs, geographic factors, age, etc.

Comparative Analysis Methodology

Step three

- The resulting PMPM costs were compared to the 80/20 plan to develop relative values
  - Benefit designs with a relative value greater than 1.0 are projected, on average, to pay for more covered services than the 80/20 plan; conversely plan designs with a relative value less than 1.0 are, on average, projected to pay less for covered services than the 80/20 plan
  - Example: Based on benefit design, the State of Arizona's PPO offering's relative value is 1.2142, or projected to be 21.142% more rich than the 80/20

Step four

- Employer share of premium was multiplied by relative value to create effective/adjusted relative value
  - The employer share of premium was calculated; employee share divided by total premium
  - Example: Arizona pays 83.246% of employee only premium; therefore the adjusted relative value is 1.0041 (.83246 x 1.2142)
    - Values may not equal due to rounding

Comparative Analysis Methodology

Step five

- Adjusted Relative Values were re-normalized to compare each plan's adjusted relative value to the Plan's 80/20 adjusted relative value
  - Example:
    - (Arizona PPO's Adjusted Value = 1.0041) divided by (80/20 Adjusted Value = 0.9714 (1.00 Relative Value x 97% Premium Share))
    - Arizona PPO's Adjusted Relative Value = 1.0337

North Carolina State Health Plan

ACA Impact on Benefit Planning for 2016

Presented by:

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November 21, 2014

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Health Care Reform

Timeline for Group Health Plans

2014

- **Health Insurance Exchange** coverage begins for individuals and small employers; premium assistance tax credits available to certain low-income individuals
- **Individual Mandate** starts, requiring individuals to obtain minimum essential coverage or pay a personal income tax penalty; 2014 penalty is the greater of $95/adult or 1% of taxable income
- **Medicaid** expansion to 133% of Federal Poverty Level (at state option)
- Group health plan standards for **all plans** (effective for plan year beginning on/after January 1, 2014): ban on waiting periods that exceed 90 days, ban on annual dollar limits on essential health benefits, ban on pre-existing condition limitations (regardless of age), wellness incentives can be raised from 20% to 30% (up to 50% for smoking cessation programs)
- Group health plan standards for **non-grandfathered plans** (effective for plan year beginning on/after January 1, 2014): cost-sharing limits, coverage relating to routine patient costs associated with approved clinical trials, provider nondiscrimination and protection of employees
- **Health Insurance Provider Fee** starts (annual fee)
- **W-2 Reporting** on the value of employer-sponsored coverage for 2013 (January 2014)
- **Comparative Effectiveness Research Fee/PCORI** rises to $2 per covered life (return/fees due by July 31)
- **Temporary Reinsurance Program Fee** enrollment count due November 15, 2014 ($63/covered life for 2014) Fee sunsets after 2016
- Use **Early Retiree Reimbursement Program (ERRP)** reimbursement monies by end of 2014
- Deadline for certain amendments to cafeteria plan documents (December 31, 2014)

2015

- **Individual Mandate Penalty** is the greater of $325/adult or 2% of taxable income
- **Employer Shared Responsibility Penalty** begins
- **W-2 Reporting** on the value of employer-sponsored coverage for 2014 (January 2015)
- First installment of 2014 **Temporary Reinsurance Program Fee** due by January 15, 2015
- **Comparative Effectiveness Research Fee/ PCORI** continues (return/fees due by July 31)
- **Temporary Reinsurance Program Fee** enrollment count due by November 15, 2015 ($44/covered life for 2015)
- Second installment of 2014 **Temporary Reinsurance Program Fee** due by November 15, 2015

2014 → **2015**

Effective Dates to be Determined in Regulations

- Auto-enrollment of new hires (awaiting guidance)
- Reporting related to transparency in coverage (for non-grandfathered plans, not sooner than 2015)
- Quality reporting (for non-grandfathered plans, awaiting guidance)
- Nondiscrimination rules for insured plans (for non-grandfathered plans, awaiting guidance)
- Plans certify compliance with HIPAA EDI standards and operating rules (proposed deadline: December 31, 2015)

August 20, 2014

Health Care Reform

Timeline for Group Health Plans

2016

- **Individual Mandate Penalty** is the greater of $695/adult or 2.5% of taxable income
- **Employer Shared Responsibility Penalty** continues
- First installment of 2015 **Temporary Reinsurance Program Fee** due by January 15, 2016
- **Large Employer Reporting to IRS** on 2015 coverage offered to full-time employees. This includes **employer reporting to employees by January 31, 2016**
- **Plan Reporting to IRS on 2015 coverage.** This includes **plan reporting to participants by January 31, 2016**
- **W-2 reporting** on the value of employer-sponsored coverage for 2015 (January 2016)
- **Comparative Effectiveness Research Fee/PCORI** continues (return/fees due by July 31)
- **Temporary Reinsurance Program Fee** enrollment count due by November 15, 2016 (final year); national per capita rate for 2016 set in 2015
- Second installment of 2015 **Temporary Reinsurance Program Fee** due by November 15, 2016

2017

- **Individual Mandate Penalty** is the greater of $695 (indexed)/adult or 2.5% of taxable income
- Exchanges may permit **large employers** to purchase Exchange coverage
- **Employer Shared Responsibility Penalty** continues
- First installment of 2016 **Temporary Reinsurance Program Fee** due by January 15, 2017
- **Large Employer Reporting to IRS** on 2016 offers of coverage (to employees by January 31, 2017)
- **Plan Reporting to IRS on 2016 coverage** (to participants by January 31, 2017)
- **W-2 reporting** on the value of employer-sponsored coverage for 2016 (January 2017)
- **Comparative Effectiveness Research Fee/PCORI** continues (return/fees due by July 31)
- Second installment of 2016 **Temporary Reinsurance Program Fee** due by November 15, 2017

2018

- **40% Excise Tax** on health plans that cost above $10,200 (single) and $27,500 (family), indexed to the CPI-U
- **Individual Mandate and Employer Shared Responsibility Penalties** continue
- **Large Employer Reporting to IRS** on 2017 offers of coverage (to employees by January 31, 2018)
- **Plan Reporting to IRS on 2017 Coverage** (to participants by January 31, 2018)
- **W-2 reporting** on the value of employer-sponsored coverage for 2017 (January 2018)
- **Comparative Effectiveness Research Fee/PCORI** (return/fees due by July 31)

2016 | **2017 and beyond**

Coming ACA Requirements for Employers/Plans

2014

- Temporary Reinsurance Program Fee - $63/covered life for 2014

2015

- Employer Shared Responsibility Penalty begins

2016

- Large employer reporting to IRS on coverage offered to full-time employees
- Plan reporting to IRS on 2015 coverage
- Employer and Plan reporting to individual participants

2018

- 40% Excise Tax on plans that cost above $10,200/$27,500

1. 40% Excise Tax Implications
2. Strategies for Avoiding the Excise Tax
3. Splitting the Retiree Population from Actives
4. Medicaid Implications

ACA Imposes a CEILING on Tax Free Benefits

40% Excise Tax on High Cost Health Plans *(2018)*

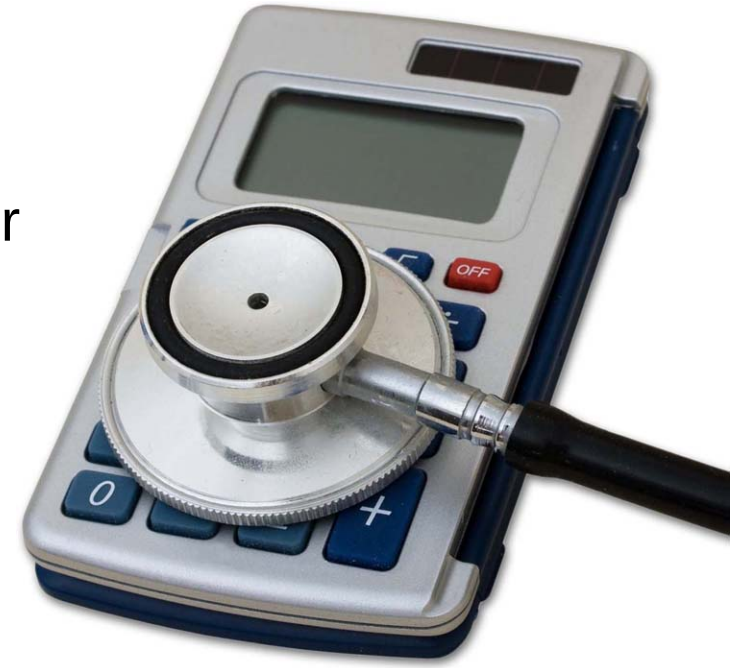
- Threshold **$10,200/$27,500** indexed to the CPI-U, not medical inflation
  - Based on total cost of coverage – Employer + Employee cost
  - No regional adjustment for cost of medical care
- Increased thresholds **($11,850/$30,950)** for **retirees** and high risk professions
  - Includes law enforcement, fire protection, out-of-hospital emergency medical care (EMTs, paramedics, first-responders)
  - Also, construction, mining, agriculture, forestry, fishing
  - Where high risk employees are majority of population
- Tax payable by plan administrator
- **No guidance yet!**

Which Plans Are Included for the Excise Tax?

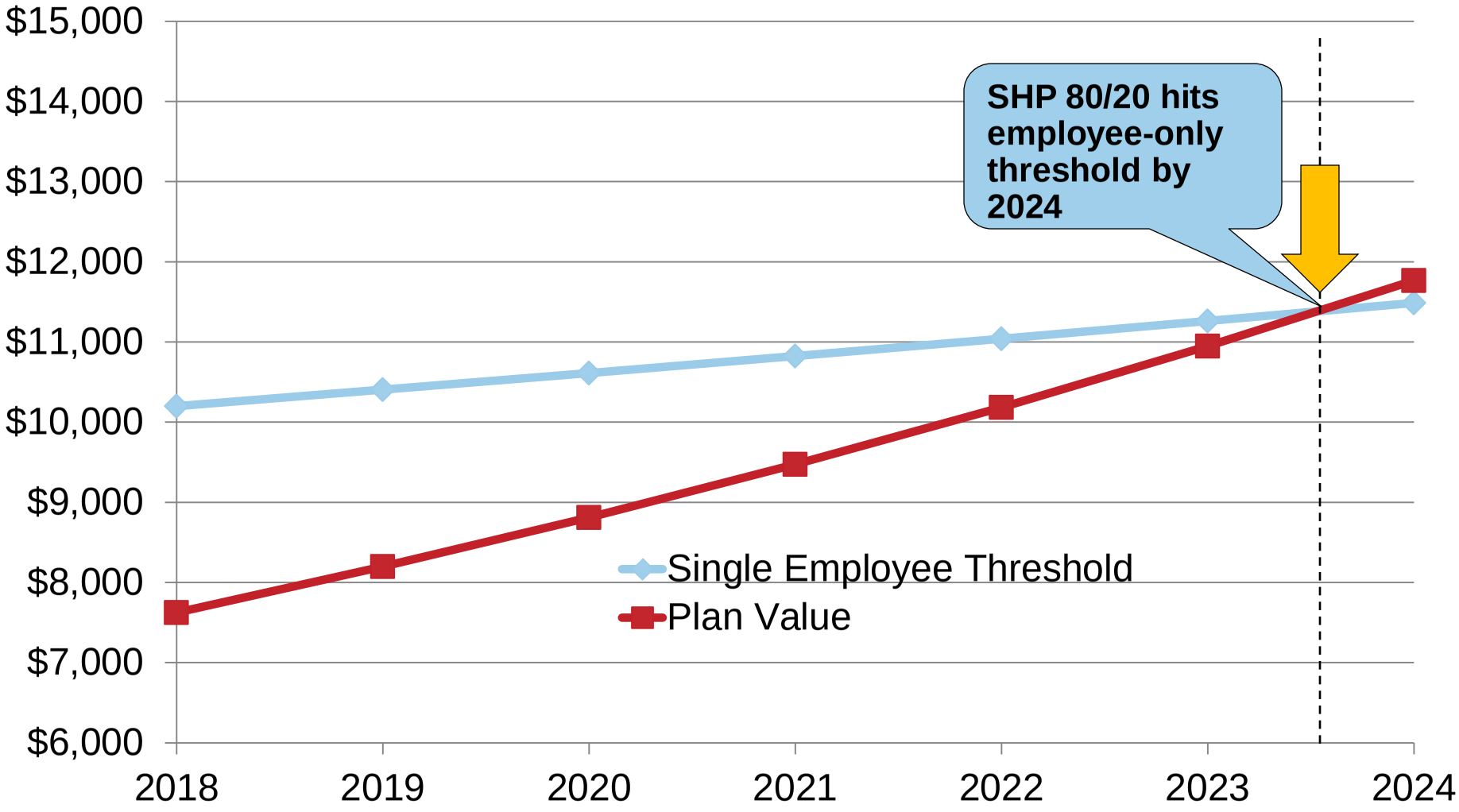
- **Medical / Hospitalization / Prescription drug**
- **Dental and vision**
  - If included under the medical plan election
- **Health Flexible Spending Accounts (FSAs)**
  - Includes amount of employee's salary reduction plus any additional employer contributions
  - No guidance yet on whether entire available amount is included or the amount each person actually elects to reduce pay for the Health FSA
- **Health Reimbursement Arrangements (HRAs)**
  - If the HRA is used for payment of health plan premiums, the HRA is counted
- **Health Savings Accounts (HSAs)** and **Archer Medical Savings Accounts (MSAs)**
  - Includes the employer contributions, but not employee contributions
- **Onsite Medical Clinic** value

Cost Threshold

- Cost threshold based on **COBRA** cost
- Combined total cost for all non-excepted plans
- Health cost adjustment increases thresholds if the actual growth in the cost of U.S. health care between 2010 and 2018 exceeds the projected growth for that period
- The value of the plan must be lowered to avoid reaching the threshold— shifting of premium cost to participants does not lower the value of the plan



