North Carolina Department of Health and Human Services

Pat McCrory
Governor

Aldona Z. Wos, M.D.
Ambassador (Ret.)
Secretary DHHS

Adam Sholar
Legislative Counsel
Director of Government Affairs

March 31, 2014

SENT VIA ELECTRONIC MAIL

The Honorable Ralph Hise, Co-Chair
Joint Legislative Oversight Committee on
Health and Human Services
Room 1026, Legislative Building
Raleigh, NC 27603

The Honorable Justin Burr, Co-Chair
Joint Legislative Oversight Committee on
Health and Human Services
Room 307A, Legislative Office Building
Raleigh, NC 27603-5925

The Honorable Mark Hollo, Co-Chair
Joint Legislative Oversight Committee on
Health and Human Services
Room 639, Legislative Office Building
Raleigh, NC 27603-5925

Dear Senator Hise and Representatives Burr and Hollo:

Pursuant to the provisions of Session Law 2012-142, Section 10.16(b), the Department of Health and Human Services is pleased to submit the report on the pilot program to enroll individuals receiving services under the AIDS Drug Assistance Program (ADAP) in Inclusive Health North Carolina. This report provides information about whether cost savings were achieved and illustrates best practices in transitioning ADAP clients to other programs.

Questions concerning this report may be directed to Maribeth Wooten within the Division of Public Health at (919) 707-5051, or at Maribeth.wooten@dhhs.nc.gov.

Sincerely,

Adam Sholar

Cc: Robin Cummings
Rod Davis
Penelope Slade-Sawyer
Maribeth Wooten
Pam Kilpatrick
Sarah Riser
Pat Porter
Kristi Huff
Brandon Greife
Susan Jacobs
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SENT VIA ELECTRONIC MAIL

The Honorable Marilyn Avila, Co-Chair
Appropriations Subcommittee on Health
and Human Services
North Carolina House or Representatives
Room 2217, Legislative Building
Raleigh, NC 27601

The Honorable Mark W. Hollo, Co-Chair
Appropriations Subcommittee on Health
and Human Services
North Carolina House of Representatives
Room 639, Legislative Office Building
Raleigh, NC 27603

The Honorable William D. Brisson, Co-Chair
Appropriations Subcommittee on Health
and Human Services
North Carolina House of Representatives
Room 405, Legislative Office Building
Raleigh, NC 27603

Dear Representatives Avila, Brisson, and Hollo:

Pursuant to the provisions of Session Law 2012-142, Section 10.16(b), the Department of Health and Human Services is pleased to submit the report on the pilot program to enroll individuals receiving services under the AIDS Drug Assistance Program (ADAP) in Inclusive Health North Carolina. This report provides information about whether cost savings were achieved and illustrates best practices in transitioning ADAP clients to other programs.

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SENT VIA ELECTRONIC MAIL

The Honorable Ralph Hise, Co-Chair
Appropriations Committee on Health
and Human Services
North Carolina Senate
Room 1026, Legislative Building
Raleigh, NC 27601

The Honorable Louis Pate, Co-Chair
Appropriations Committee on Health
and Human Services
North Carolina Senate
Room 1028, Legislative Building
Raleigh, NC 27601

Dear Senators Hise and Pate:

Pursuant to the provisions of Session Law 2012-142, Section 10.16(b), the Department of Health and Human Services is pleased to submit the report on the pilot program to enroll individuals receiving services under the AIDS Drug Assistance Program (ADAP) in Inclusive Health North Carolina. This report provides information about whether cost savings were achieved and illustrates best practices in transitioning ADAP clients to other programs.

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Legislative Report on

Pre-Existing Condition Insurance Program (PCIP) Pilot

Conducted by the AIDS Drug Assistance Program (ADAP)

Session Law 2012-142, Section 10.16

State of North Carolina

Department of Health and Human Services

April 1, 2014

Legislative Reporting Requirement

Session Law 2012-142 (House Bill 950) Section 10.16 required the NC AIDS Drug Assistance Program (ADAP) to manage a pilot that provided Pre-Existing Condition Insurance Program (PCIP) coverage to up to 10% of HIV positive individuals enrolled in ADAP who were uninsured and met all federal PCIP requirements. The purposes of the pilot were (1) to determine cost savings to ADAP through enrollment of ADAP recipients into a PCIP and (2) to inform the Department of best practices in transitioning ADAP recipients to Medicaid as they become eligible.

The North Carolina General Assembly established Inclusive Health North Carolina as the North Carolina Health Insurance Risk Pool (NCHIRP or "Risk Pool") in accordance with North Carolina G.S. 58-50-175, et seq., to provide health insurance to each eligible North Carolina resident applying to the Pool for insurance coverage. Inclusive Health was tasked with managing the state run PCIP. The PCIP Pilot necessitated a contract between Inclusive Health and ADAP because Inclusive Health was the only source of PCIP coverage available for residents of North Carolina. The legislation allowed ADAP to partner with the three medical providers that had the highest volume of patients living with HIV disease because these agencies had the strongest infrastructure to manage PCIP enrollment.

Executive Summary

Since HB 950 was passed in 2012, authorizing an ADAP PCIP pilot, a number of factors related to the Affordable Care Act subsequently changed. Due to the Supreme Court's ruling in June of 2012, states can now choose whether to expand their Medicaid coverage without incurring penalties; North Carolina opted not to expand Medicaid. The state also opted not to operate a state-run health benefits exchange, instead allowing eligible North Carolinians to use the federally-run exchange. Pre-existing condition insurance pools were created in the ACA legislation as a 'bridge' to be used for coverage for people with illnesses that prevented them from obtaining affordable insurance, prior to the full roll out of ACA insurance options in January of 2014. However the federal funding for all PCIPs ran short, resulting in the premature end to North Carolina's ADAP PCIP pilot on June 30, 2013.

This report on the ADAP PCIP pilot summarizes the program's experience with the PCIP, which was cut short due to the external factors outlined more fully below. As a result, only limited insights can be gained about the value of the planned pilot. The detailed report provided by the contracted actuarial company is attached for further detail.

Beginning in November of 2012, up to 10 percent of North Carolina ADAP clients were to be enrolled with Inclusive Health for insurance coverage; ADAP would pay all premiums and deductibles. The ADAP PCIP pilot enrollment was implemented for coverage that began on January 1, 2013, to end on December 31, 2013. When federal funding for all PCIPs ran short the ADAP PCIP pilot was terminated. The pilot ran for six months and produced six months of data. Mercer Government Human Services Consulting (Mercer) was engaged to provide a pre-pilot analysis to determine that such a pilot would be cost-neutral for the Division of Public Health. Mercer's analysis projected that ADAP would incur cost savings between 20% and 24% during

the pilot year. Mercer also provided a post-pilot analysis after the unexpected early closing of the pilot.

Under the pilot, ADAP funds were used to purchase insurance through North Carolina's Pre-existing Condition Insurance Plan, operated by Inclusive Health, which is responsible for administering North Carolina's Health Insurance Risk Pool and the federally funded, state run PCIP. Clients participating in the pilot had access to a full range of medical services and prescription coverage. The NC ADAP PCIP pilot provided 475 ADAP clients with access to health care via health insurance coverage for six months; all PCIP pilot enrollees were returned to ADAP enrollment when the pilot ended.

Mercer analyzed the six months of data available and projected that if the pilot program had remained open until December 2013, the annual program savings for calendar year 2013 would have been approximately 9%, resulting in savings of approximately $335,000. Mercer concluded that due to the large upfront deductible and early termination the pilot cost the program 47% more than the ADAP program for the 6-month period of January 2013 through June 2013, resulting in an excess cost to ADAP of approximately $868,000.

Although there was limited data available from the shortened pilot, Mercer was able to determine that 87% of pilot participants had an undetectable HIV viral load at the conclusion of the study and that the majority of the PCIP pilot enrollees used health insurance to address medical needs that they had not been able to address previously.

The insights and conclusions gained from the ADAP PCIP pilot have helped to form the foundation for a proposed two-phase pilot in 2015 to examine cost sharing by NC ADAP for its enrollees.

Background

ADAP PCIP Pilot Early Closure

The ADAP PCIP pilot was unable to run for 12 months, the timeframe upon which projected cost-neutrality had been based. Inclusive Health administered the PCIP in North Carolina under an agreement with the federal Centers for Medicare and Medicaid Services (CMS). When it was announced that the federal government lacked the funding to continue to pay for PCIPs nationwide, Inclusive Health ended its administration of the North Carolina PCIP on June 30, 2013. (CMS had contacted state-based PCIP contractors in May of 2013 with a proposed updated contract to operate PCIP programs from July to December 2013. The proposed contract set a ceiling on the amount CMS would pay for PCIP operations and claims, requiring contractors to accept liability for any costs over that limit after June 30, 2013. Inclusive Health was unable to accept the liability.)