Excise Tax Collision is Coming



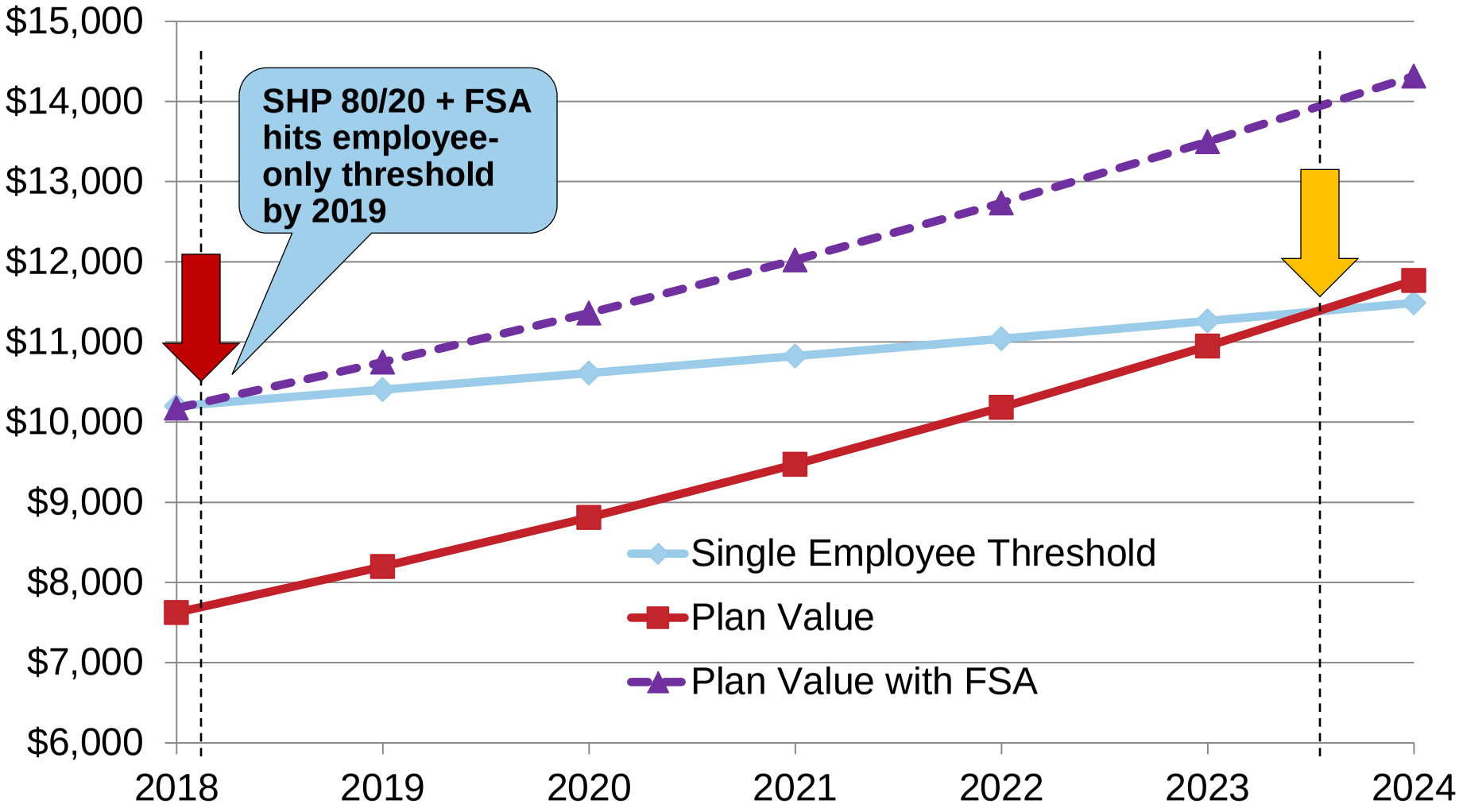
Assumptions:
- SHP projected cost of $7,625 for employee only in 80/20 plan
- Trends: 7.5% for SHP plan cost; 2% for CPI-U

How Close Will the State Health Plan Be in 2018?

- Illustration assuming 7.5% trend increase in overall plan cost
- $2,550 maximum health care flexible spending account salary reduction for 2015 remains constant through 2018

	Employee Only	Employee + Family
COBRA Rate 2015 – 80/20	$521.91	$1,201.62
Annual Cost *(x0.98 x12 months)*	$6,138	$14,131
7.5% Trend – 3 yrs. to 2018	1.2423	1.2423
2018 Projected Annual Cost	$7,625	$17,555
FSA Maximum *(OSHR NC Flex)*	$2,550	$2,550
Total Plan Cost 2018	**$10,175**	**$20,105**
Excise Tax Threshold 2018	**$10,200**	**$27,500**

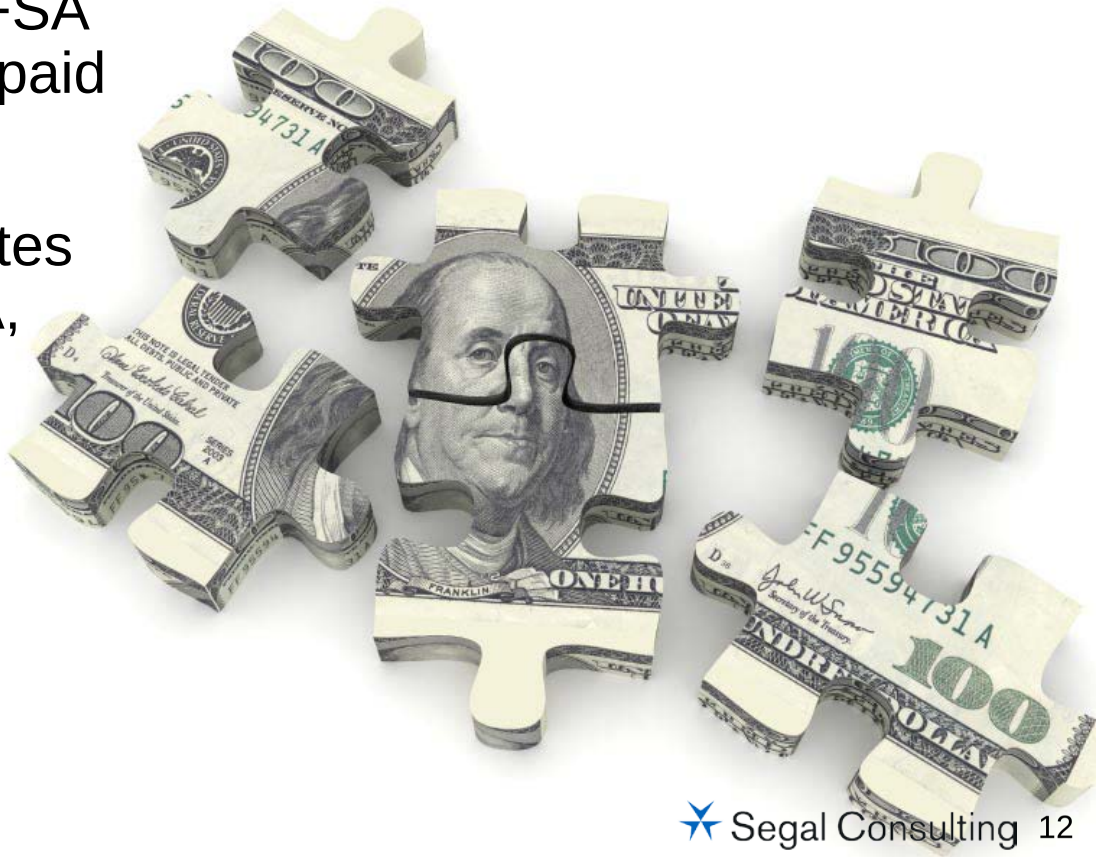
Excise Tax Collision is Coming Sooner



Assumptions:
- SHP projected cost of $7,625 for employee only in 80/20 plan + **$2,550 FSA**
- Trends: 7.5% for SHP plan cost; 2% for CPI-U

Who Pays?

- Insurer for insured plan
- Plan administrator for self-insured group health plan, Health FSA or HRA
- Where the employer acts as plan administrator to a self-insured group health plan, a Health FSA or an HRA, the excise tax is paid by the employer
- Where an employer contributes to an HSA or an Archer MSA, the employer pays



Employer Responsibility

- The employer is responsible for calculating the excise tax on an employee's coverage
  - The employer must combine the cost of the different benefits, calculate the amount of the excess benefit, and determine the pro rata share of the excess attributable to each type of benefit
  - Then, the employer must report the taxable excess benefit attributed to each coverage provider to both the provider and the IRS
- Penalties may be assessed on employers or plan sponsors who do not accurately perform the required calculations
  - No penalty to coverage providers, but they must pay any additional tax assessment
  - The penalty amount is 100% of the additional excise tax that must be paid by coverage providers due to the miscalculation, plus interest based on IRS underpayment interest rate
  - Penalties do not apply in certain cases, e.g., if error due to reasonable cause and not to willful neglect and was corrected within 30 days of discovery

1. 40% Excise Tax Implications
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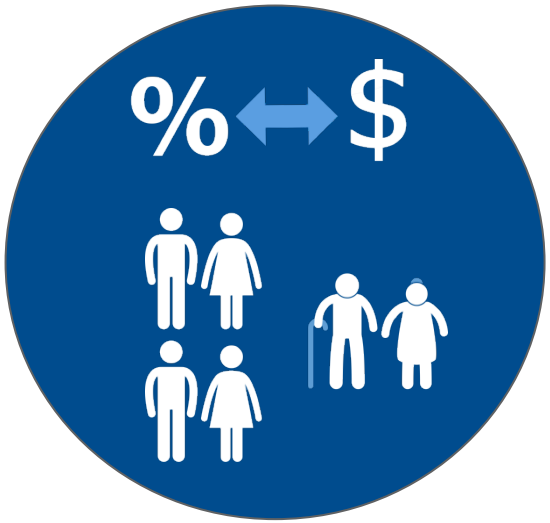
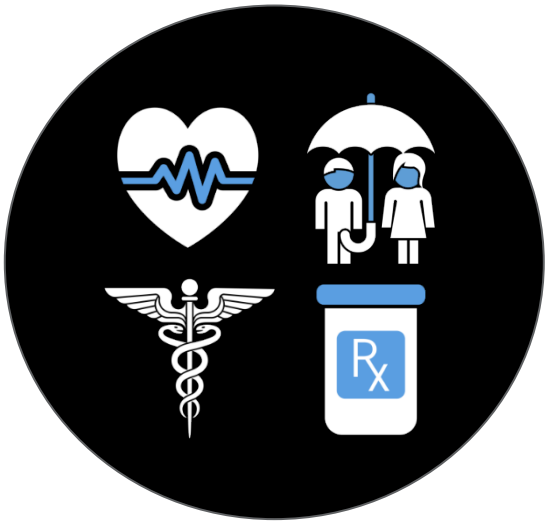
Strategy: Lower the Baseline Cost

Cost Control Strategies

Calculation Strategies



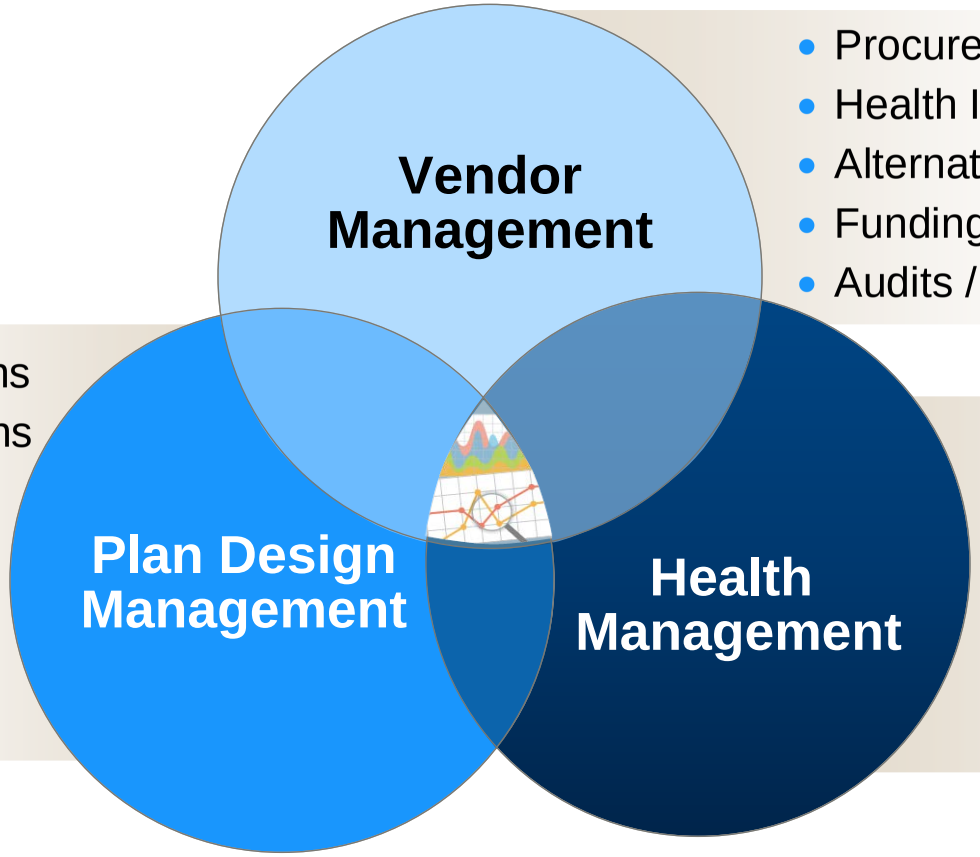
Retiree Strategies



Calculation Strategies

- Review all pre-tax benefits available to members to determine which are excepted and which must be counted for excise tax purposes
  - Dental/vision
  - Health Reimbursement Arrangements (HRAs)
  - Medical Flexible Spending Accounts (FSAs)
  - Other benefits
- Determine strategy for participating employers who sponsor their own pre-tax benefits outside of State control or monitoring
- Which plan takes precedence if there will be an excise tax issue?

Control Costs Where Possible



- Procurement / Contracting
- Health Insurance Exchanges
- Alternative Delivery Models
- Funding Arrangements
- Audits / Ongoing Monitoring

- Value-Based Designs
- Account-Based Plans
- Eligibility Provisions
- Employee Contributions
- Quality-Based Networks

- Culture Change
- Individual Behavior Modification / Incentives
- Disease Management
- Communications
- Health Status Metrics

To avoid the ACA Excise Tax, plan sponsors can deploy strategies in all three areas.

Top Medical and Prescription Drug Plan Cost-Management Strategies Implemented in 2014

Medical Plan Strategies

- Expand use of low-cost primary-care access (Telehealth, Walk-in Clinics, Worksite Clinics)
- Reference-based pricing[1]
- Follow the Medicare Hospital Readmissions Reduction Program to reduce hospital readmissions
- Value-based contracting, including:
  - Accountable Care Organizations (ACOs)[2]
  - Patient-Centered Medical Homes (PCMHs)[3]
  - Use of Narrow/Tiered Networks[4]
- Defined contribution approaches with or without the use of private exchanges
- Continued focus on wellness

Prescription Drug Plan Strategies

- Medication Therapy Management Program
- RetroDUR Program[5]
- EGWP[6] Implementation
- Formulary Management
- Prior Authorization
- Step Therapy
- Physician Dispensing and Pharmacy Network Management
- Specialty Pharmaceutical Management

Source: **2015 *Segal Health Plan Cost Trend Survey***

[1] Reference pricing involves designs where a plan sets a maximum price for covering the cost of a particular service to steer patients away from higher-priced providers who have no evidence of providing higher-quality services.

[2] ACOs, which have mainly been developed for the Medicare population, are networks of providers and suppliers that agree to be jointly accountable for managing the health of participating populations across the care continuum.

[3] PCMHs focus an increased level of comprehensive health care resources on primary care and prevention for patients with chronic conditions.

[4] Tiered networks require lower cost sharing if participants use high-quality, preferred providers within a network.

[5] RetroDUR stands for retrospective drug utilization review.

[6] EGWP is an abbreviation of Employer Group Waiver Plan.

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Carve Retirees Into a Separate Pool and Trust

Rationale

- Can provide clear picture of actual costs by employee/retiree group
- Allows cross-subsidization among groups to be identified where there are multiple funding sources
- Matches approach used for GASB OPEB liability calculations
- Allows tailoring of separate plan designs for actives and retirees to meet specific needs of each group
- May allow avoidance of many ACA requirements for retirees if there are no active employees in those plans
  - Many ACA benefit mandates do not apply (e.g., lifetime / annual maximums)

Impacts

- To maintain equity and consistency, adjustment of overall employer subsidy for active employees and for retirees is required.
  - Typically increases Pre-Medicare retiree and dependent rates
  - Reduces Active employee and Medicare retiree rates
- Does not help contain the overall cost of the program for actives and retirees
- Medicare retirees already reflect savings from Federal subsidy

Separate Retiree Pool – SHP Dynamics

Funding philosophy

- Employer contributions already support most of the employee/retiree cost
- Medical loss ratios are fairly close for active and retiree groups, so cost leverage between actives and retirees is not a primary factor
  - Medicare retirees and pre-65 retirees are balanced within the overall cost for reitrees
- Carving retirees out may not generate savings over current single value funding approach
  - State funding requirement might be reduced somewhat for active employees
  - But, per member cost for retirees separately could require Increased State funding through Retirement System

Premium subsidy policy

- Would require adjustment of employer subsidy share to maintain current member premium cost
- May require State to provide a direct subsidy of dependent costs for retirees

Plan design

- SHP has already created Medicare specific plan options through the Medicare Advantage plans

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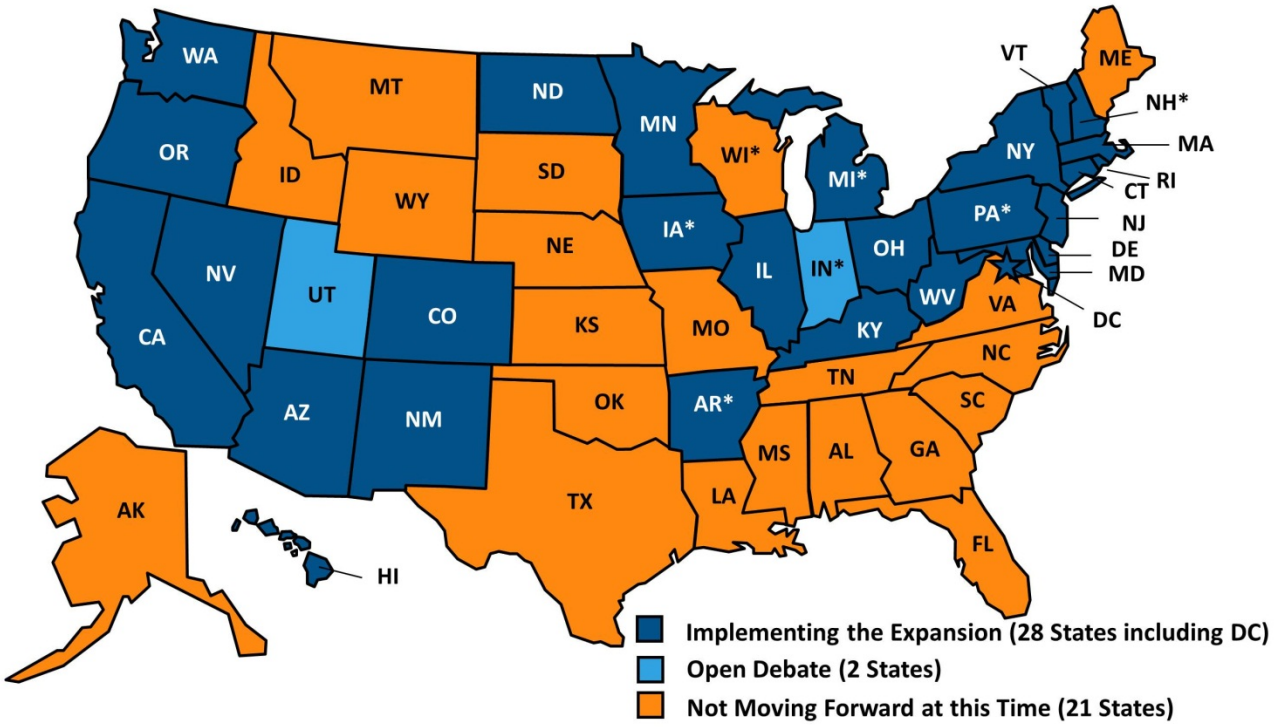
Medicaid Expansion

Current Status of State Medicaid Expansion Decisions



NOTES: Data are as of August 28, 2014. *AR, IA, MI, and PA have approved Section 1115 waivers for Medicaid expansion. In PA, coverage will begin in January 2015. NH is implementing the Medicaid expansion, but the state plans to seek a waiver at a later date. IN has a pending waiver to implement the Medicaid expansion. WI amended its Medicaid state plan and existing Section 1115 waiver to cover adults up to 100% FPL in Medicaid, but did not adopt the expansion.
SOURCES: Current status for each state is based on data from the Centers for Medicare and Medicaid Services, available here, and KCMU analysis of current state activity on Medicaid expansion.

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Medicaid Expansion – Impact

- Expansion to 133% of Federal Poverty Level
  - Increases number of citizens eligible for programs
  - Puts pressure on state budget
  - But also brings in more Federal revenue to help pay for care that the state is likely already providing through indigent care and the uninsured
  - Forces reconsideration of Medicaid models (managed care growth) to provide the most efficient delivery of care
- More citizens will be eligible for Medicaid benefits
  - Even if state doesn't expand Medicaid eligibility
  - Enrollment in state exchange triggers determination of eligibility for Medicaid and Federal subsidies
  - Lower paid employees may meet the Medicaid eligibility requirements for themselves and/or for their dependents
  - Early retirees eligible for exchange subsidies even if eligible for employer plan

Medicaid Expansion – Considerations

- Coordination with employer provided benefits
  - Working poor may be better off in Medicaid than in employer plan
  - As employers trim benefits to fit between minimum required (Shared Responsibility and mandates) and maximum allowed (40% Excise Tax), more lower paid employees are likely to find Medicaid more attractive
    - This is already happening among private sector employers
    - Not yet a major trend among public employers
  - Similar dynamics for child dependents – is it better to qualify them for CHIP benefits or to pay premiums to employer plan?
  - Rebalancing of employer provided benefits availability vs employee's ability to pay premiums
  - Can/should State allow Medicaid participation along with or instead of employer health plan participation?

Medicaid Expansion – Considerations

- Coordination with Medicare eligible and Pre-Medicare retirees
  - Dual eligibles – Medicare and Medicaid
  - Pre-Medicare retiree eligibility for state health marketplace coverage
- Federal exchange subsidies
  - Only available if not eligible for coverage in an employer plan
  - Early retirees can qualify for federal subsidies even if eligible for employer plan
- State Health Plan considerations
  - Maintain an affordable plan for employees at all pay levels (e.g., minimum value plan option in addition to regular plan offerings)
  - Monitor early retiree participation

Resources

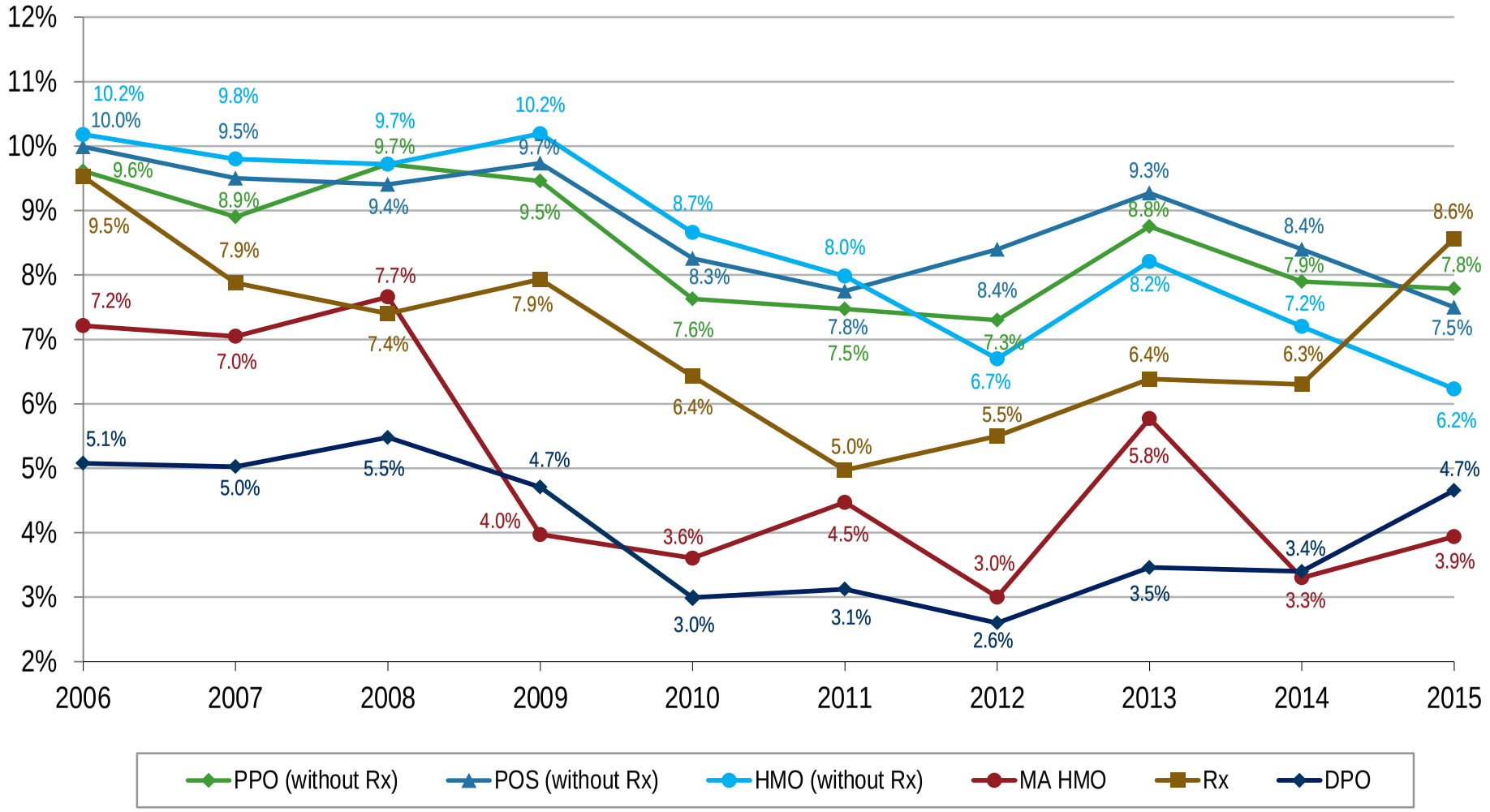
Guidance on the 40% Excise Tax

- No regulations or actuarial guidance yet
- Best resource is Joint Committee on Taxation Report on ACA
  - https://www.jct.gov/publications.html?func=startdown&id=3673
  - ACA Section 9001; IRC Section 4980I
  - Page 57

Affordable Care Act Resources

- Patient Protection and Affordable Care Act of 2010 (Pub. L. 111–148) as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152)
- The Center for Consumer Information & Insurance Oversight
  - http://www.cms.gov/cciio/index.html
- Affordable Care Act Tax Provisions
  - http://www.irs.gov/uac/Affordable-Care-Act-Tax-Provisions
- Department of Labor Affordable Care Act
  - http://www.dol.gov/ebsa/healthreform/

Ten-Year Summary of Selected Medical, Prescription Drug Carve-Out and Dental Trends: 2006 – 2013 Actual and 2014 and 2015 Projected[1]



Source: 2015 *Segal Health Plan Cost Trend Survey*

[1] All trends are illustrated for actives and retirees under age 65, except for MA HMOs.

[2] Prescription drug trend data for 2006 – 2007 only reflects retail. For 2008 – 2015, prescription drug retail and mail order delivery channels are combined.

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

Benefit Design Options for Achieving Strategic Priorities

Board of Trustees

November 21, 2014

Objective of Design Discussion

Develop a benefit design strategy for Plan Years 2016 and 2017 that furthers the Plan's mission and contributes to achieving the Board's strategic priorities and initiatives.

- Board feedback in the following areas:
  - Relative Value of Benefit Plan Options
  - Healthy Activities to Earn Premium Credits
  - Plan Design Elements and Incentives
  - Plan Differentiation
  - Other Benefit Design Considerations
  - Next Steps

Mission & Guiding Principles

Our mission is to improve the health and health care of North Carolina teachers, state employees, retirees, and their dependents, in a financially sustainable manner, thereby serving as a model to the people of North Carolina for improving their health and well-being.

- It is the intent of the Board and Plan leadership team to support the development of benefit offerings that are **affordable** to state employees, retirees and their dependents and the State of North Carolina. Therefore, the Board and Plan leadership team will make every effort to work on behalf of the members and State of North Carolina to develop the competitively priced offerings that **improve the health and well-being of its members**.

- It is the intent of the Board and Plan leadership team to effectively manage premiums that members are required to pay for coverage and for out-of-pocket health care expenses. The Board and Plan leadership team **support the development of programs and benefit offerings that encourage healthy lifestyles** and the appropriate use of incentives and cost sharing as levers in influencing the use of health care services and improving the health of plan members. Ongoing communication and education will be critical.

  - Improve Affordability
  - Improve Members' Health
  - Ensure Access to Quality Care
  - Incent Member Engagement
  - Expand Value-Based Design Elements
  - Promote Health Literacy
  - Provide Member Choice
  - Maintain Financial Stability

Key Strategic Initiatives

- Assist Members to Effectively Manage High Cost, High Prevalence Chronic Conditions: Focused programs designed to assist members and their providers to effectively manage a member's chronic condition(s). The targeted chronic conditions include asthma, COPD, cardiovascular diseases & diabetes. This includes a focus on members with multiple and complex chronic conditions

- Offer Health-Promoting and Value-Based Benefit Designs: Benefit designs that reduce barriers to care and are directed at sustaining long-term health and managing chronic disease and incent members to seek treatment from high quality, cost effective providers

- Promote Health Literacy: Provide access to tools and resources designed to assist members in understanding costs, treatment and provider options to support members in communicating with their provider and engaging in their health care decisions.