On the national level, CMS offered all state run PCIP enrollees a very short window to transition to a federal PCIP plan. ADAP did not pursue this option for the pilot enrollees because the plan required an additional $2,000 deductible per patient and increased monthly premiums by approximately 20%, eliminating any possibility of cost neutrality. On July 1, 2013 the ADAP PCIP pilot clients transitioned back onto ADAP and once again began receiving only ADAP medication coverage.

ADAP Funds and Cost Savings

The state used ADAP funds to buy full insurance coverage for participating ADAP clients through Inclusive Health during this PCIP pilot study. Clients received an insurance card to use for medications and full medical services. ADAP funds paid for all premiums and deductibles. Everyone enrolled in this pilot received health insurance coverage at rates based on those paid by healthy people in the individual insurance market.

- Cost savings of 20 – 24% had been anticipated as a result of the pre-pilot analysis completed by Mercer.

- Early closure of the pilot resulted in costs that were 47% higher than equivalent ADAP costs for the same period, primarily due to the annual deductible which was paid at the beginning of the pilot for each client.
    - Had the pilot remained intact for the anticipated 12 months, cost savings estimates were projected to be approximately 9%.

- During the pilot, ADAP clients benefited by receiving a significantly broader range of services through PCIP coverage compared to that available through ADAP or through the Ryan White funds, which are only available for HIV-related conditions. ADAP only covers a limited list of medications to treat HIV and conditions related to it. Providing PCIP coverage for ADAP clients expanded their coverage to include primary and specialty care, hospital care, and all prescription medications.

- Participants received more drug benefits during the pilot, since the PCIP covered a wider range of medications than ADAP (over $1M in non-HIV medication).
- Other critical healthcare benefits were also accessed that would not have otherwise been available ($1.3M in additional services).

- Participating clients had been served through Ryan White funded providers for their medical care prior to enrollment in the PCIP pilot. These providers were able to bill the Inclusive Health insurance for medical services provided, thus making additional Ryan White funds available for use by other uninsured clients.

- The lowest premium amount for the PCIP population was $88 per month and the highest premium was $364 per month. This range is the result of age and smoking status, which affects the monthly premium cost set by Inclusive Health.

Eligibility and Enrollment

Clients were required to be enrolled in ADAP and to meet the eligibility requirements for the PCIP in order to participate in the pilot. Clients were:

- US citizens or a legal residents who had been in the United States for at least 5 years
- residents of North Carolina
- uninsured for at least 6 months prior to enrollment
- diagnosed with a pre-existing condition (HIV automatically qualified)

475 clients were enrolled in the pilot at its inception. Through the course of the ADAP PCIP pilot a small number of the clients were terminated as they became eligible for Medicaid, Medicare or private insurance. According to federal ADAP and PCIP regulations, clients are no longer eligible for coverage if they begin receiving other health insurance. Approximately 38 clients were terminated from the pilot after becoming eligible to receive other insurance or due to failure to renew their ADAP coverage during the required ADAP renewal period.

The ADAP PCIP pilot was offered to patients at the three North Carolina clinics with the most ADAP clients as they had the strongest infrastructure to manage PCIP (as required by the Special Provision). These clinics were Wake Forest Baptist University Hospital, University of North Carolina Hospital, and Duke University Hospital. The case managers at each clinic were trained by Inclusive Health and the ADAP staff and enrolled clients on a first come, first served basis. The enrollment period began in early November, lasting only 30 days because clients and case managers acted quickly in order to access the care under the pilot. The successful enrollment process was assisted by the clients' relationship with the case managers, whom the clients trusted for advice with their medical needs.

Medicaid

ADAP applicants are required to apply for Medicaid before they can be found eligible for ADAP; applicants enrolled in Medicaid are not eligible for ADAP. If an ADAP client becomes eligible for Medicaid their ADAP coverage should be terminated immediately. Up to 70% of

ADAP clients on the pharmacy program would transition to Medicaid from ADAP with expanded Medicaid under ACA. Best practices and recommendations for transitioning a large number of clients to Medicaid from ADAP can be inferred from the program experience of the transition from ADAP to PCIP and back to ADAP of over 400 clients.

Best Practices and Recommendations

- Viral suppression is the ultimate goal in HIV treatment today because people living with HIV who are virally suppressed are 96% less likely to transmit HIV to others. Viral load measurements indicate the amount of HIV found in an individual's blood plasma. Mercer was unable to identify significant changes in health outcomes during the 6-month pilot period but they did determine that 87% of pilot participants had an undetectable viral load at the close of the 6-month study.

- ADAP clients receive medical case management through Ryan White funds, in order to assure that they stay in care and on treatment. Medical case managers' support for clients participating in the pilot had a profound impact and was essential when transitioning clients into the PCIP pilot at its start and in transitioning back to ADAP at the end of the pilot. Case Managers have built strong relationships with clients over time so clients felt comfortable expressing their concerns about these transitions. An important best-practice gathered from this pilot was the opportunity for clients to speak with their case managers in order to understand what the ADAP PCIP pilot could offer, how it would actually work (many clients had never had insurance before) and to seek reassurance that their ADAP coverage would remain in place when the PCIP program ended, assuring quality of care and education about the transition.

- A majority of the ADAP PCIP pilot enrollees used health insurance to address further medical needs that they could not afford previously and which were not covered by Ryan White. Although the ADAP PCIP pilot ended sooner than intended due to federal funding constraints, a significant amount of 'pent up medical need' for low income HIV clients was addressed as a result of having insurance, in some cases for the first time.

- Insurance programs which provide primary care services could result in an opportunity to use Ryan White dollars to support other critical wrap around services, including medical case management and bridge counseling. ADAP will continue to be essential as a safety net to ensure that people living with HIV can access the lifesaving medications this vulnerable population requires.

- The Ryan White Program continues to serves a critical role, one that will not be replaced by insurance coverage: providing medical case management and support services to assure that clients are linked into medical care and are re-engaged if they fail to come to appointments. This is important because those living with HIV disease who are out of care have a higher likelihood of transmitting virus to others and poorer health outcomes for themselves.

Challenges were also identified during the ADAP PCIP pilot:

- PCIP clients, case managers and ADAP staff expressed difficulties faced when working directly with the insurance carrier. Most programs that coordinate third party coverage are managed by a Pharmacy Benefits Manager (PBM). PBMs provide added benefits by managing drug prescriptions, pharmacy benefits and clinical management. A PBM was not engaged to manage this pilot due to the limited time available for planning and the short pilot duration.
  - Future pilots should consider contracting with a PBM for coordination of health and pharmacy transitions rather than contracting directly through an insurance company.
  - The number of clinical visits and specialty medications required by the ADAP population make care coordination vital. The experience of this pilot confirmed that, in addition to PBM services, there is a need for medical case management.

Client Feedback

Upon the closing of the PCIP pilot, ADAP staff reached out to all pilot enrollees to ensure they understood why the program ended early and how the transition would impact them. The ADAP staff also conducted a short informal survey to gather feedback. A particularly poignant statement stood out: "I loved having insurance because I felt like a person. I was actually treated better because I had insurance. I know that might sound funny but it's true." Many of the clients also reported that having insurance gave them a safety net in case they had any serious medical emergencies. Clients reported using the insurance for surgeries and procedures they had been delaying because they could not afford adequate care (considered 'pent up need'). The overall feedback about having insurance was overwhelmingly positive. The majority of clients were very disappointed about the early termination but were thankful that their Case Manager and ADAP staff were supportive during the transition. Almost all pilot enrollees reported using the insurance, having easy access to medical coverage and having the ability to fill prescriptions.

Mercer conducted a formal client survey by telephone in the fall of 2013. They had a 40% response rate which is an acceptable rate for this mode of data collection. 90% of respondents reported filling a prescription. 96% of respondents reported that it was easy to fill prescriptions. 93% of respondents reported using the insurance to see a doctor. 91% of respondents reported having a positive experience. Comments such as "it saved my life," "I wish the program did not end" and "having insurance coverage made me feel like I was a part of society" were commonplace.