Value Comparison of SHP Plan Options

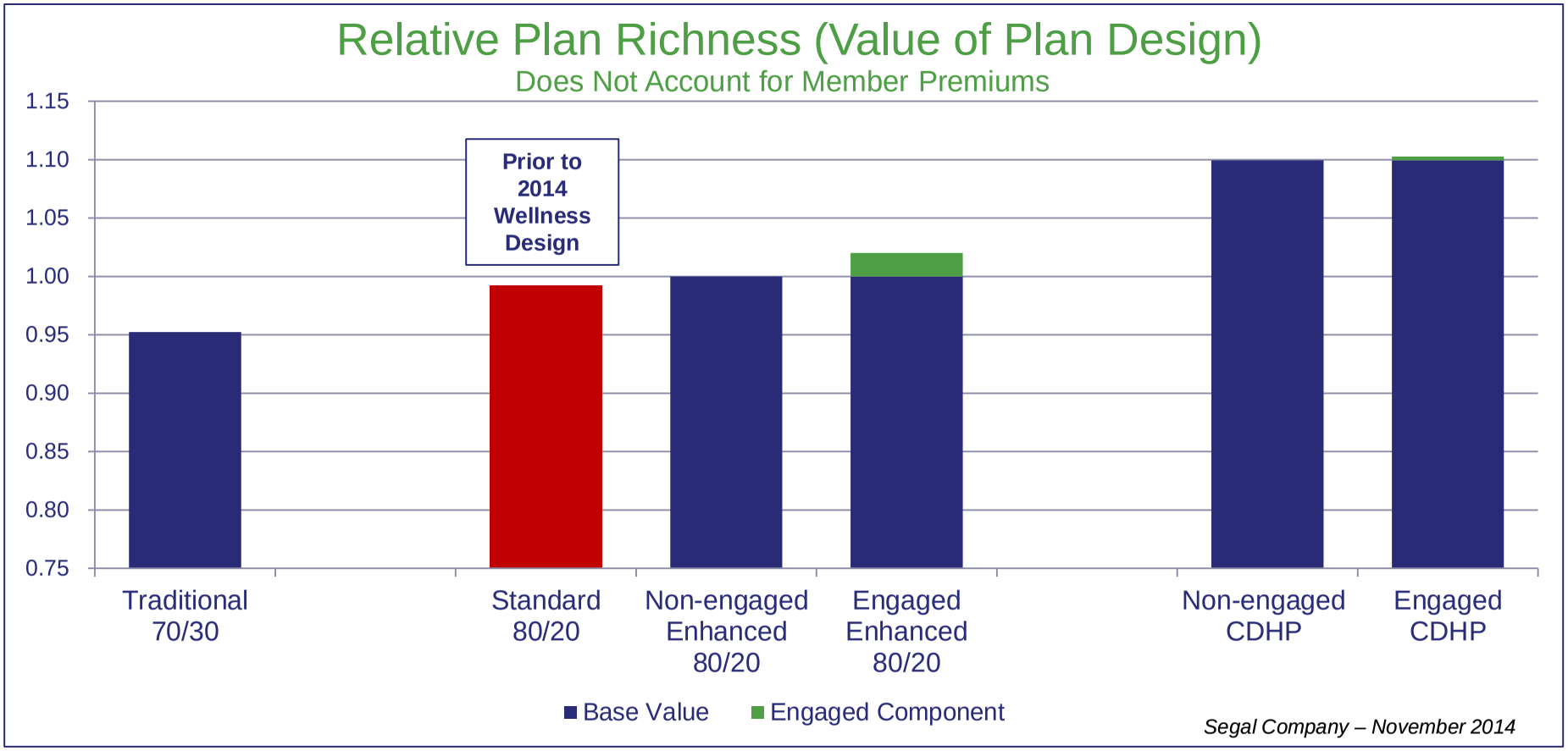
- Using Comparative Analysis of State Health Plans methodology conducted more detailed internal value comparison of current options
- Plan options for active employees and non-Medicare retirees
- Engaged member vs. non-engaged member
  - Engaged member is defined as one who:
    - Completes all healthy activities and earns all premium credits
    - Only uses selected PCP
    - Only uses Blue Options Designated providers
  - Non-engaged member is defined as one who
    - Does not earn any premium credits
    - Never uses Blue Options Designated providers

Value Comparison of SHP Plan Options

Internal value comparison includes current Plan options and former Standard 80/20 PPO option:

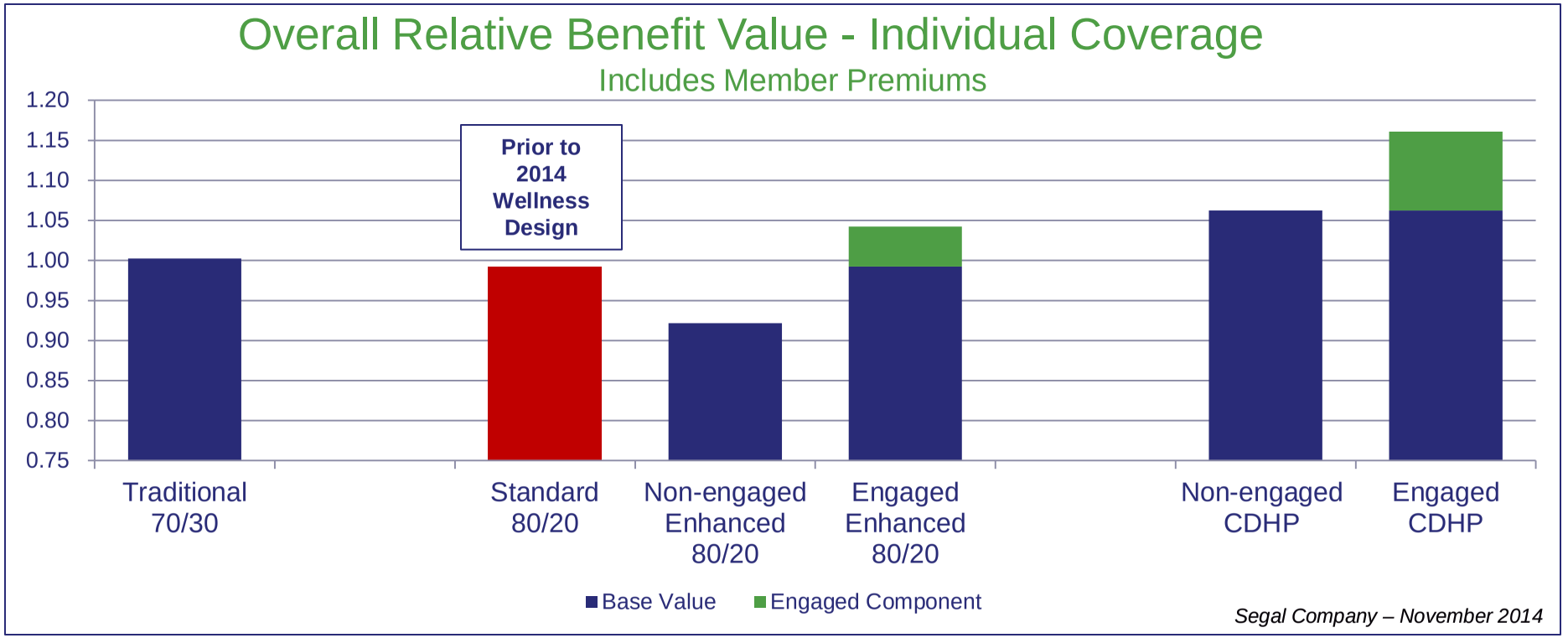
- Traditional 70/30 member
- Standard 80/20 member (Option as offered in FY 2012-13, prior to Board-Approved Wellness Design effective for CY 2014)
- Engaged Enhanced 80/20 member
- Non-engaged Enhanced 80/20 member
- Engaged CDHP member
- Non-engaged CDHP member

Engaged Employees/Retirees Earn Richer Plan



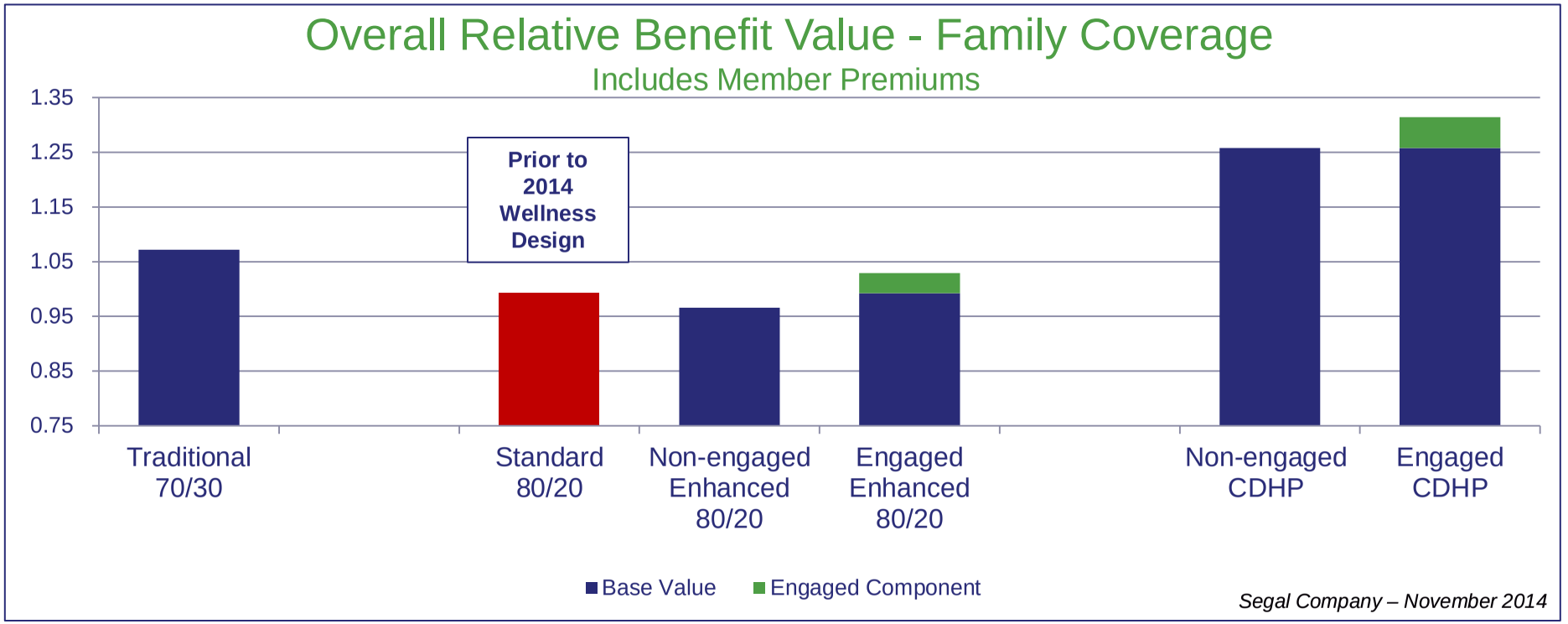
- 16% difference in relative value of richest plan (CDHP) and least rich plan (Traditional 70/30)
- Relative difference in value 70/30 and non-engaged 80/20 is 5%
- Engaged 80/20 and CDHP members earn higher value coverage

Engaged Employees/Retirees Receive the Richest Overall Benefit



- Current benefit plans offer richer benefit options than the former Standard 80/20 plan
- Members have the opportunity to significantly increase the value of their benefit by completing healthy activities, earning premium credits and using their selected PCP and Blue Options Designated providers
- Taking wellness credits and incentives into account, an engaged CDHP member receives a 26% richer overall benefit than a non-engaged Enhanced 80/20 member
- For members who do not want to engage, the CDHP and Traditional 70/30 plans offer the best value

Engaged Families *May* Receive the Richest Overall Benefit



- Current benefit plans offer richer benefit options than the former Standard 80/20 plan
- Engaged employees/retirees and dependents have the opportunity to significantly increase the value of their benefit
- An engaged CDHP family receives a 36% richer overall benefit than a non-engaged Enhanced 80/20 family
- The Traditional 70/30 plan provides better overall value for families than the Enhanced 80/20 plan regardless of engagement level

Value Comparison Key Takeaways

- 2014 Board Approved Wellness Design has created richer plan designs and added overall value to benefit options available to members
  - Non-engaged members do not receive these benefits
- CDHP offers the richest plan design and overall benefit value by a significant margin and for many members would result in the lowest out-of-pocket costs
- Enhanced 80/20 plan provides less value than the CDHP; however, many members find the copay model more attractive
- Modifying healthy activities, premium credits and wellness incentives to encourage more engagement will increase plan richness and overall benefit value

Value Comparison Discussion Points

- Are members being offered meaningful choice?
- How do the current options address the Strategic Plan and where do they fall short?
- Are there values or value differentials the Plan should target or create?
  - To what degree should benefit value be modified through:
    - Premiums
      - Ratio or share of employer vs. employee contributions
      - Premium credits
        - Number and type of healthy activities required to earn
        - To reduce dependent contribution rates
    - Plan Design
      - Incentive based reductions in member cost share
      - Other modifications to member cost share
- Is the Traditional 70/30 truly the “low option?”
- Is it important to have a plan option that does not incent engagement?
  - Should that plan be less rich and/or priced differently?

Wellness Design: Healthy Activities & Premium Credits

Goal: Reward members for engagement and establish process to help improve members' health

- Only tied to the 80/20 and CDHP in 2014 & 2015
- Original intent:
  - Add design to 70/30 plan beginning in 2016
  - Wellness premiums and credits to increase over time
  - Healthy activities to evolve and intensify over time
- Can tie other wellness incentives to premium credit activities (e.g., reduced PCP copay for visit to selected PCP)
- Current actuarial forecast assumes adding wellness premiums and credits to the 70/30 plan in CY 2016 at same level planed for 80/20 and CDHP

Wellness Design: Healthy Activities & Premium Credits

Developing a stair-stepped approach to future credits

- Intentional, planned progression of healthy activities and engagement over next few years
- Ideally, Board will approve healthy activities and premium credit amounts for CYs 2016 & 2017
- Allow more time for:
  - Communication campaign
  - Members to engage and complete activities
  - Implementation and administration

Current Healthy Activities & Premium Credits

2014 & 2015 Plan Years Subscriber Credits Earned for the Following:

Smoker Attestation

- Subscriber and, if applicable, their spouse attest to being a non-smoker or participating in a cessation program.

Health Assessment Completion

- Subscriber completes or updates their Health Assessment between Nov. 1, 2013, and Oct. 31, 2014, to receive credit.

Primary Care Provider Selection

- Subscribers who select a Primary Care Provider for themselves and all covered dependents receive credit.