MERCER

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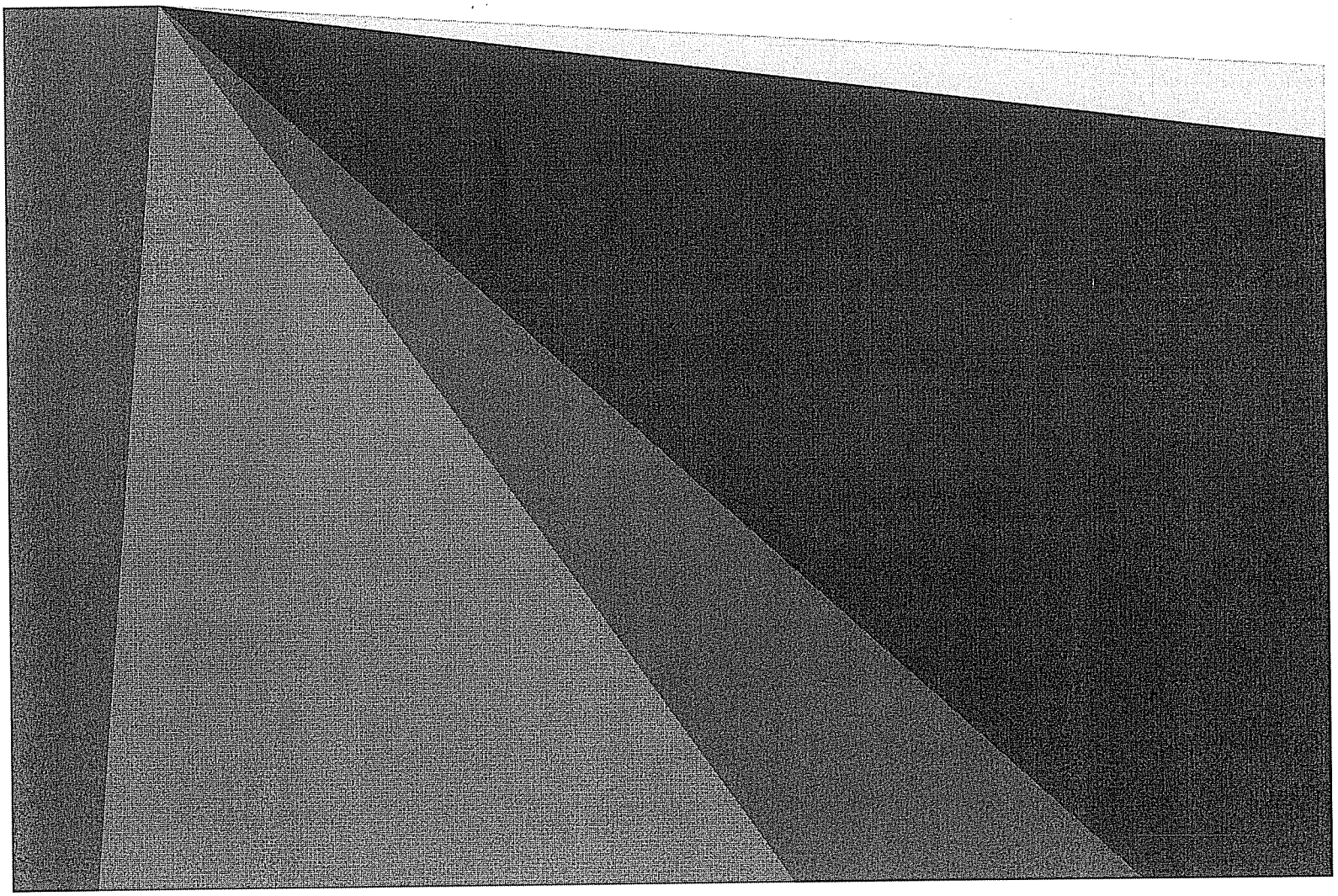
NORTH CAROLINA AIDS DRUG ASSISTANCE PILOT PROGRAM ANALYSIS

NORTH CAROLINA DIVISION OF PUBLIC HEALTH

JANUARY 14, 2014

Government Human Services Consulting



MARSH & McLENNAN COMPANIES

CONTENTS

1

Introduction

The North Carolina Division of Public Health (DPH) asked Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, to evaluate the results of the AIDS Drug Assistance Program (ADAP) pilot conducted under SESSION LAW 2012-142 HOUSE BILL 950. This report serves as a follow-up to the Pre-Existing Condition Insurance Program (PCIP) Pilot Cost Neutrality Analysis, dated September 14, 2012, demonstrating the cost neutrality of enrolling ADAP recipients in Inclusive Health North Carolina (SECTION 10.16.(a)). Please see Appendix A for the September 14, 2012 cost neutrality report.

Participants were enrolled in a PCIP program that began on January 1, 2013. Due to exhausting available funds for the program, the pilot was ended six months early, effective June 30, 2013. The PCIP pilot participants were then enrolled back into the ADAP, effective July 1, 2013.

The report includes the following:

- Pilot program participant identification
- A cost analysis of the pilot program, including a cost comparison between participants in the original ADAP and participants in the PCIP pilot
- Feedback from the pilot program participants
- Improved health outcomes

A copy of the PCIP pilot participant survey can be found in Appendix B of this report.

Mercer's analysis was based upon summary data provided by DPH and not based upon a review of detailed claims. The analysis and results represent an estimate and should be used for such purposes, as appropriate. As the data have not been reviewed for completion or accuracy, they should not be used for financial reporting. All the dollar amounts have been rounded to the nearest thousand.

The legislation directed that the report also includes best practices identified by DPH for transitioning ADAP recipients to Medicaid as they become eligible. ADAP participants were not transitioned to Medicaid; consequently, Mercer excluded this section under the direction of DPH.

2

Executive Summary

Based on Mercer's September 14, 2012 analysis, DPH could expect drug cost savings between 20.0% and 24.0% for the enrollees in the pilot program compared to their drug costs under ADAP during calendar year (CY) 2013 (January 2013 through December 2013). At the start of the pilot, 475 members were enrolled in the program, however, due to exhausting available funds for the program, the pilot program was ended six months early (June 30, 2013) and the remaining 440 enrollees were moved back to ADAP, effective July 1, 2013.

The PCIP cost of $2,724,000 was 47.0% higher than the equivalent ADAP cost of $1,856,000, for the period of January 2013 through June 2013. This was mainly due to the annual deductible that was prepaid at the beginning of the program for all PCIP participants. Due to the large upfront deductible, the early termination of the pilot (effective June 30, 2013) presented a challenge in the cost neutrality of the program. If the pilot program remained open until December 2013, the annual drug cost savings for CY 2013 would have been approximately 9.0%.

For HIV drug benefits, participants who received services through PCIP experienced a lower cost-to-benefit ratio (costs relative to benefits, expressed in monetary terms) compared to participants who received services through ADAP. Although the PCIP participants received HIV drug benefits similar to the ADAP recipients, the PCIP program presented the participants with access to additional health care services that would not have been available without this program.

Mercer solicited feedback from pilot program participants via a telephone survey. Overall, the majority of participants reached had a positive experience during the pilot program and expressed gratitude for the opportunity to participate.

It is extremely important for patients taking HIV medications to take them consistently and exactly as directed. Failure to take them as directed will lead to a lower level of immune system defenders called CD4 cells and cause the patient's viral load to increase. Consequently, the drugs will then become less effective. Mercer evaluated various health outcome measures of pilot program participants as related to the medication possession ratio and found that there were no significant changes during the six month pilot period.

3

Cost Analysis

This section describes the data used and the results from the detailed analysis of the PCIP pilot program experience in the Inclusive Health of North Carolina plan.

Data

DPH provided Mercer with:

- Summarized PCIP and ADAP program demographic information
- Summarized PCIP program drug cost and enrollment data for the January 2013 through June 2013 time period
- Summarized monthly ADAP data consisting of total clients enrolled, clients served, prescriptions dispensed, monthly costs including paid claims and dispensing fees from January 2013 through December 2013
- PCIP prepaid premium fee schedules and annual deductible information
- ADAP benefit information
- Detailed PCIP benefits information (Appendix C)

For the January 2013 through June 2013 time period, Mercer used actual program cost and enrollment data for the ADAP and PCIP programs.

ADAP Costs

For ADAP, actual costs represent the paid claims for benefits provided to the ADAP participants. In order to make a valid comparison to the PCIP program, the ADAP per member per month, based on the ADAP actual costs, was multiplied by the PCIP monthly enrollment counts. This expected expense amount is referred to as "ADAP cost for PCIP participants" in this report. This also represents the value of the HIV drug benefit for ADAP participants. The ADAP cost for PCIP participants are displayed in Exhibit 3, identified with the label {[D] – Actual ADAP Drugs + Dispense Fees}.

PCIP Costs

For PCIP, actual costs represent the $4,500 annual per participant deductible and the monthly premiums, determined by the participant's age and smoking status, for the Inclusive Health North Carolina High Deductible Health Plan 4500 (HDHP), which provided the coverage benefits. These costs are displayed in Exhibit 3, identified with the label {[A] – Costs to ADAP Program}. Mercer was only able to obtain pharmacy paid claims data in total (but not National Drug Code-specific information). Thus, in order to determine the value of the HIV drug benefit for

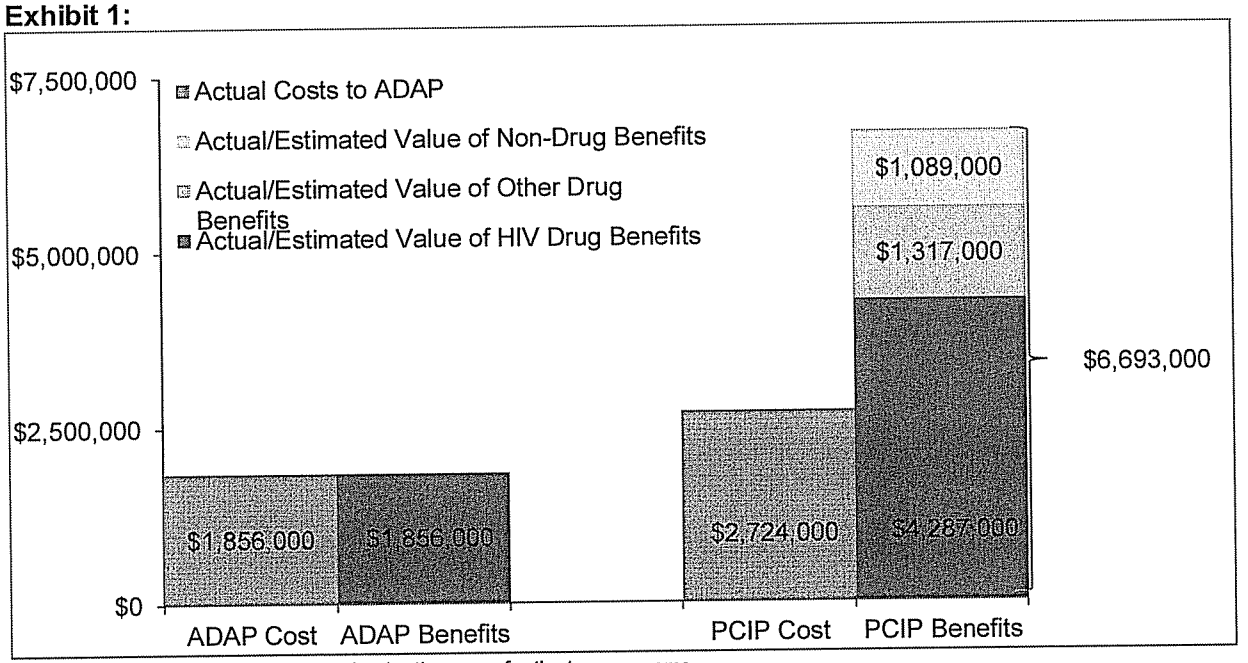
the PCIP participants, Mercer's Pharmacy Team developed low and high estimates for the percentage of total drug expenses that could be attributed to HIV prescriptions. The values of the drug and HIV-drug benefits are displayed in Exhibit 3, identified with the labels {[B] – Total Drugs Expenditures} and {[C] – Estimated HIV Drugs Expenditures}.

In order to make an annualized CY 2013 comparison between the two programs, Mercer had to estimate the pilot program premium costs and benefits values for the period of July 2013 through December 2013, due to the early termination of the pilot program (June 30, 2013). This was done similarly to the cost neutrality analysis of the September 14, 2012 report. In estimating these costs and benefits, Mercer used generally accepted actuarial principles and practices. This method uses historical payment patterns to predict future payment amounts, adjusted for seasonality and trends. These values are displayed in Exhibit 3, identified with the label {Jul-Dec 2013 Estimation}.

Results

The actual costs of the ADAP and PCIP programs as well as the estimated value of the HIV drug benefits for the period of January 2013 through June 2013 are as follows.

Exhibit 1:



Note: The drugs prices were assumed to be the same for the two programs.

The PCIP cost of $2,724,000 was 47.0% higher than the equivalent ADAP cost of $1,856,000. The higher PCIP program cost was mainly driven by the annual deductible that was prepaid at the beginning of the pilot for all participants. However, the value of the HIV drug benefits

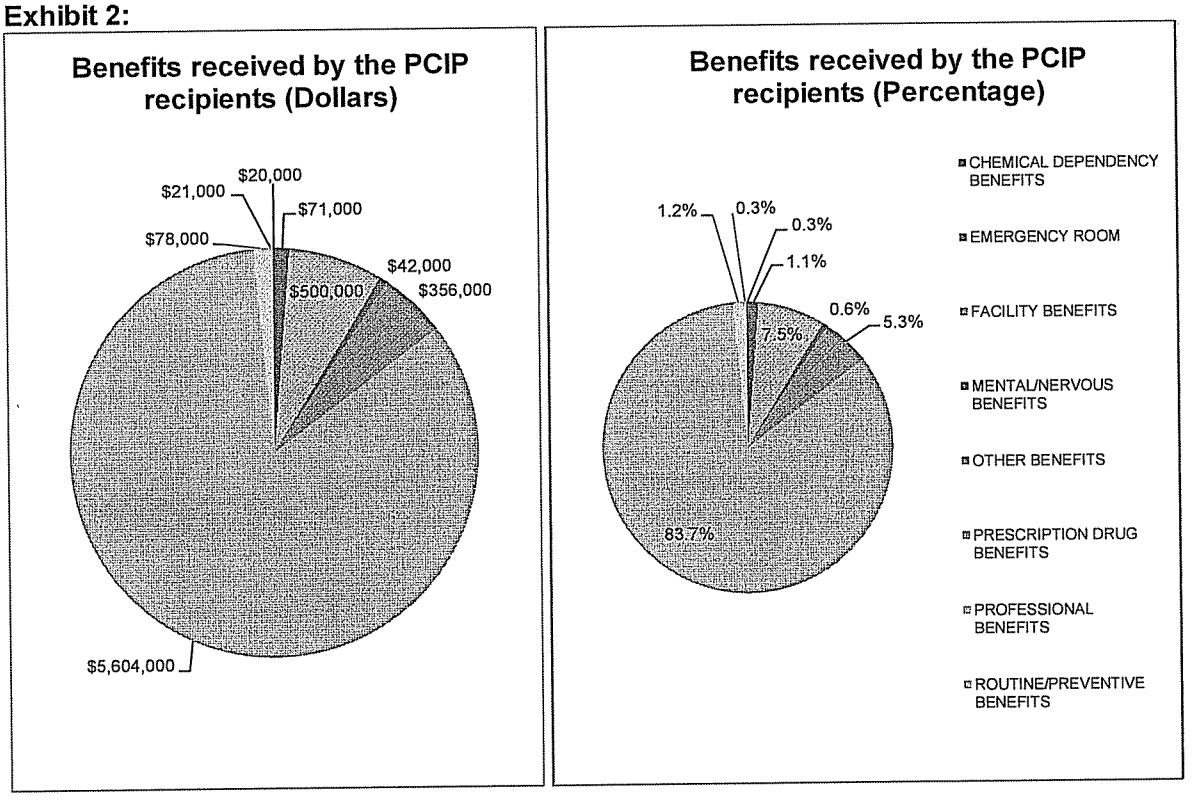
received by the PCIP recipients, estimated at $4,287,000, was higher than the PCIP program cost of $2,724,000. Thus, while the actual PCIP program cost was greater than the ADAP program cost, recipients under the PCIP program were able to receive more drug benefits.

The cost-to-benefit ratio for the PCIP pilot was only 0.64, while for the ADAP program, the cost of the program equaled the cost of the HIV drug benefit to the recipients. The $4,287,000 estimated value of the HIV drug benefit represents the best estimate of total HIV drug expenses in the PCIP program.

The PCIP program's benefits included drug benefits beyond the HIV drugs, as well as other critical health care services that the participants would not have access to in the ADAP program. These additional services amounted to approximately $1,317,000 and $1,089,000 for non-HIV drug and non-drug benefits, respectively.

Below is a summary of all the benefits received by the PCIP recipients during the period of January 2013 through June 2013.

Exhibit 2:



The total value of these benefits was approximately $6,693,000, based on the PCIP experience between January 2013 and June 2013.

PCIP Cost Neutrality Analysis (September 14, 2012 Report)

At the time of the cost neutrality analysis, Mercer, based on discussions with DPH, used reasonable assumptions regarding the following factors:

- Age/gender of the PCIP program participants
- Smoking status of the participants
- Cost and utilization trend for the ADAP program

The demographics (age/gender and smoking status) of the actual recipients who enrolled in the PCIP program was slightly different, but this did not have a significant impact on the costs of the program.