Healthy Activities & Premium Credits under Consideration

2016

- **Tobacco Attestation**
  - Credit for non-tobacco user
  - Credit for QuitlineNC enrollment
    - Subscriber Credit/Spouse Credit
- **Health Assessment**
  - Subscriber Credit if questions completed and biometrics self-reported
- **PCP Selection**
  - Subscriber Credit if selected for subscriber and all enrolled dependents
- **Contact Information**
  - Subscriber Credit if provide or confirm address, phone number and email address

2017

- **Tobacco Attestation**
  - Credit for non-tobacco user
  - Credit for QuitlineNC enrollment
    - Subscriber Credit/Spouse Credit
- **Health Assessment**
  - Subscriber Credit if questions completed and biometrics reported by lab or PCP
- **PCP/PCMH Selection**
  - Credit for PCP selection by subscriber and all enrolled dependents
  - Consider additional credit if certified PCMH selected
    - Subscriber Credit/Consider Spouse Credit
- **Contact Information**
  - Subscriber Credit if provide or confirm address, phone number and email address
- **Health Literacy**
  - Subscriber Credit for completion of learning module (e.g., choosing a plan option or using transparency tools)
- **Health Engagement Program**
  - Subscriber Credit for engaging with one NC Health*Smart* resource (e.g. call a coach, digital health coaching, Eat Smart, Move More, Weigh Less) or participation in one wellness/fitness activity or challenge

2018

- **Tobacco Attestation**
  - Credit for non-tobacco user
  - Credit for QuitlineNC program completion
    - Subscriber Credit
    - Spouse Credit
- **PCMH Selection**
  - Replace PCP selection with Credit for selection of certified PCMH by subscriber and all enrolled dependents
    - Subscriber Credit
    - Consider Spouse Credit
- **Health Literacy**
  - Subscriber Credit for completion of learning module (e.g., understanding care options)
- **Health Engagement Program**
  - *Low risk members*: Subscriber Credit for preventive screening determined by PCP & engagement/participation with two NC Health*Smart* resources or wellness/fitness activities or challenges
  - *High risk members:* Subscriber Credit for primary and secondary preventive screenings determined by PCP and engagement/participation with two NC Health*Smart* resources or wellness/fitness activities or challenges

Red activities/credits represent change from prior year

Healthy Activities & Premium Credits Key Takeaways

- Need to take strategic approach aimed at helping members become healthier and better consumers of health care
- Build on original philosophy and intent to increase the premium credit amounts and intensity of the activities over time to change behavior
  - Incent members to increase engagement annually to receive higher premium reductions and enhanced benefits
- Multi-year progression to ease members into the approach, give members time to engage, and allow the Plan to accurately/effectively administer the benefit
- To encourage engagement throughout the year and allow sufficient time to complete certain activities, not all healthy activities will need to be completed during Open Enrollment
  - Members will be given several months to earn certain credits prior to the Open Enrollment period

Healthy Activities & Premium Credits Discussion Points

- Thoughts on the healthy activities and timing over multi-year schedule?
- Is the progression appropriate?
- Do these activities support the Strategic Plan?
- Other activities for consideration?

- How many activities can be effectively communicated and understood by members in a year?
- How many activities can be effectively managed and administered by the Plan in a year?

Wellness Design: Incenting Engagement

Plan designs for CYs 2014 and 2015 include enhanced coverage and value-driven components to encourage member engagement and promote wellness:

- Free preventive services (80/20 and CDHP)
- Copay reduction/HRA credit for using the PCP selected at enrollment (80/20 and CDHP)
- Cost share reductions/HRA credits for using high quality/lower cost Blue Options Designated providers (80/20 and CDHP)

- Design elements modestly increased plan costs while providing meaningful increase in the value of member benefits

Wellness Design: Incenting Engagement

Strategies for Building on the Wellness Design

- To further incent and increase engagement and promote a culture of wellness, the CY 2016 and 2017 plan designs should seek to:
  - Engage and reward both low and high risk members
  - Provide a foundation for future enhancements and progression of incentives and engagement

Wellness Design: Incenting Engagement

Potential approaches and options for CYs 2016 and 2017:

- Add Wellness Design (premium credits, design incentives and enhancements) to Traditional 70/30 plan
- Offer additional or increased cost share reductions/HRA credits
- Offer Value-Based Insurance Design (VBID) plan option
- Incorporate VBID or other value-based design elements in one or more plan options
  - Focus on helping members manage chronic diseases
    - Incent secondary prevention
    - Reduce the costs of maintenance medication for engaged members

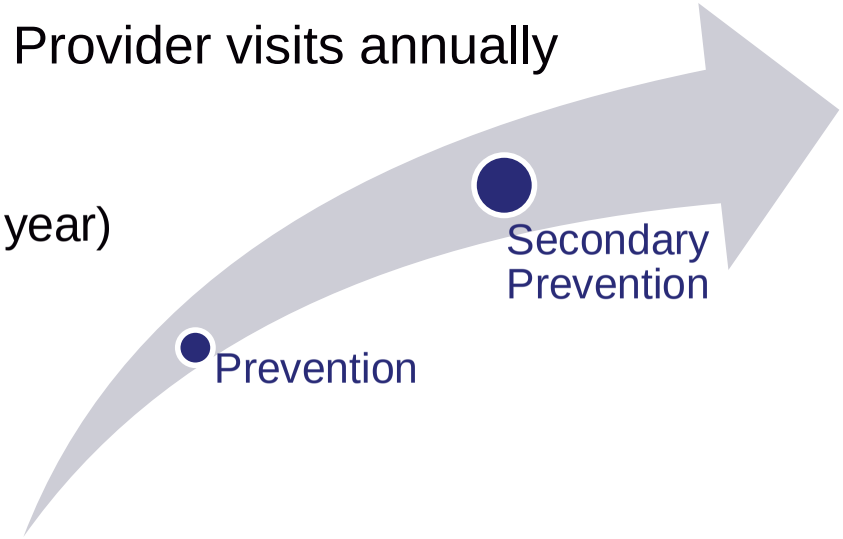
Chronic Disease Health Engagement Program under Consideration

- Starting January 1, 2016, incent disease and case management engagement with
  - Reduced copays or HRA credits for engaging in appropriate health management activities (e.g., PCP visits, testing, counseling/coaching)
  - Reduced pharmacy copays or HRA credits for chronic condition management medications for:
    - Diabetes
    - Cardiovascular disease
    - Asthma/COPD

- This value-based benefit design supports the Plan's strategic initiative to improve member's health by assisting members to effectively manage high cost high prevalence chronic conditions through increased member engagement and improved medication adherence.

Chronic Disease Health Engagement Program under Consideration

- Support chronic disease management of diabetes, asthma, and hypertension by offering the following high value services to members on the Enhanced 80/20 and CDHP with these conditions:
  - 2 additional $0 copay Primary Care Provider visits annually
  - Members with diabetes
    - $0 copay for testing of HbA1c (2 per year)
    - $0 copay for microalbumin testing (1 per year)
    - 2 $0 copay visits with a Certified Diabetes Educator (CDE)
  - Access to the Diabetes Primary Prevention (DPP) program
    - An evidence-based lifestyle change program for delaying onset and reducing complications related to diabetes



CDHP members would receive HRA credits

Chronic Disease Health Engagement Program under Consideration

Who is Eligible for Reduced Pharmacy Cost Share

- Non-Medicare primary members diagnosed with diabetes, cardiovascular disease, asthma, and COPD enrolled in the Enhanced 80/20 or CDHP

How to Qualify

- Pharmacy copay reduction or HRA credit for members who:
  - Complete Health Assessment with all biometrics within last 12 months
  - Engage with NC Health*Smart* by completing one call with a health coach or completing a digital health coaching session within the last 6 months (engagement required twice a year)

Incentive

- Members who qualify for the program will receive the following incentive for a 30-day supply of their chronic disease management medications:
  - Enhanced 80/20 Plan: Tier 1 $6 copay, Tier 2 $20 copay (50% reduction)
  - CDHP: $5 added to HRA

Chronic Disease Health Engagement Program under Consideration

Potential Progression of Engagement

2016

- Complete Health Assessment and biometric measures
- Engage with one NC Health*Smar*t resource (e.g., Coach once prior to enrollment
- Engage with Health Coach once again within 6 months of enrollment

2017

- Health Assessment w/ biometrics (once per year)
- Call with a health coach or digital health coaching module (2 per year)
- Set a health goal with your Health Coach (attested by the coach)
- Complete all recommended clinical screenings (i.e., HbA1c twice per year for diabetics, etc.)

2018

- Health Assessment w/ biometrics (once per year)
- Call with a health coach or digital health coaching module (2 per year)
- Achieve health goal (attested by the health coach)
- Complete all recommended clinical screenings

Health Engagement Program for Healthy/Low Risk Members

Potential Progression of Engagement

2016	2017	2018
• Complete Health Assessment and biometric measures • Engage with one NC Health*Smart* resource (e.g., call a coach, digital health coaching, Eat Smart, Move More, Weigh Less) prior to enrollment	• Health Assessment w/ biometrics (once per year) • Engage with one NC Health*Smart* resource (e.g., call a coach, digital health coaching, Eat Smart, Move More, Weigh Less) or participate in one wellness/fitness activity or challenge prior to enrollment	• Health Assessment w/ biometrics (once per year) • Complete preventive screening determined by PCP and engage or participate with two NC Health*Smart* resources or wellness/fitness activities or challenges

Rewards/cost share reductions to be determined

Wellness Design Key Takeaways

- Need to take strategic approach aimed at engaging and helping members manage their health conditions
- Multi-year progression to ease members into the approach, give members time to engage, and allow the Plan to accurately/effectively administer the benefit
- Need different design elements and incentives for low risk and high risk members

Wellness Design Discussion Points

- Thoughts on approach and progression over multi-year schedule?
- Do these activities support the Strategic Plan?

- How many programs and incentives can be effectively communicated and understood by members in a year?
- How many programs and incentives can be effectively managed and administered by the Plan in a year?

Plan Design Differentiation

Considering the relative value of SHP plan options, should the Board approve plan design changes to modify the relative plan richness or overall benefit value of existing options?

- Option for adjusting the relative value of the Traditional 70/30 and Enhanced 80/20 plans:
  - Increase cost-sharing on Traditional 70/30 to grandfather limits
  - Improve Pharmacy cost-sharing and add additional value based components on the Enhanced 80/20
    - Reduce cost share of Tier 1 medications on the Enhanced 80/20 to be in line with the marketplace
    - Incorporate a coinsurance minimum and maximum cost share on Enhanced 80/20 to promote member consumerism

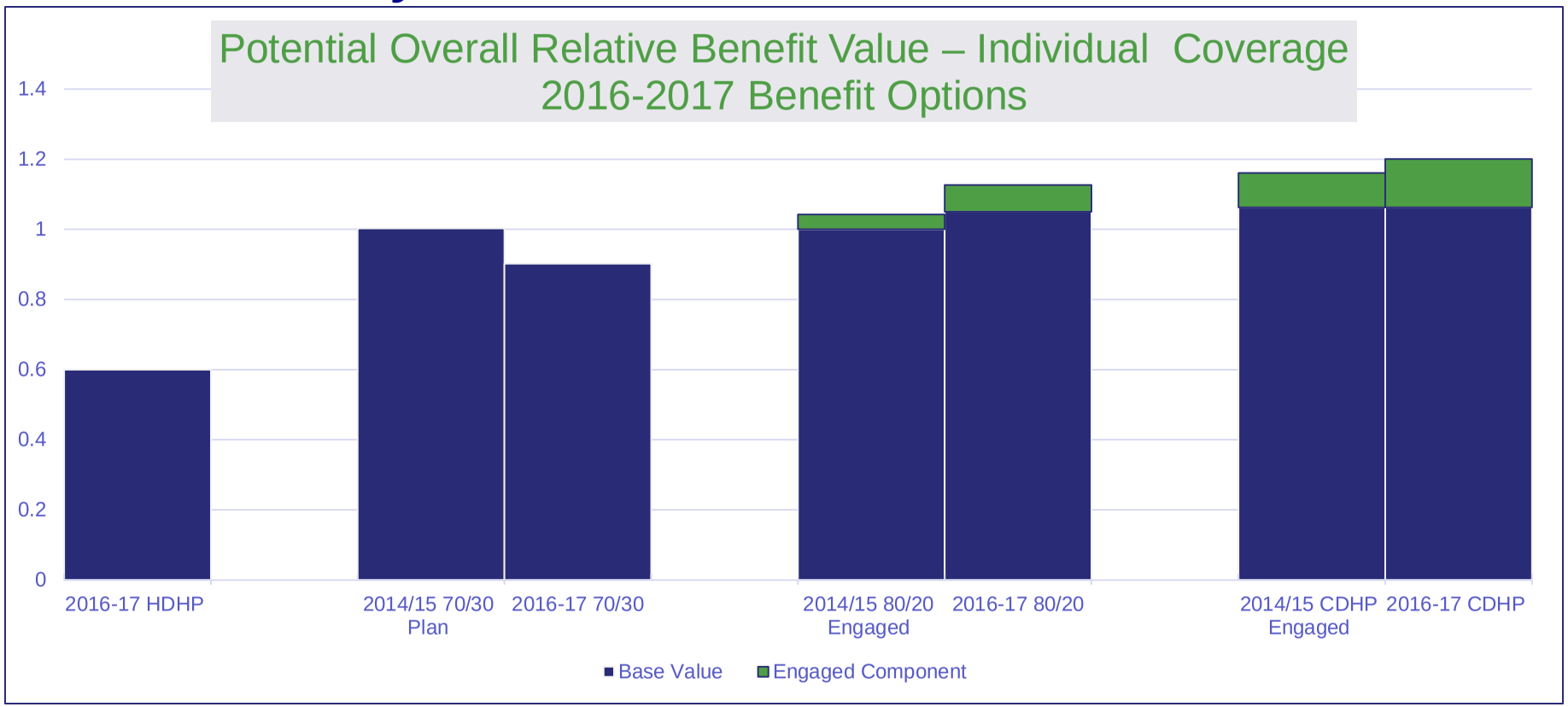
Option for Plan Design Differentiation

	70/30 Current	70/30 2016 Proposed	80/20 Current	CDHP
Annual Deductible	$933 Individual $2,799 Family	**$1,054 Individual $3,162 Family**	$700 Individual $2,100 Family	$1,500 Individual $4,500 Family
Coinsurance Maximum	$3,793 Individual $11,379 Family	**$4,282 Individual $12,846 Family**	$3,210 Individual $9,630 Family	N/A
Out-of-Pocket Maximum	N/A	**N/A**	N/A	$3,000 Individual $9,000 Family
Pharmacy Out-of-Pocket Maximum	$2,500	**$3,294**	$2,500	Included in OOP
Preventive Care	$35 PCP $81 Specialist	**$39 PCP $92 Specialist**	$0	$0
Office Visits				
PCP	$35	**$39**	$30 for primary doctor; $15 if you use PCMH on ID card	15% after deductible; $15 added to HRA if you use PCMH on ID
Specialist	$81	**$92**	$70 for specialist; $60 if you use Blue Options Designated specialist	15% after deductible; $10 added to HRA if you use Blue Options Designated specialist
Urgent Care	$87	**$98**	$87	15% after deductible
Chiro/PT/OT	$64	**$72**	$52	15% after deductible
Emergency Care	$291, then 30% after deductible	**$329, then 30% after deductible**	$233, then 20% after deductible	15% after deductible
Inpatient Hospital	$291, then 30% after deductible	**$329, then 30% after deductible**	$233 copay, then 20% after deductible; copay not applied if you use Blue Options Designated hospital	15% after deductible; $50 added to HRA if you use Blue Options Designated hospital

Option for Plan Design Differentiation

	70/30 Current	70/30 2016 Proposed	80/20 Current	80/20 2016 Proposed	CDHP Current	CDHP 2016 Proposed
Pharmacy Benefit						
Tier 1	$12	**$15**	$12	**$8**	15% after deducible for in network benefits, 35% after deductible out of network	15% after deducible for in network benefits, 35% after deductible out of network
Tier 2	$40	**$46**	$40	**20%, $25/Min, $40/Max**		
Tier 3	$64	**$72**	$64	**20%, $40/Min, Max/$64**		
Tier 4	25% up to $100	25% up to $100	25% up to $100	25% up to $100		
Tier 5	25% up to $125	**25% up to $132**	25% up to $125	**25% up to $132**		
OOP	$2,500 Rx Only	**$3,294 Rx Only**	$2500 Rx Only	$2,500 Rx Only	Integrated with Medical	Integrated with Medical
ACA Preventive Medications	No	No	Yes	Yes	Yes	Yes
CDHP Preventive Medications	N/A	N/A	N/A	N/A	Yes	Yes
Grandfather Status	Grandfathered	Grandfathered	Grandfathered	Grandfathered	Non-Grandfathered	Non-Grandfathered

Potential Impact of Plan Differentiation
Illustrative Only



- Can drive additional value-based components on the Enhanced 80/20 and CDHP while creating greater member choice by reducing the Traditional 70/30
- Approach would incent members to engage while allowing them an option to maintain coverage

Other Benefit Design Considerations

- Modeling Premium Strategies
  - Salary-based premium schedule – across the board or plan option specific?
  - Reduce dependent premiums – across the board or plan option specific?
- Retiree Plan Options
  - Statutory requirement to offer premium free option
  - Medicare Advantage premium rates for 2016 not available until June 2015
  - Options for offering Medicare Supplement (Medigap) Coverage
- Specialty Pharmacy
    - Working with BCBSNC regarding options for Medical Specialty
    - Consider modifying member cost share
      - Copay “parity” with Pharmacy benefit vs. Incenting lower cost care settings
- Maternity coverage for dependents
- Telehealth

Design Planning Discussion Points

How do Design Elements under Consideration Align with the Strategic Plan?