The actual CY 2013 costs for the ADAP program was lower than the ADAP costs used in the September 2012 estimation, which caused the larger difference in savings between the September 2012 and January 2014 estimations. This is due to actual trends being much lower than trends built in the cost neutrality analysis.

Based on updated cost and enrollment information, had the PCIP program been in place until the end of CY 2013, the annual cost savings would have been approximately 9.0%, in lieu of 22.0%, as estimated in September 2012.

Please note that both the September 2012 and the January 2014 estimations represent the best estimate scenarios.

CY 2013 Cost Savings Estimate

Program	September 2012 Estimation	January 2014 Estimation
ADAP Costs	$4,224,000	$3,633,000
PCIP Costs	$3,293,000	$3,298,000
Expected Savings	22.0%	9.0%

The following table shows a more detailed January 2013 through June 2013, July 2013 through December 2013 and annualized CY 2013 comparisons of the ADAP and PCIP program costs.

Exhibit 3:

Experience Analysis of the North Carolina PCIP Program for CY2013

	PCIP Program				Costs under ADAP Program	Benefit from PCIP Program[3]	Savings from PCIP Program[3]
	Costs to ADAP Program		Total Drugs Expenditures[1]	Estimated HIV Drugs Expenditures[2]	Actual ADAP Drugs + Dispense Fees	(Compared to PCIP actual costs)	(Compared to ADAP equivalent actual costs)
		(A)	(B)	(C)	(D)	(E)=(C)-(A)	(F)=(D)-(A)
Jan-Jun 2013 Actuals	Total Premium Paid	$ 586,000					
	Total Deductible	$ 2,138,000					
	Total	$ 2,724,000	$ 5,604,000	$ 4,287,000	$ 1,856,000	$ 1,563,000	$ (868,000)
Jul-Dec 2013 Estimation	Estimated Costs to ADAP Program[4]		Total Drugs Expenditures[1,5]	Estimated HIV Drugs Expenditures[2]	Actual ADAP Drugs + Dispense Fees	(Compared to PCIP projected costs)	(Compared to ADAP equivalent projected costs)
	Total Premium Paid	$ 574,000					
	Total Deductible	$ -					
	Total	$ 574,000	$ 5,324,000	$ 4,073,000	$ 1,777,000	$ 3,499,000	$ 1,203,000
	CY2013 Total	$ 3,298,000	$ 10,928,000	$ 8,360,000	$ 3,633,000	$ 5,062,000	$ 335,000

Footnotes:

1. Assume HIV-related drug formulary costs in the PCIP program to be equivalent to the ADAP drug formulary costs
2. Based on average estimate with low and high assumptions of 70% and 83%, respectively, for the portion of HIV-related drug costs in the PCIP program.
3. Positive amounts indicate savings to NC ADAP; conversely, negative amounts indicate excess cost to NC ADAP
4. Assume constant enrollment in PCIP for July - December 2013 estimates
5. Based on average estimate with low and high assumptions of 90% and 100%, respectively (July - December 2013 PCIP drug cost estimate, as a percentage of the actual January - June 2013 PCIP drug costs)

- Due to the large upfront deductible, The PCIP pilot program cost 47.0% more than the ADAP program for the period of January 2013 through June 2013, resulting in an excess cost to the ADAP of approximately $868,000.
- Had the PCIP program been in place until December 2013, the PCIP pilot program would have cost 68.0% less than the ADAP program for the period of July 2013 through December 2013, resulting in savings to the ADAP of approximately $1,203,000.
- Overall, for the period of January 2013 through December 2013, the PCIP pilot program would have cost 9.0% less than the ADAP program, resulting in savings to the ADAP of approximately $335,000, if the pilot had been in place until December 2013.

Assumptions and Limitations

The following assumptions and limitations were used in this final cost analysis:

- Mercer estimated the PCIP program's HIV drug costs to be between 70.0% and 83.0% of the total drug costs, based on review of Mercer experience with similar programs. Mercer relied on dispensing and wholesale data provided by DPH, but did not audit the information. Mercer did not apply explicit completion factors to the data used in this analysis for incurred but not reported claims. Mercer relied on DPH for PCIP premiums.

- For our analysis, Mercer relied on data, information and other sources of data as described in this report. We have relied upon this data without an independent audit. Although we have reviewed the data for reasonableness and consistency, we have not audited or otherwise verified this data. It should also be noted that our review of data may not always reveal imperfections. We have assumed that the data provided is both accurate and complete. The results of our analysis are dependent upon this assumption. If the data or information is inaccurate or incomplete, our findings and conclusions may need to be revised.

- In addition, the projections we show in this report are dependent upon a number of assumptions regarding the future economic environment including: medical and pharmacy trend rates, prescriber behavior, behavior of individuals, providers in light of incentives and penalties, as well as a number of other factors.

- All estimates are based upon the information available at a point in time and are subject to unforeseen and random events. Therefore, any projection must be interpreted as having a likely range of variability from the estimate. Any estimate or projection may not be used or relied upon by any other party or for any other purpose than for which it was issued by Mercer. Mercer is not responsible for the consequences of any unauthorized use.

4

Participant Feedback

Methodology

Mercer was asked to collect feedback from PCIP participants enrolled in the pilot program. Mercer met with DPH representatives to seek additional direction on the key concepts to be addressed as questions were developed for the survey. DPH chose to focus on the following conceptual areas:

- PCIP pilot program meeting the needs of the participants
- PCIP pilot program participants' satisfaction with the program

Following this discussion, Mercer drafted several questions, which were reviewed by DPH. Based on the feedback, Mercer revised the questions for a short (8 item) survey. Please see Appendix B for the complete survey. At the request of the DPH, Mercer conducted a telephone only survey.

DPH provided Mercer with an Excel file of contact information for all members who participated in the PCIP pilot program. The total number of participants in the PCIP pilot program was 475. Mercer solicited feedback from all pilot program participants with a valid phone number, or 355 participants. Mercer representatives attempted to contact the PCIP pilot participants telephonically between the dates of November 12, 2013 and December 10, 2013. Two to three attempts were made to reach each participant.

Response Rate

The following table presents the response rate for the pilot program survey.

Population	475
No valid telephone number	120
Number of valid telephone numbers	355
Members with valid telephone numbers but with whom no personal contact was made (no answer, only left messages)	205
Member reached but declined to participate in the survey	6
Language barrier	2
Members who completed the survey	142
Final response rate calculation*	40.0%

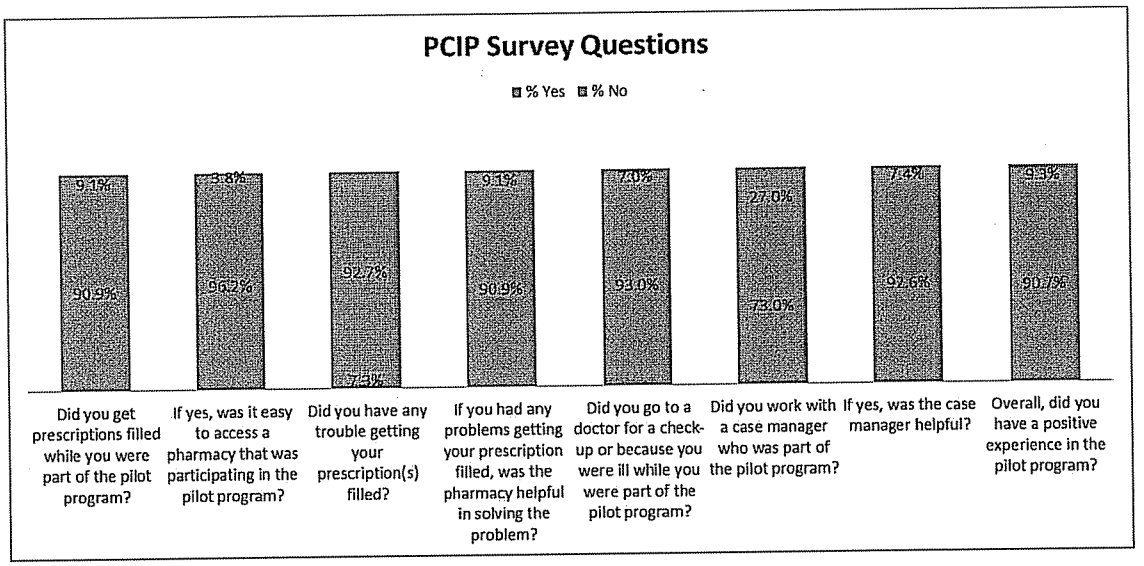
*Response rate calculated as members who completed the survey out of total members with a valid telephone number.

Reaching an individual to complete a survey via telephone has become a significant challenge. As one article has described, contact rates over time (the percent of households in which an adult was reached) have dropped from 90.0% in 1997 to just 62.0% in 2012. When factoring in a declining cooperation rate (percent of households contacted that yielded an interview), the response rate (percent of households sampled that yielded an interview) was 9.0%, down from 36.0% in 1997 and 25.0% in 2000.[1] Potential respondents are continually becoming more selective in answering calls from unidentified numbers on both land lines and cell phones. Also, potential respondents, if reached, may not be willing to use cell phone plan minutes to complete surveys. Mercer was unable to reach 205, or 57.0%, of PCIP pilot participants with valid telephone numbers. The 40.0% response rate achieved amongst the pilot program participants is an acceptable telephone survey response rate.

[1] Telephone Survey Response Rates Dropping; Accuracy Remains High. May 17, 2012 by MarketingCharts staff, http://www.marketingcharts.com/wp/direct/telephone-survey-response-rates-dropping-accuracy-remains-high-22107/, accessed on December 17, 2013.

Results

The following chart presents the results for the individual questions.



- The conclusions of the survey are based solely on the participants' responses of those that completed the survey. Mercer was successful in contacting 150 pilot program participants: 142 completed the survey, 6 declined to complete the survey and 2 did not speak English.
- Based on the survey results, it appears that the PCIP pilot program participants that Mercer spoke with had an overall positive experience (90.7%).
- Although many pilot participants were surprised that the program was ended after six months, the majority of the participants Mercer spoke with had very positive feedback about the opportunity to participate in the pilot. Comments such as "it saved my life," "having insurance coverage made me feel like I was a part of society," and "I wish the program did not end" were commonplace.
- Sixty-two of the participants Mercer spoke with were disappointed that the program ended after six months and/or wished that the program would be continued.
- Twenty-six participants commented that the program was good, great or helpful.
- Participants conveyed that having easy access to a pharmacy (96.2%) and having the ability to fill prescriptions with minimal challenges had a major impact on how they felt about the experience.
- Of those surveyed, 93.0% were able to utilize medical/physician services during the pilot.
- Participants were also able to access a case manager during the pilot (73.0%). Participants that worked with a case manager stated that the case manager gave participants a "sense of security" and that "the case manager provided guidance and educated participants about the program".
- Overall, the majority of participants Mercer spoke to had a positive experience during the pilot program and expressed gratitude for the opportunity to participate.

5

Health Outcomes

Medication Possession Ratio Methodology

Persistence and adherence to antiretroviral therapy (ART) in HIV/AIDS patients is crucial to maintaining the health of the patient. Non-compliance with ART regimens can be associated with increased rates of virological failure, development of antiretroviral resistance and increased morbidity and mortality. Inconsistent use can lead to resistance to a medication, which will decrease the number of treatment options available to a particular patient.

The table on the following pages provides medication possession ratios (MPR) statistics for PCIP program participants. MPR statistics are considered an industry standard for measuring a population's adherence to prescribed drug therapy.

Mercer's medication persistence and adherence calculations are based on published methodologies commonly used in the commercial and government sectors. However, there are a few items to note about these statistics:

- Mercer's methodologies only calculated MPRs for PCIP participants who were utilizing the pharmacy benefit. If we did not have a participant's HIV drug therapy history, they were not reflected in the analyses.
- Mercer did not utilize medical claims data. Therefore, no adjustments were made to the calculations for inpatient hospital stays.
- Mercer's calculations have not been statistically validated, which is consistent with MPR calculations described by the Pharmacy Quality Alliance and evaluated by commercial pharmacy benefit managers.

The population for the persistence and adherence measures was defined as all PCIP participants that were eligible for the pilot study during the study period (January 1, 2013 through June 30, 2013). Utilization was supplied by DPH.

Medication Possession Ratio Results

MPRs measure the amount of HIV medication a participant had on hand during the study period (January 1, 2013 through June 30, 2013 for the pilot period and July 1, 2012 through December 31, 2012 for the pre-pilot period). For each participant, the calculation is the total days' supply of HIV medication divided by the total number of days in the study period interval. The MPR total summary is derived by taking the average of all the participants' MPRs.

The following MPR ranges are commonly referenced in medical and pharmaceutical literature to help gauge a population's persistence or compliance:

- Full compliance = MPR between 80.0% and 100.0%
- Partial compliance = MPR between 60.0% and 80.0%
- Poor compliance = MPR between 40.0% and 60.0%
- Non-compliance = MPR less than 40.0%

The MPR total summary statistics for the pilot participants is presented in the following table.

Medication Possession Ratio

Status	Pre-Pilot Period	Pre-Pilot % of Total	Pilot Period	Pilot Period % of Total
Full Compliance	309	86.3%	289	80.7%
Partial Compliance	40	11.2%	32	8.9%
Poor Compliance	5	1.4%	17	4.7%
Non-Compliance	4	1.1%	20	5.6%
Total Participants	358	100.0%	358	100.0%

- It is extremely important for patients taking HIV medications to take them consistently and exactly as directed. Failure to take them as directed will lead to a lower level of immune system defenders called CD4 cells and cause the patient's viral load to increase. Consequently, the drugs will then become less effective.
- The median MPR for the pilot period was 95.6%, a slight increase from the pre-pilot period (95.2%).
- The number of pilot participants that exhibited full compliance decreased by 5.6 percentage points during the pilot period. At the same time, the number of patients with non-compliance increased by 4.5 percentage points.
- Overall, the number of participants with an increase in MPR during the pilot study was 178, while 169 participants showed a decrease in MPR, and 11 had no change. From the study data, it is not possible to discern why there was a decrease in adherence. There are many factors that could have impacted adherence, such as side effects, opportunistic infection or simply the limited data.
- The decrease in MPR from the pre-pilot period to the pilot period could be influenced by the amount of medication the participants had on-hand at the start of the pilot period. Some of the participants may have received an additional refill through the ADAP pharmacy.
- Additionally, there were 255 participants with greater than 90.0% compliance during the pilot period, which was an increase of 1 participant from the pre-pilot period.

Laboratory Values Methodology

Two markers are routinely used to assess the immune function and level of virus, CD4 lymphocyte cells (T-cells or T-helper cells) count (CD4 count) and plasma HIV RNA (viral load). DPH supplied Mercer with participant self-reported CD4 counts and viral loads collected on January 10, 2013 and June 26, 2013. The markers were used to evaluate medication efficacy for those pilot study participants. It is important to note that there are several limitations in the data received: the marker values were self-reported by the pilot participants, the study period only covers six months and Mercer has no knowledge of where each participants lies in disease progression. Therefore, the following evaluations are not statistically valid and are merely observations.

CD4 Count Results

The CD4 count is used to categorize the patient's disease, determine risk for illnesses/infections, assess prognosis and guide the clinician on when to start ART.[1] According to HIV treatment guidelines, an adequate CD4 response for most patients on ART is defined as an increase in CD4 count in the range of 50 to 150 cells/mm^3 per year. Subsequent increases in CD4 counts average approximately 50 to 100 cells/mm^3 per year in patients with good virologic control, until a steady state level is reached[2].

The following table contains an evaluation that compares the change in CD4 count during the pilot period as classified by the participants' medication possession ratio. Compliance is reported as the number of pilot participants in each grouping that had MPR data for the pilot period.

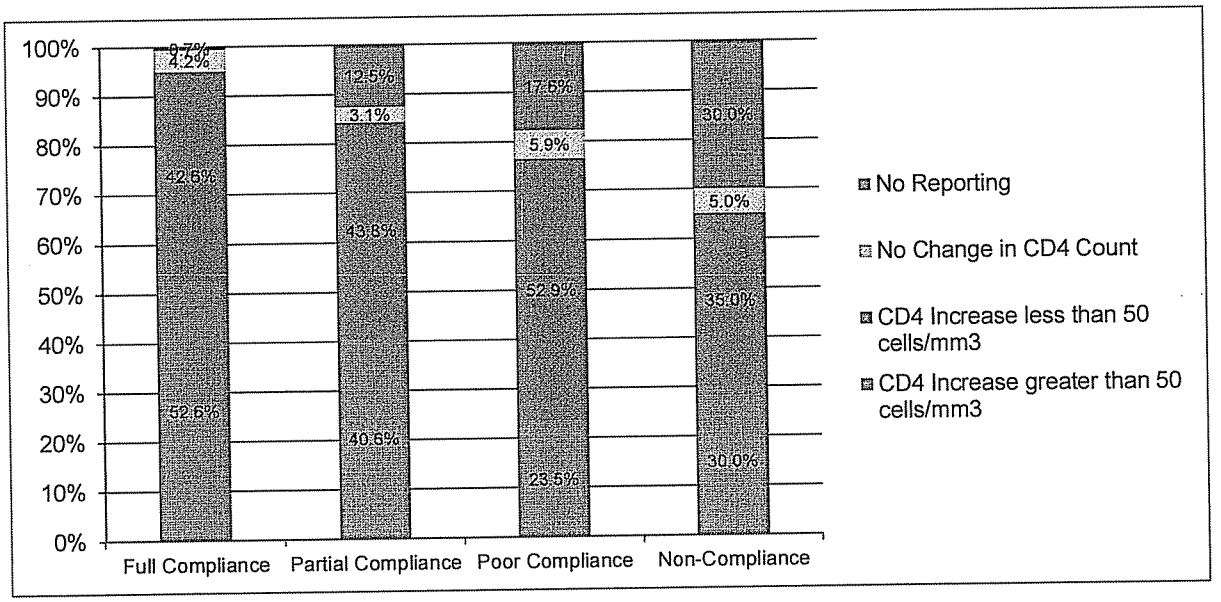
CD4 Count Changes during Pilot Period

Status	Full Compliance	Partial Compliance	Poor Compliance	Non-Compliance	Total Participants
CD4 Increase greater than 50 cells/mm^3	152	13	4	6	175
CD4 Increase less than 50 cells/mm^3	123	14	9	7	153
No Change in CD4 Count	12	1	1	1	15
No CD4 Reporting*	2	4	3	6	15
Total	*289*	*32*	*17*	*20*	*358*