- Offer Health-Promoting and Value-Based Benefit Designs
- Assist Members to Effectively Manage High Cost Conditions
- Maximize Patient-Centered Medical Home Effectiveness
- Target Acute Care and Specialists Expense
- Target Rx Expense
- Promote Health Literacy

Next Steps

- Work with VBID Experts to develop recommended plan design change for consideration
- Input from BOT Strategic Workgroups and Stakeholders
- Financial Projection from Segal
  - What is the premium impact?
  - How will this impact enrollment?

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

Final Benefit Approvals for 2015: ACA Preventive Services

Board of Trustees Meeting

November 21, 2014

Presentation Overview

- Board Approval of Benefits
- Affordable Care Act (ACA) Compliance
- Review of August Approvals
- Federal Preventive Care Updates
- Financial Impact
- Recommendation

BOT Approval Required

Pursuant to NCGS 135-48.30 and 135-48.22, the Treasurer sets benefits subject to approval of the Board of Trustees.

Affordable Care Act (ACA) Compliance

- The Consumer-Directed Health Plan is a non-grandfathered plan and must comply with all ACA preventive service requirements.

- The Board previously approved coverage of ACA preventive services at $0 member cost share under the Enhanced 80/20 Plan, a grandfathered plan that does not have to comply with all ACA preventive service requirements.

August Approvals – CDHP and 80/20 Plans

Primary Breast Cancer Preventive Medication Coverage*

- Generic tamoxifen
- Generic raloxifene
- Brand Soltamox (tamoxifen liquid)

** Coverage at 100% subject to age and gender recommendations*

Tobacco Cessation Interventions**

- Extended QuitlineNC treatment time period to 90 days
- Added lozenges to QuitlineNC nicotine replacement therapy
- Added coverage of prescription generic bupropion sustained-release 150mg and brand varenicline (Chantix)

*** Coverage at 100% limited to members ≥18 years of age*

Federal Preventive Care Updates

- ## Screening for Hepatitis C Virus (HCV)

  The US Preventive Services Task Force (USPSTF) recommends screening high risk persons at risk for HCV. The recommendation also includes offering a one-time screening for HCV infection to adults born between 1945 and 1965.

- ## BRCA Risk Assessment and Genetic Counseling

  For women who have family members with breast, ovarian, tubal or peritoneal cancer with one of several screening tools designed to identify a family history that may be associated with an increased risk for potentially harmful mutations in breast cancers susceptibility genes (BRCA1 or BRCA 2). Women with positive screening results should receive genetic counseling and, if indicated, BRCA testing.

Federal Preventive Care Updates *(continued)*

- ## Lung Cancer Screening

  Annual screening for lung cancer with low-dose computed tomography (CT) in adults age 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.

- ## Chemoprevention of Dental Caries

  Primary care clinicians to prescribe oral fluoride supplementation at currently recommended doses to preschool children >6 months of age whose primary water source is deficient in fluoride. Primary care clinicians apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption.

Federal Preventive Care Updates *(continued)*

- Tobacco Use for Children and Adolescents

  Provide interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents. Applicable for members over the age of 5.

Segal Financial Impact Analysis

Preventive Services To Be Covered at 100%	Additional Cost
Screening for Hepatitis C Virus	$211,090
BRCA Risk Assessment and Genetic Counseling	213,180
Lung Cancer Screening	173,003
Chemoprevention of Dental Caries	25,000
Prevention of Tobacco Use for Children and Adolescents	No cost*
Total Annual Cost (2015)	**$622,273**

**Assumes this service will be provided during routine physician visits at no additional cost*

Recommendation ACA Preventive Services Coverage

Plan staff recommends adding 100% coverage of the preventive services described on slides 6, 7 and 8 under the CDHP and Enhanced 80/20 Plans, effective January 1, 2015.

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

Final Benefit Approvals for 2015: High Deductible Health Plan

Board of Trustees Meeting

November 21, 2014

Presentation Overview

- Board Approval of Benefits
- Review of August Approval to Establish HDHP
- Overview of Benefits
- Coverage Recommendation

BOT Approval Required

Pursuant to NCGS 135-48.30 and 135-48.22, the Treasurer sets benefits subject to approval of the Board of Trustees.

High Deductible Health Plan (HDHP)

- At the August meeting the Board approved an alternative benefit option to comply with G.S. 135-48.40(e).

- The High Deductible Health Plan provides the following coverage:
  - Deductibles ($5,000/$10,000)
  - Coinsurance (50% in-network, 40% out-of-network)
  - ACA preventive medical and pharmacy covered at 100%
  - Member services for Teladoc, HealtheReports, Personal Care Management, and Personal Health Suite
  - Express Scripts National Formulary

Overview of Benefits

- Coverage of services and supplies are consistent with traditional products with two proposed differences around bariatric surgery and coverage for replacement of lost teeth.
- Exclusions match those of traditional products with one proposed difference: Applied Behavior Analysis (ABA).
- Neutral Benefit (same coinsurance in or out-of-network) proposed for certain services.
- Fewer utilization management (UM)* programs. UM only provided for the following:
    - Inpatient admissions (including bariatric surgery)
    - Hospital Observation stays of more than 48 hours
    - CT scan, MRI and PET scan diagnostic procedures
    - Transplant Services

**UM programs are set by the Treasurer and do not require Board approval. See NCGS 135-48.30(a)(8).*

Recommended Coverage

- Include dental services for the replacement of teeth lost as a direct result of chemotherapy or radiation.
- Include coverage for bariatric surgery subject to UM.
- Exclude Applied Behavior Analysis from coverage.
- Neutral Benefit for the following services:
  - Emergency Services
  - Emergency Medical Transportation
  - Urgent Care
  - Skilled Nursing Care
  - Durable Medical Equipment
  - Hospice Services
  - Home Health Care

Recommendation HDHP Coverage

Plan staff recommends coverage under the HDHP as described in the Benefits Booklet, which includes the recommendations set forth on slide 6 of this presentation, effective January 1, 2015.

Appendix

- HDHP Summary of Benefits and Coverage *(attached)*
  http://www.shpnc.org/library/pdf/annual-enrollment/2015/HDHP-USC.pdf

- HDHP Benefit Booklet
  http://www.shpnc.org/library/pdf/annual-enrollment/2015/HDHP2015Final.pdf

State Health Plan: High Deductible Health Plan 50/50

Coverage Period: 01/01/2015 – 12/31/2015

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual, Individual + Spouse, Individual + Children, Family | **Plan Type:** High Deductible PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at http://www.shpnc.org and click on High Deductible Health Plan or by calling 866-740-3881.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$5,000** person / **$10,000** family for in-network; **$10,000** person / **$20,000** family for out-of-network; doesn't apply to in-network preventive care.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible.**
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. **$6,450** person / **$12,900** family for in-network; **$12,900** person / **$25,800** family for out-of-network.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Your cost for services when required pre-authorization was not obtained; premiums, balance-billed charges and health care services this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out–of–pocket limit.**
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network.** See the chart starting on page 2 for how this plan pays different kinds of **providers.**
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.

Are there services this plan doesn't cover?	Yes.	Some of the services this plan does not cover are listed on a later page. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $35) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 15% would be $150. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance**

Common Medical Event	Services You May Need	Your cost if you use an In-Network Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	50% coinsurance after deductible	60% coinsurance after deductible	——————none——————
	Specialist visit	50% coinsurance after deductible	60% coinsurance after deductible	——————none——————
	Other practitioner office visit	50% coinsurance after deductible	60% coinsurance after deductible	Coverage is limited to a combined 30 visits per benefit period for chiropractic care, physical therapy and occupational therapy and 30 visits per benefit period for speech therapy.
	Preventive care/screening / immunization	$0/visit	60% coinsurance after deductible	The **deductible** does not apply to in-network provider services.

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you have a test	Diagnostic test (X-ray, blood work)	50% coinsurance after deductible;	60% coinsurance after deductible;	No coverage for tests not ordered by a doctor.
	Imaging (CT/PET scans, MRIs)	50% coinsurance after deductible	60% coinsurance after deductible;	Prior authorization is required or services will not be covered.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.shpnc.org	Prescription drugs	50% coinsurance after deductible	60% coinsurance after deductible	Per 30-day supply.
	Affordable Care Act Preventive Medications	0% coinsurance; no deductible	60% coinsurance after deductible	Prescription must be written and filled at the pharmacy counter.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	50% coinsurance after deductible	60% coinsurance after deductible	——————none——————
	Physician/surgeon fees	50% coinsurance after deductible	60% coinsurance after deductible	——————none——————
If you need immediate medical attention	Emergency room services	50% coinsurance after deductible	50% coinsurance after deductible	——————none——————
	Emergency medical transportation	50% coinsurance after deductible	50% coinsurance after deductible	——————none——————
	Urgent care	50% coinsurance after deductible	50% coinsurance after deductible	——————none——————

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you have a hospital stay	Facility fee (e.g., hospital room)	50% coinsurance after deductible / admission	60% coinsurance after deductible	Precertification required.
	Physician/surgeon fee	50% coinsurance after deductible	60% coinsurance after deductible	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	50% coinsurance after deductible	60% coinsurance after deductible	——————none——————
	Mental/Behavioral health inpatient services	50% coinsurance after deductible / admission	60% coinsurance after deductible	Precertification may be required.
	Substance use disorder outpatient services	50% coinsurance after deductible	60% coinsurance after deductible	——————none——————
	Substance use disorder inpatient services	50% coinsurance after deductible / admission	60% coinsurance after deductible	Precertification required.

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you are pregnant	Prenatal and postnatal care	50% coinsurance after deductible	60% coinsurance after deductible	——————none——————
	Delivery and all inpatient services	50% coinsurance after deductible / admission	60% coinsurance after deductible	——————none——————
If you need help recovering or have other special health needs	Home health care	50% coinsurance after deductible	50% coinsurance after deductible	——————none——————
	Rehabilitation services	50% coinsurance after deductible	60% coinsurance after deductible	——————none——————
	Habilitation services	Not covered	Not covered	Excluded
	Skilled nursing care	50% coinsurance after deductible	50% coinsurance after deductible	Coverage is limited to 100 visits per benefit period. Precertification required.
	Durable medical equipment	50% coinsurance after deductible	50% coinsurance after deductible	——————none——————
	Hospice services	50% coinsurance after deductible	50% coinsurance after deductible	——————none——————
If your child needs dental or eye care	Eye exam	Not covered	Not covered	——————none——————
	Glasses	Not covered	Not covered	Excluded
	Dental check-up	Not covered	Not covered	Excluded

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Benefits paid as a result of injuries caused by another party may need to be repaid to the health plan or paid for by another party under certain circumstances
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Child)
- Eye exams (Child)
- Glasses
- Habilitation services
- Hearing aids (age 22 and older)
- Hospital inpatient precertification required
- Long-term care
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic care (up to 30 visits per benefit period)
- Telemedicine
- Hearing aids (under age 22)
- Infertility treatment (limited to 3 ovulation induction cycles)
- Emergency care when traveling outside the U.S.
- Private Duty Nursing

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-855-859-0966. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or **www.dol.gov/ebsa**, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or **www.cciio.cms.gov**.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: State Health Plan Customer Service at 1-800-795-1023 or **shpnc.org**. You may also receive assistance from the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or **www.dol.gov/ebsa/healthreform**, if applicable. You may also contact North Carolina Department of Insurance at 1201 Mail Service Center, Raleigh, NC 27699-1201, or 919-807-6750 (in North Carolina), 800-546-5664 (outside North Carolina), if applicable.

Does This Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage". **This plan or policy does provide minimum essential coverage.**

Does This Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of health plan. **The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en español, llame al número que aparece al respaldo de su tarjeta del seguro.
Tagalog (Tagalog): Para matulungan sa Tagalog, tawagan ang numerong nasa likuran ng insurance card.
Chinese (中文):如需國語或廣東話協助，請致電您保險卡背面的電話號碼。
Navajo (Dine):Diné bizaad bee shíká'adoowoł nínzingo kwojį' hólne', naaltsoos áłts'ísí nantinígíí bine'dęę' binámboo bikáá'.

----------*To see examples how this plan might cover costs for a sample medical situation, see the next page* ----------

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $1,250
- **You pay** $6,290

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$5,000
Copays	$0
Coinsurance	$1,140
Limits or exclusions	$150
Total	**$6,290**

Note: These numbers assume the patient has given notice of her pregnancy to the plan. If you are pregnant and have not given notice of your pregnancy, your costs may be higher. For more information, please contact: 866-740-3881.

Managing type 2 diabetes
(routine maintenance of well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $1,480
- **You pay** $3,920

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$2,420
Copays	$0
Coinsurance	$1,420
Limits or exclusions	$80
Total	**$3,920**

Questions and Answers about Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs do not include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and are not specific to a particular geographic area or health plan.
- Patient's condition was not an excluded or pre-existing condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment is not covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You cannot use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you will find the same Coverage Examples. When you compare plans, check the "Patient Pays" box for each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you will pay in out-of-pocket costs, such as **deductibles**, and **coinsurance**. You should consider also contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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

State Health Plan for Teachers and State Employees

High Deductible Health Plan (HDHP)

Benefits Booklet

January 1 – December 31, 2015

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

High Deductible Health Plan (HDHP) Benefits Booklet

January 1 – December 31, 2015

Dear Member,

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

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

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

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

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

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SERVICES AND INFORMATION

State Health Plan **Website** www.shpnc.org	To obtain information on Pharmacy benefits, search for a provider and other plan related information.
Member Online Portal www.medcost.com	To enroll in a safe, secure customer service website in order to: Check claim status, or request a new *Identification Card (ID card).*
State Health Plan **Customer Service** 866-740-3881 8:30 a.m-5 p.m., Monday-Friday, except holidays	For questions regarding your benefits, claim inquiries and new *ID card* requests.
State Health Plan **Enrollment and Billing Center** 855-442-6272 8 a.m.-5 p.m., Monday-Friday, except holidays	For questions regarding *member* eligibility and enrollment.
COBRA Administration and Individual Billing Services Customer Service 877-679-6272 8 a.m.-5 p.m., Monday-Friday, except holidays	For questions relating to premium payments for Retirees/COBRA/Surviving Spouses.
Express Scripts Customer Service 800-336-5933 24 hours a day, 7 days per week, except for Thanksgiving and Christmas day	For questions regarding your *prescription* benefits, to obtain the 2015 Express Scripts National Preferred Formulary, information on *prior authorizations*, refills, and more.
Accredo Specialty Pharmacy 877-988-0059	For information regarding the specialty pharmacy services offered or to obtain *specialty medications*.
TelaDoc Available 7 days a week 1-800-TelaDoc (835-2362)	Quick answers to medical concerns.

PRIOR AUTHORIZATION (CERTIFICATION)

Certification 866-740-3881	To request *prior authorization* (*certification*) for medical claims for certain *out-of-network* or out-of-state services.
Express Scripts - ***Prior Authorization*** **Number** 800-417-1764	To initiate a *prior authorization* request for a *prescription drug*.

CLAIMS FILING

Medical Claims Filing

Mail completed medical claims to:
State Health Plan
c/o *MedCost*
PO Box 25307
Winston-Salem, NC 27114-5307

Prescription Drug **Claims Filing**

Mail completed *prescription drug* claim forms to:
Express Scripts, Inc.
ATTN: Direct Claims
P.O. Box 2824
Clinton, IA 52733-2824

APPEALS

Medical *Appeals*
866-740-3881

See "*Appeals* Correspondence" in "What If You Disagree With A Decision?"

Pharmacy Appeals

See "*Appeals* Correspondence" in "What If You Disagree With A Decision?"

ADDITIONAL RESOURCES

N.C. Department of State Treasurer
Retirement System Division
325 North Salisbury Street
Raleigh, NC 27603-1385
919-733-4191 or 877-733-4191 toll-free
www.myncretirement.com

If you are a benefit recipient (*Retirees*, Beneficiaries, Disability recipients) and you have questions about your retirement benefits.

Tips for Getting the Most out of Your Health Care Benefits

Understand your health care plan

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

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

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

Save on prescription drugs

Print out the 2015 Express Scripts National Preferred Formulary and take it with you when visiting your *doctor*. Ask your *doctor* to authorize a *generic* substitute whenever a *generic* is available. You will save money using *generics* since they typically have the lowest *cost*.

Pick a Primary Care Provider

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

Take charge of your health

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

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

Member Rights and Responsibilities

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

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

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

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

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

Important Notices

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

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

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

Benefits Booklet

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

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

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

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

Introduction to the High Deductible Health Plan

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

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

Aviso Para Miembros Que No Hablan Ingles

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

High Deductible Health Plan (HDHP) Summary of Benefits

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

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

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

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

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

Urgent Care Centers and *Emergency* Room

Urgent Care Centers	50% after *deductible*	50% after *deductible*
***Emergency* Room Visit**	50% after *deductible*	50% after *deductible*

Ambulatory Surgical Center

Ambulatory Surgical Services	50% after *deductible*	60% after *deductible*

Outpatient

Outpatient Services	50% after *deductible*	60% after *deductible*

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

Inpatient

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

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

Skilled Nursing Facility

	50% after *deductible*	50% after *deductible*

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

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

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

TelaDoc	$40 per visit

Mental Health and Substance Abuse Services

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

Prescription Drugs

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

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

Affordable Care Act Preventive Medications	0% *coinsurance*	60% after deductible

A list of *Affordable Care Act Preventive Medications* is listed on the Plan's website at www.shpnc.org under High Deductible Health Plan.

NOTICE: All non-acute specialty drugs covered under the pharmacy benefit must be obtained through Accredo Specialty Pharmacy.

Certification Requirements

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

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

Certain prescription drugs require prior review and *certification* before they are covered. Your physician may call Express Scripts at 1-800-417-1764 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.

Whom Do I Call?

***State Health Plan* Website**

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

www.shpnc.org .....

***State Health Plan* Customer Service**

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

Enrollment and Billing Support Center

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

COBRA Administration and Individual Billing Services Customer Service

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

Pharmacy Benefit Manager

The current *Pharmacy Benefit Manager (PBM)* is:
Express Scripts.....800-336-5933
Express Scripts Prior Authorization.....800-417-1764
Accredo Specialty Pharmacy 877-988-0059

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

Out of North Carolina Care

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

Prior Review

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

How the HDHP Works

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

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

Here's a look at how it works:

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

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

Out-Of-Network Benefit Exceptions

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

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

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

Carry Your Identification Card

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

For *ID card* requests, please visit www.medcost.com or call Customer Service at the number listed in "Whom Do I Call?"

The Role of A Primary Care Provider (PCP)

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

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

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

Understanding Your Share of the Cost

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

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

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

Covered Services

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

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

Also keep in mind as you read this section:

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

Office Services

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

Office Services Exclusions

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

Affordable Care Act (ACA) Preventive Services

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

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

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

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

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

Nutritional Counseling

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

Routine Physical Examinations and Screenings

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

Well-Baby and Well-Child Care

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

Well-Woman Care

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

Contraceptive Methods

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

Contraceptive Methods Exclusions

- Male contraceptives

Immunizations

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

Immunizations Exclusion

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

Bone Mass Measurement Services

The Plan covers scientifically proven and approved bone mass measurement for the diagnosis and evaluation of osteoporosis or low bone mass during any 23-month period for certain qualified individuals only. Additional follow-up bone mass measurement tests will be covered if medically necessary. Please note that bone mass measurement tests will be covered under your diagnostic benefit (not your preventive care benefit) if the claim for these services indicates a primary diagnosis of something other than preventive or wellness. Your diagnostic benefit will be subject to your *in-network* benefit level for the location where services are received.

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

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

Colorectal Screening

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

Gynecological Exam and Cervical Cancer Screening

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

Newborn Hearing Screening

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

Ovarian Cancer Screening

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

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

Prostate Screening

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

Screening Mammograms

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

A female member is "at risk" if she:

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

Diagnostic Services

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

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

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

Diagnostic Services Exclusion

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

Emergency Care

The Plan provides benefits for *emergency services*.

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

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

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

What to do in an Emergency

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

life-threatening *emergencies*. Prior review is not required for *emergency services*. Your visit to the *emergency* room will be covered if your condition meets the definition of an *emergency*.

Benefits for services in the *emergency* room

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

Urgent Care

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

Family Planning

Maternity Care

Maternity care, which includes prenatal care, labor and delivery, and post-delivery care, is available to all female members. However, maternity benefits for *dependent children* cover only the treatment

for *complications of pregnancy*. Coverage for breastfeeding counseling and certain breast pumps for pregnant or postpartum members are covered under your preventive care benefit. Purchase is limited to one per pregnancy and purchase from a retail store is not covered.

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

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

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

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

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

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

Complications of Pregnancy

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

Complications of Abortion

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

Infertility Services

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

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

Sexual Dysfunction Services

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

Sexual Dysfunction Exclusion

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

Sterilization

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

Family Planning Exclusions

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

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

Facility Services

Benefits are provided for:

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

  Prior review must be requested and c*ertification* must be obtained in advance for *inpatient* admissions to avoid a penalty, except for maternity deliveries and *emergencies*. See "Maternity Care," if applicable, and "*Emergency* Care."
- Surgical services received in an *ambulatory surgical center*
- Covered services received in a skilled nursing facility; skilled nursing *facility services* are limited to a combined in- and out-of-network day maximum per *benefit period.*

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

Other Services

***Ambulance* Services**

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

- From a member's home, scene of an accident, or site of an *emergency* to a *hospital*
- Between *hospitals*
- Between a *hospital* and a skilled nursing facility when such a facility is the closest one that can provide covered services appropriate to the member's condition. Benefits may also be provided for *ambulance* services from a *hospital* or skilled nursing facility to a member's home when medically necessary.
- The plan covers services in an air *ambulance* traveling from the site of an *emergency* to a *hospital* when such a facility is the closest one that can provide covered services appropriate to the member's condition. Air *ambulance* services are eligible for coverage only when ground transportation is not medically appropriate due to the severity of the illness, or the pick-up point is inaccessible by land.

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

Ambulance Service Exclusion

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

Morbid Obesity and Bariatric Surgery

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

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

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

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

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

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

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

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

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

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

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

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

Approved Bariatric Surgery Procedures

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

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

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

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

The following procedures are NOT COVERED:

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

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

Repeat Bariatric Surgery or Reoperation

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

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

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

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

Blood

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

Blood Exclusion

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

Clinical Trials

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

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

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

Clinical Trials Exclusions

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

Dental Treatment Covered Under Your Medical Benefit

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

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

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

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

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

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

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

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

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

Dental Treatment Excluded Under Your Medical Benefit

Treatment for the following conditions:

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

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

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

Diabetes Related Services

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

Durable Medical Equipment

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

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

Durable Medical Equipment Exclusions

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

Hearing Aids

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

Home Health Care

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

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

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

Home Health Care Exclusions

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

Home Infusion Therapy Services

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

Hospice Services

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

Hospice Services Exclusions

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

Lymphedema-Related Services

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

Lymphedema-Related Services Exclusion

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

Medical Supplies

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

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

Medical Supplies Exclusion

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

Orthotic Devices

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

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

Orthotic Devices Exclusions

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

Private Duty Nursing

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

Private Duty Nursing Exclusion

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

Prosthetic Appliances

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

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

Prosthetic Appliances Exclusions

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

Surgical Benefits

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

Cosmetic surgery is not covered except as specifically identified.

Multiple surgical procedures performed on the same date of service and/or during the same patient encounter, may not be eligible for separate reimbursement. When multiple procedures are performed during the same operative session, benefits will be based on Medically Necessary services. Allowable expenses will be determined based on the complexity of the procedures. 100% of the allowable expense for the most complex will be considered and 50% of the allowable expense or billed charge will be considered for each additional procedure. An assistant surgeon will be considered eligible when Medical Necessity has been determined based on standard practices. Benefits will be based on 20% of the allowable expense or billed charge.

Anesthesia

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

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

Mastectomy Benefits

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

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

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

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

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

Temporomandibular Joint (TMJ) Services

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

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

Temporomandibular Joint (TMJ) Services Exclusions

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

Therapies

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

Short-Term Rehabilitative Therapies

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

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

Other Therapies

The Plan covers:

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

  Therapy Exclusions

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

Transplants

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

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

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

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

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

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

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

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

Mental Health and Chemical Dependency Benefits

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

Office Visit Services

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

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

Outpatient Services

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

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

Inpatient Services

Covered *inpatient* treatment services also include:

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

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

Mental Health and Chemical Dependency Services Exclusions

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

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

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

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

Prescription Drug Benefits

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

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

The HDHP will utilize the 2015 Express Scripts National Preferred Formulary. The 2015 Express Scripts National Preferred Formulary is a national drug list of the most commonly prescribed drugs that may be covered by the Plan for members of the HDHP. The list is not an all-inclusive list. The formulary represents an abbreviated version of drugs that may be covered. Certain brand-name medication with covered preferred alternatives may not be covered by the Plan and not all the drugs listed are covered by the Plan. The 2015 Express Scripts National Preferred Formulary can be viewed at www.shpnc.org under HDHP.

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

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

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

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

For *certification* of your prescription drugs, your physician may call the PBM's Prior Authorization number listed in "Whom Do I Call?" to initiate a *certification* request.

Using an In-network Pharmacy

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

- Visiting the *State Health Plan*'s website, or
- Calling the *PBM* at the number listed in "Whom Do I Call?"

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

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

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

Affordable Care Act Preventive Medications

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

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

Prescription Drug Exclusions

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

Diabetic Testing Supplies

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

Tobacco Cessation Coverage

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

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

Specialty Pharmacy

Specialty medications are covered injectable and non-injectable medications administered at home or in your provider's office with **one** or more of the following characteristics:

- Require specialized clinical care due to
    - Frequent dosing adjustments due to complex therapies for complex diseases
    - Intensive clinical monitoring due to unique patient adherence and safety monitoring requirements
    - Intensive patient training and coordination of care required prior to therapy initiation and/or during therapy
- Require specialized channel and handling needs due to
    - Limited or exclusive specialty distribution
    - Specialized handling and administration based on unique requirements for handling, shipping, and storage

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

How to File a Claim for *Prescription Drugs*

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

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

Express Scripts
ATTN: Direct Claims
PO Box 2824
Clinton, IA 52733-2824

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

- Date *prescription* filled
- Name and address of pharmacy
- *Doctor* name or *ID number*
- National Drug Code (NDC)

- Name of drug and strength
- Quantity and day supply
- *Prescription* number (Rx number)
- DAW (Dispense As Written)
- Amount paid

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

Drug receipts from the label or bag should not be submitted. Claims will be returned if not properly completed. For information on how to properly submit a pharmacy claim, call Express Scripts Customer Service at the number given in "Whom Do I Call?"

Special Programs

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

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

What is not Covered?

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

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

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

A

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

B

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

C

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

or thighs, and surgery for psychological or emotional reasons, except as specifically covered by the Plan

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

D

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

E

- **Ear** piercing
- Services primarily for **educational** purposes including, but not limited to, evaluation, books, tapes, pamphlets, seminars, classroom, Web or computer programs, individual or group instruction, counseling, and vocational counseling

except as specifically covered by the Plan

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

F

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

G

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

H

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

I

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

L

- Services provided and billed by a **lactation** consultant, except when covered as preventive care.

M

- Services or supplies deemed not **medically necessary.**

N

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

O

- Any treatment or regimen, medical or surgical, for the purpose of reducing or controlling the weight of a member or for treatment of **obesity,** except for surgical treatment of morbid obesity, or as specifically covered by the Plan.

P

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

R

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

S

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

T

- The following types of **therapy:**
  - Applied Behavior Analysis (ABA) therapy
  - Music therapy, remedial reading, recreational or activity therapy, all forms of special education and supplies or equipment used similarly
  - Maintenance therapy
  - Massage therapy
- **Travel**, whether or not recommended or prescribed by a *doctor* or other licensed health care professional, except as specifically covered by the Plan.

V

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

W

- **Wigs**, hairpieces and hair implants for any reason.

Utilization Management

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

Rights and Responsibilities Under the UM Program

Your Member Rights

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

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

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

The State Health Plan's Responsibilities

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

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

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

Prior Review (Pre-Service)

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

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

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

Urgent Prior Review

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

An urgent review may be requested by calling State Health Plan Customer Service at the number listed in "Whom Do I Call?"

Concurrent Reviews

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

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

Urgent Concurrent Review

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

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

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

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

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

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

Case Management

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

Continuity of Care

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

An ongoing special condition means:

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

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

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

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

Further Review of Utilization Management Decisions

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

What if you disagree with a Decision?