*Participant did not report CD4 count in one or more of the reporting periods.

[1] Guide for HIV/AIDS Clinical Care, U.S. Department of Health and Human Services Health Resources and Services Administration HIC/AIDS Bureau, Published January 2011, http://hab.hrsa.gov/deliverhivaidscare/clinicalguide

[2] HIV Guidelines http://aidsinfo.nih.gov/contentfiles/lvguidelines/adultandadolescentgl.pdfpx



- Of those participants with full compliance, 52.6% of participants had good virologic control with an increase in CD4 count of 50 cells/mm3 or greater. Overall, of those participants with MPR data, 48.9% had a CD4 count of 50 cells/mm3 or greater.
- Out of the 153 patients overall that did not see an increase of more than 50 cells/mm^3, 115 of them actually experienced a decrease in CD4 count during the study period.
- Mercer is not aware of where each pilot participant is in their disease progression. We are unable to determine if a participant has reached steady state. At some point, the CD4 count will not continue to move upwards.

Viral Load Results

The viral load measurement indicates the number of copies of HIV RNA per milliliter of plasma. The goal of ART is to decrease the viral load. Viral load, like CD4 count, is used to assess the risk of disease progression and can help to guide initiation of therapy. It is critical in monitoring virologic response to ART.[3] "Optimal viral suppression is generally defined as a viral load persistently below the level of detection (<20 to 75 copies/mL, depending on the assay used). For the purposes of clinical trials, the AIDS ClinicalTrials Group (ACTG) currently defines virologic failure as a confirmed viral load >200 copies/mL, which eliminates most cases of apparent viremia caused by blips or assay variability."[4]

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[3] Guide for HIV/AIDS Clinical Care, U.S. Department of Health and Human Services Health Resources and Services Administration HIC/AIDS Bureau, Published January 2011, http://hab.hrsa.gov/deliverhivaidscare/clinicalguide

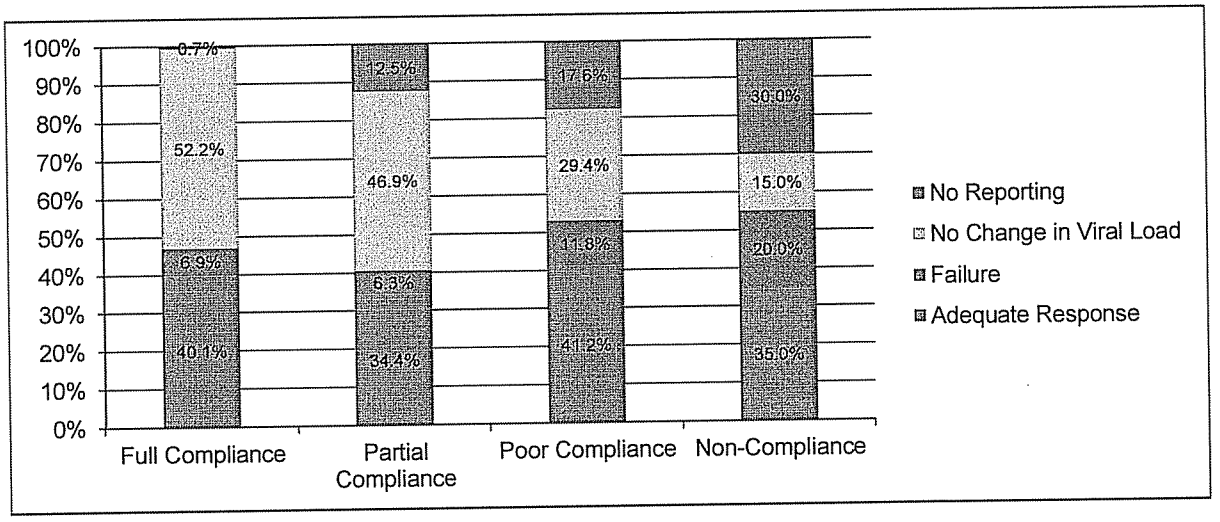
[4] Guide for HIV/AIDS Clinical Care, U.S. Department of Health and Human Services Health Resources and Services Administration HIC/AIDS Bureau, Published January 2011, http://hab.hrsa.gov/deliverhivaidscare/clinicalguide

The following evaluation compares the change in viral load during the pilot period as classified by the participant medication possession ratio. For this analysis, adequate response is considered a viral load less than 200 copies/mL, while failure is considered anything greater than 200 copies/mL. Compliance is reported as the number of pilot participants in each grouping that had MPR data for the pilot period.

Viral Load Changes during Pilot Period

Status	Full Compliance	Partial Compliance	Poor Compliance	Non-Compliance	Total Participants
Adequate Response	116	11	7	7	141
Failure	20	2	2	4	28
No Change in Viral Load	151	15	5	3	174
No Viral Load Reporting*	2	4	3	6	15
Total	289	32	17	20	358

*Participant did not report viral load in one or both of the reporting periods.



- In the participants with no change in viral load, all but two had a viral load less than 200 copies/mL.
- In the patients that fell in the failure category during the study period, 50.0% started the study with a viral load over 400 copies/mL.

APPENDIX A

September 14, 2012 Cost Neutrality Report

MERCER

PRE-EXISTING CONDITION INSURANCE PROGRAM (PCIP) PILOT COST NEUTRALITY ANALYSIS – SEPTEMBER 14, 2012

North Carolina Division of Public Health

The State of North Carolina's Division of Public Health (DPH) engaged Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, to determine whether enrolling AIDS Drug Assistance Program (ADAP) beneficiaries in Inclusive Health North Carolina (IHNC) would provide any drug cost savings or prove to be cost neutral during calendar year (CY) 2013 (January through December 2013).

In order to estimate the impact of enrolling ADAP beneficiaries in IHNC, Mercer used DPH provided demographic enrollment data for August 2012 as the base population for the savings analysis. Costs were projected for CY 2013 for the ADAP and IHNC benefits.

Since the size and demographic of the PCIP pilot subgroup is unknown at this time, Mercer performed the cost neutrality analysis on the entire population enrolled in the ADAP during August 2012. This analysis assumes that the PCIP pilot subgroup selected would exhibit similar characteristics as the overall ADAP population.

Results

Based on Mercer's analysis, DPH can expect drug cost savings between 20% and 24% for the enrollees in the PCIP pilot program compared to their drug costs under the ADAP program.

CY 2013 Cost Estimates

Program	Low Trend Scenario	High Trend Scenario
ADAP Costs	$47,900,000	$50,100,000
PCIP Costs	$38,200,000	$38,200,000
Expected Savings	20%	24%

PCIP Cost Calculation

Costs for the beneficiaries receiving HIV drug benefits through the PCIP program would include the annual deductible and monthly premiums for the IHNC High Deductible Health Plan 4500 (HDHP). Under HDHP 4500, beneficiaries would pay a $4,500 deductible per year plus a premium determined by the beneficiary's age and smoking status.

As of August 2012 there are 5,176 beneficiaries enrolled in the ADAP, of which approximately 70% are male and 29% are female. According to a study referenced by the Duke Legal Project[1], which examined the smoking habits of HIV patients, approximately 63% of male and 48% of female HIV patients are smokers. As a result, approximately 59% of the overall ADAP population is assumed to be smokers for this analysis.

Mercer then grouped enrollment by age bands to calculate costs under the PCIP program. Premiums under the PCIP program for CY 2013 were obtained by applying a 10% trend to 2012 premiums at each age band. This 10% trend was provided by DPH based on their discussions with PCIP officials.