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

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

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

Steps To Follow In the *Grievance* Process

First Level *Grievance* Review

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

Any request for review should include:

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

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

Second Level *Grievance* Review

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

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

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

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

Expedited Review

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

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

External Review

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

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

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

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

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

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

Standard External Review

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

Expedited External review

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

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

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

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

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

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

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

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

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

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

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

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

Third Level *Grievance* Review

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

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

Pre-Service Claims

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

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

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

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

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

Post-Service Claims

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

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

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

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

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

Appeals Correspondence

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

Medical Appeals

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

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

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

Pharmacy Appeals

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

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

Express Scripts
Attn: Clinical Appeals Department
PO Box 66588
St Louis, MO 63166-6588
Fax 1 877- 852-4070

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

Express Scripts
Attn: Administrative Appeals Department
PO Box 66587
St Louis, MO 63166-6587
Fax 1 877- 328-9660

Additional Terms of Your Coverage

Benefits to Which Members are Entitled

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

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

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

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

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

Disclosure of Protected Health Information (PHI)

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

Administrative Discretion

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

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

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

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

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

Provider Reimbursement

Services Received In North Carolina, South Carolina and Virginia

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

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

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

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

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

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

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

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

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

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

Right of Recovery/Subrogation Provision

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

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

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

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

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

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

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

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

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

Notice of Claim

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

Limitations of Actions

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

Coordination of Benefits (Overlapping Coverage)

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

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

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

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

The term “benefit plan” does not include:

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

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

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

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

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

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

Benefits are coordinated on a Plan Year basis.

Rules for Benefits Plan Payment Order

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

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

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

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

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

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

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

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

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

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

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

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

Medicare as a Secondary Payer

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

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

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

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

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

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

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

MEDICAID

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

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

When Coverage Begins and Ends

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

Eligibility

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

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

Dependent Eligibility

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

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

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

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

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

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

Enrolling in the Plan

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

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

Dual Enrollment

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

Timely Enrollees

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

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

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

Adding or Removing a Dependent

If you want to add or remove a *dependent* due to a qualifying life event, contact your *HBR*. Failure to timely notify your *HBR* of the need to remove a *dependent* could result in loss of eligibility for continuation of coverage.

To add a *dependent*, you must notify the *HBR* or add your *dependent* through your online enrollment system. For coverage to be effective on the date the *dependent* becomes eligible due to a qualifying life event or the first day of the month following the qualifying life event, the completion of the enrollment must occur within 30 days after the *dependent* becomes eligible.

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

In order for a newborn child to be covered from the date of birth, the coverage *effective date* must be the first day of the month in which the child is born. If you choose to enroll your newborn the first day of the month following delivery, you will be responsible for any claims *incurred* in the birth month by the newborn. For more information, see "Newborn Care" in "*Covered Services*."

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

child is born or to the first of the month in which the date of placement occurred for adoptive and *foster children*.

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

Qualified Medical Child Support Order

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

Effective Dates of Coverage

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

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

Types of Coverage

Your health benefit plan offers the following types of coverage:

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

Reporting Changes

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

When Coverage Ends

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

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

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

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

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

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

Definitions

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

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

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

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

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

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

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

c) Does not provide *inpatient* accommodations,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

EXPERIMENTAL — see *Investigational*.

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

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

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

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

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

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

HBR — see *Health Benefits Representative*.

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

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

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

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

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

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

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

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

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

e) Is acceptable to *MedCost*.

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

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

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

c) Is acceptable to *MedCost*.

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

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

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

INFERTILITY — the inability of a heterosexual couple to conceive a child after 12 months of unprotected male/female intercourse.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

OUT –OF-NETWORK PHARMACY – a pharmacy that has not been designated as participating in Express Scripts' Pharmacy Network.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SPECIALTY MEDICATION – medications that may require specialized clinical care due to frequent dosing, intensive clinical monitoring or intensive patient training and coordination of care or medications that may require specialized handling and administration or have a limited distribution.

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

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

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

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

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

a) The correction of fractures and dislocations

b) Usual and related preoperative and postoperative care

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

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

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

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

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

Notice of Privacy Practices

Original *Effective Date*: April 14th, 2003

Revised *Effective Date*: September 23rd, 2013

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

PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Introduction

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

What information is protected?

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

How the Plan May Use and Disclose your PHI

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

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

Primary Uses and Disclosures of PHI

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

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

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

Other Uses and Disclosures of PHI

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

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

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

Your Rights Regarding PHI

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

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

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

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

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

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

Changes to This Notice

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

Complaints

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

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

Privacy Contact

The Privacy Contact is:

State Health Plan
Attention: HIPAA Privacy Officer,
4901 Glenwood Avenue, Suite 300,
Raleigh, NC 27612-3820
919-881-2300

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

Implementation of Applied Behavior Analysis Benefit

Board of Trustees Meeting

November 21, 2014

Applied Behavior Analysis (ABA)

- In May the Board approved coverage for ABA when:
  - The member is younger than age 26, and
  - Diagnosed with Autism Spectrum Disorder (ASD) by a licensed physician (MD or DO) or a licensed doctoral level clinical psychologist (PsyD or PhD) utilizing results from a face-to-face evaluation and a clinically recognized, validated tool accepted by the Mental Health Care Manager, and
  - Treatment is determined by the Mental Health Care Manager to be medically necessary.
- Coverage for ABA is limited to a maximum of $36,000 per benefit year and is only available in-network.
- Coverage is subject to copay, deductible and coinsurance as applicable (depends on ABA component and place of service).

Implementation – BCBSNC Network Providers

- Benefit configuration is on track for January 1, 2015, effective date.
- Training on the new benefit has been completed for both member and provider Customer Service Representatives.
- Benefit information has been posted on the BCBSNC provider portal:

  http://www.bcbsnc.com/content/providers/news-and-information/news/SHP_Autism_Benefit.htm

- Promotional information, including the above link, was included in the weekly provider email blast on October 31, 2014. The blast is distributed to all in-network providers.

Information – Non-Network Providers

- BCBSNC has provided supplemental information and training to the Provider Services and Network Management teams for more effective and consistent handling of calls including those from certified ABA therapists who are not licensed and do not have the credentials to participate in the network.
- Non-network providers who call the BCBSNC 1-800 number will receive information about the benefit through the interactive voice response (IVR) system.
- Customer service has set up a warm transfer protocol to Network Management for non-network providers seeking additional information about network requirements, credentialing or joining the network.

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

Strategic Plan Scorecard – Measuring Success

Board of Trustees Meeting

November 21, 2014

A Division of the Department of State Treasurer

Presentation Overview

- Review of Strategic Plan Metrics
- Summary of Proposed Methodology
- Illustrative Example of Scoring
- Next Steps

Review of Approved Strategic Plan Metrics

- The Board-approved Strategic Plan includes a series of metrics to evaluate State Health Plan progress in achieving the goals set forth in the Strategic Plan
- While there are multiple metrics to measure success, the Board-approved metrics and future targets attempt to address the needs of the Plan's members and stakeholders
- The approved metrics aim to measure how well the Plan is:
  - Improving members' health,
  - Improving members' experience, and
  - Ensuring a financially sustainable State Health Plan
- Several metrics require collaboration with the Plan's vendor partners to measure results

Approved Metrics – Improve Members' Health

Priority	Description	Goal Description
Improve Members' Health	PCMH Utilization	Increase % of members receiving care from a NCQA recognized PCMH
	Quality of Care	Increase % of members with targeted high prevalence conditions receiving care according to national clinical standards
	Worksite Wellness	Increase number of worksites offering worksite wellness

These metrics reflect areas of focus for the Plan and initiatives aimed at meeting the goals and future targets will help lead to:

- Healthier and more engaged members,
- Better managed chronic disease, and
- Members receiving high quality, coordinated care

Approved Metrics – Improve Members' Experience

Priority	Description	Goal Description
Improve Members' Experience	Customer Satisfaction	Maintain or improve overall Customer Satisfaction score.
	Annual Enrollment Service Level Agreements	Improve Annual Enrollment customer service SLAs.
	Member Engagement	1. Increase in the # of active members registered as users on TPA site 2. Increase in the usage of TPA's provider search and transparency tools 3. Increase in attendance at educational roadshows

These metrics reflect areas of focus for the Plan and initiatives aimed at meeting the goals and future targets will help lead to:

- Increased member engagement,
- Higher level of trust, and
- More informed members who are empowered in their decision making

Approved Metrics – Ensure a Financially Stable State Health Plan

Priority	Description	Goal Description
Ensure a Financially Stable State Health Plan	Net Income/Loss	Net income/loss actual at or above certified or authorized budget for plan year
	PMPM Claims Expenditures	PMPM claims expense at or below certified or authorized budget (as forecasted by actuaries) for plan year
	Member Cost-Sharing	% of total claims cost paid by members through copays, deductibles and coinsurance at or below benchmark

These metrics reflect areas of focus for the Plan and initiatives aimed at meeting the goals and future targets will help lead to:

- Reduced costs for members and the Plan
- Reduced fraud, waste, abuse and overuse
- Delivery of appropriate care in the appropriate setting
- Payment for quality and value rather than quantity

Summary of Proposed Methodology

- Each of the strategic measures were chosen to illustrate the progress the Plan is making (or not making) in achieving the Strategic Plan
  - Additionally, they are items that can be measured
- Where appropriate, the two benchmark periods will be FY 2012-13 and CY2014 to reflect the last two full plan years *(Note: the Strategic Plan adopted by the Board assumes CY 2013 as the benchmark period)*
  - This serves to reflect (directionally) the trends related to each metric
- Beginning in CY 2015, each measure will have a threshold, target, and stretch goal
- The scorecard will be a high level summary of detailed analyses that is easy to digest
- Success will be measured by meeting at least two of three priority groupings, minimizing those below threshold, and identifying targets to achieve the stretch measures

Sample Summary Score Card – Illustrative

Strategic Priority	Description	Below Threshold	Met or Exceeded Threshold	Met or Exceeded Target	Met or Exceeded Stretch Goal	Annual Result (Unmet or Met)
Improve Members' Health	PCMH Utilization				X	Met
	Quality of Care			X		
	Worksite Wellness			X		
Improve Members' Experience	Customer satisfaction			X		Met
	Annual Enrollment service level agreements			X		
	Member engagement			X		
Ensure a Financially Stable State Health Plan	Net income/loss		X			Met
	PMPM claims expenditures			X		
	Member cost-sharing			x		

Improve Members' Health Sample Card - Illustrative

		Benchmark Periods					
Description	**Metric**	**FY 2012-13 Actual**	**CY 2014 Actual**	**CY 2015 Result**	**Met or Exceeded Threshold**	**Met or Exceeded Target**	**Met or Exceeded Stretch Goal**
PCMH Utilization	Increase % of members receiving care from a NCQA recognized PCMH	Level One: Level Two: Level Three: Overall:	Level One: TBD Level Two: TBD Level Three: TBD Overall: TBD	Level One: Level Two: Level Three: Overall:	Overall +4%	Overall +8%	3% increase in level three
Quality of Care	Increase % of members with targeted high prevalence conditions receiving care according to national clinical standards	Asthma: 3% CHF: 8% Diabetes: 15% Hypertension: 50%	Asthma: TBD CHF: TBD Diabetes: TBD Hypertension: TBD	Asthma: CHF: Diabetes: Hypertension	Two of four conditions improve by 5%	Three of four conditions improve by 5%	Four of four conditions improve by 5%
Worksite Wellness	Increase number of worksites offering worksite wellness	Number of sites:	Number of sites: TBD	Number sites:	+4%	+8%	+10%

Targets should be set to reflect goals and priorities that can be addressed through benefit design, programs and services

Improve Members' Experience Sample Card - Illustrative

		Benchmark Periods					
Description	**Metric**	**FY 2012-13 Actual**	**CY 2014 Actual**	**CY 2015 Target**	**Met or Exceeded Threshold**	**Met or Exceeded Target**	**Met or Exceeded Stretch Goal**
Customer satisfaction	Maintain or improve overall Customer Satisfaction score.		TBD				
Annual Enrollment service level agreements	Improve Annual Enrollment customer service SLAs.		TBD				
Member engagement	1. Increase in the # of active members registered as users on TPA site 2. Increase in the usage of TPA's provider search and transparency tools 3. Increase in attendance at educational roadshows		1.TBD 2. TBD 3. TBD				

Targets should be set to reflect goals and priorities that can be addressed through benefit design, programs and services

Ensure a Financially Stable State Health Plan - Illustrative

Strategic Initiative	Goal Description	FY 2012-13 Actual	CY 2014 Actual	CY 2015 Target	Met or exceeded threshold	Met or exceeded target	Met or exceeded stretch goal
Net income/loss	Net income/loss actual or above certified or authorized budget for plan year	Variance vs. Budget	Variance vs. Budget	Authorized Budget	+/- 4.5% of budget	+/- 3% of budget	+/- 1.5% of budget
PMPM claims expenditures	PMPM claims expense at or below certified or authorized budget (as forecasted by actuaries) for plan year	Variance vs. Budget	Variance vs. Budget	Authorized Budget	Within 8% of projection	Within 5% of projection	Within 2% of projection
Member cost-sharing	% of total claims cost paid by members through copays, deductibles and coinsurance at or below benchmark	1. PCP: a. Preventive: b. Other PCP : 2. Specialist 3. Inpatient 4. Hospital: 5. Pharmacy: 6. Overall:	1. PCP: a. Preventive: b. Other PCP : 2. Specialist 3. Inpatient 4. Hospital: 5. Pharmacy: 6. Overall:	1. PCP: a. Preventive: b. Other PCP 2. Specialist 3. Inpatient 4. Hospital: 5. Pharmacy: 6. Overall:	Meet goals for 2 out of four measures	Meet goals for 3 out of four measures	Meet goals for 4 out of four measures

- Targets should be set to reflect goals and priorities that can be addressed through benefit design, programs and services
- Goals should be consistent with Plan's Strategic Priorities and Initiatives
- Member cost-share design should reflect steerage toward high value services and sites of care

Next Steps

- Review CY 2014 results
- Set CY 2015 thresholds, targets, and stretch goals
- Discuss how CY 2016 plan options and benefit design changes can impact these areas of focus

BOT Workgroups

Original Workgroups	Revised Workgroups Phase 1 Discovery Report	
	Operational Workgroups	Strategic Workgroups
Forecasting & Finance	**Audit, Forecasting & Finance**	**Affordability, Value & Financial Stability**
Genell Moore, David Rubin, Director OSBM	David Rubin, Lee Roberts, Bill Medlin	Paul Cunningham, Kim Hargett, Lee Roberts
Member Outreach	**Member & Legislative Outreach**	**Quality of Care and Access**
Charles Johnson, Kim Hargett, Bill Medlin	Charles Johnson, Noah Huffstetler, Kim Hargett	Bill Medlin, Warren Newton, David Rubin
Legislative	**Product & Provider Network Operations**	**Health Engagement & SHP Offerings**
Noah Huffstetler, Charles Johnson, Kim Hargett	Paul Cunningham, Genell Moore, Warren Newton	Noah Huffstetler, Charles Johnson, Genell Moore
Strategic Planning/Board Development		
Paul Cunningham, Genell Moore, Warren Newton		