In order to calculate the total annual PCIP costs, Mercer assumed that the $4,500 deductible was applied to each enrollee. Next, the estimated percentage of the ADAP population that smokes is applied to premiums for smokers and non-smokers using the following equation:

Total Cost = $4,500 + [(Smoking Premium) x 12 months x 0.59] + [(Non-Smoking Premium) x 12 months x (1-0.59)]

Using this equation, the estimated total annual PCIP costs are approximately $38.2M.

ADAP Cost Calculation

PMPM Validation

Mercer validated the ADAP per member per month (PMPM) cost calculated by DPH during a cost neutrality analysis performed in March 2012. In order to estimate and validate the annual ADAP costs, Mercer used dispensing and wholesale pricing information provided by DPH.

Initially, Mercer applied the wholesale pricing information to the dispensing data provided by DPH based on the dispensing date provided. Next, Mercer developed a purchase price per unit by using the wholesale price provided divided by the package size published in First DataBank (national compendia of drug pricing information). Lastly, Mercer used the purchase price per unit, applied the quantity dispensed on the claim and the dispensing fee appropriate on that date of service to calculate paid amounts for each transaction. (Dispensing fees paid to the pharmacies were $11.75 per claim prior to June 2011 and increased to $14.00 per claim starting June 2011.) The cost per claim was calculated using the following formula:

Cost Per Claim: [(Wholesale Price / Package Size) * Quantity Dispensed] + Dispensing Fee

Some claims were not able to be re-priced using the above formula for the following reasons:

- No quantity dispensed on the claim
- No wholesale price on the date of service

[1] Neumann, T., Reinsch, N., Esser, S., Krings, P., Konorza, T., Woiwoid, T., Miller, M., Brockmeyer, N. and Erbel, R. (2010) Smoking behavior of HIV-infected patients. *Health*, **2**, 913-918.doi: 10.4236/health.2010.28135.

For each month of service, the total ADAP costs for each transaction were summed to calculate total costs per month. Next, based on enrollment data provided by DPH, Mercer calculated an ADAP PMPM using total costs per month and the total ADAP enrollees for that month. Mercer used the most recent 12 months of dispensing and wholesale data (July 2011 through June 2012) to calculate base period annual costs.

Due to insufficient quantity dispensed data for all claims in both July and August 2011, a composite PMPM was calculated using September 2011 through June 2012 costs. The weighted average PMPM based on this approach is approximately $645 PMPM.

Using actual aggregate cost and enrollment data provided by DPH, the average PMPM for July 2011 through June 2012 was approximately $708 PMPM. The discrepancy between these values is probably due to the inability to price all claims as well as potential differences in unit price calculations.

CY 2013 Cost Calculation

Using the average cost of $708 PMPM discussed above, Mercer applied a combined cost and utilization trend band of 9% and 14% for the 2013 time period. This resulted in CY 2013 PMPMs of $772 for a low trend assumption and $807 for a high trend assumption. These trend factors take into account marketplace trends including brand/generic drug mix, release of new drugs and brand inflation factors. The total CY 2013 costs for each ADAP enrollee provided by DPH was calculated using the following formula:

Low Trend Costs: $772 x 12 x 5,176
High Trend Costs: $807 x 12 x 5,176

Total ADAP costs for CY 2013 therefore range approximately between **$47.9M** and **$50.1M**.

Assumptions and Limitations

The following assumptions and limitations were used in the analysis:

- The PCIP pilot group selected reflects the same demographic characteristics as the August 2012 ADAP enrollment.
- Under the PCIP, it is assumed all enrollees will meet or exceed the $4,500 annual deductible.
- The portion of the ADAP population, as well as the PCIP pilot group, that are smokers is similar to prevalence of smoking habits in the HIV population study cited by the Duke Legal Project.
- Mercer did not apply explicit completion factors to the most recent months of ADAP dispensing data for incurred but not reported claims.
- Based on discussions with DPH, Mercer determined the impact of the ADAP enrollee re-certifications would not significantly affect average aggregate enrollment across the entire

calendar year. As a result, the August 2012 enrollment group was not modified for use in projecting ADAP costs in 2013.

- Mercer estimated cost and utilization trend for HIV drugs to be between 9% and 14%. These trend factors take into account marketplace trends including brand/generic drug mix, release of new drugs and brand inflation factors.
- The Mercer pharmacy team provided input on new HIV drugs and cost trends for CY 2013, which is reflected in the considerations in our trend selection.
- Mercer limited the ADAP PMPM validation analysis to include only drugs present on the ADAP drug formulary provided by DPH.
- Mercer relied on dispensing and wholesale data provided by DPH, but did not audit the information.
- Mercer did not apply explicit completion factors to the data used in this analysis for incurred but not reported claims.
- Mercer did not include consideration for population expansions up to 300% of FPL during the projected time period.
- Mercer relied on DPH for IHNC premium trends.

For our analysis, Mercer relied on data, information and other sources of data as described in this report. We have relied upon this data without an independent audit. Although we have reviewed the data for reasonableness and consistency, we have not audited or otherwise verified this data. It should also be noted that our review of data may not always reveal imperfections. We have assumed that the data provided is both accurate and complete. The results of our analysis are dependent upon this assumption. If the data or information is inaccurate or incomplete, our findings and conclusions may need to be revised.

In addition, the projections we show in this report are dependent upon a number of assumptions regarding the future economic environment including; medical and pharmacy trend rates, prescriber behavior, behavior of individuals, providers in light of incentives and penalties, as well as a number of other factors.

APPENDIX B

PCIP Pilot Participant Survey

I am calling on behalf of the North Carolina ADAP Program. The ADAP Program is asking people who were part of the Inclusive Health PCIP pilot program about their experience. You were one of the participants in this pilot, which allowed you to use the health insurance for your prescriptions and doctor visits. We would like to ask you eight quick yes/no questions, which will only take a couple minutes. Your answers will remain confidential.

1. Did you get prescriptions filled while you were part of the health insurance pilot program?

   Yes ____ No____

2. A. If yes, was it easy to access a pharmacy that was participating in the pilot program?

   Yes____ No____

   B. Did you have any trouble getting your prescription(s) filled?

   Yes____ No____

   C. If you had any problems getting your prescription filled, was the pharmacy helpful in solving the problem?

   Yes____ No____

3. Did you go to a doctor for a check-up or because you were ill while you were part of the pilot program?

   Yes____ No____

4. A. Did you work with a case manager who was part of the pilot program?

   Yes____ No____

   B. If yes, was the case manager helpful?

   Yes____ No____

5. Overall, did you have a positive experience in the pilot program?

   Yes____ No____

6. Is there any more information you would like to tell us about your experience?

APPENDIX C

PCIP Benefits Summary

INDIVIDUAL HEALTH INSURANCE PLAN

NORTH CAROLINA HEALTH INSURANCE RISK POOL, INC.
d/b/a INCLUSIVE HEALTH - FEDERAL OPTION

Policyholder: [John Doe]
Policy number: [xxxxxxx]

Effective Date: [02/01/2013 as of 12:01 a.m.]
Initial premium amount: [$]

The North Carolina Health Insurance Risk Pool, Inc. d/b/a Inclusive Health – Federal Option ("the Risk Pool," "We," "Us," or "Our") agrees to provide the benefits set forth in this Policy, subject to all the terms and conditions of this Policy. We reserve the full and exclusive right to interpret the terms of this Policy and to determine the benefits payable hereunder.

This Policy is issued in consideration of the Policyholder's application, which is made part of this Policy, and payment of premiums in accordance with Policy provisions. A copy of your application was returned to You with Your NCHIRP letter of approval. We issued this coverage in reliance upon the accuracy and completeness of the information contained in the application and We reserve the right to rescind coverage if a material omission or misstatement is made in the application, subject to the Time Limit on Certain Defenses provision.

This Policy becomes effective at 12:01 A.M. Eastern Time on the Effective Date stated above. This Policy and the insurance it provides terminate at 12:00 Midnight Eastern Time on the date of termination as provided in the Eligibility and Termination Provisions section.

Renewability: This Policy is renewable at the option of the Policyholder except as provided in the Eligibility and Termination Provisions section of this Policy.

YOUR POLICY MAY NOT BE IN FORCE WHEN YOU HAVE A CLAIM! PLEASE READ! Your Policy was issued based on the information entered in Your application, a copy of which was returned to You with Your enrollment application approval letter. If, to the best of your knowledge and belief, there is any misstatement in Your application or if any information concerning the medical history of any Covered Person has been omitted, You should advise Us immediately regarding the incorrect or omitted information; otherwise, Your Policy may not be a valid contract.

RIGHT TO RETURN POLICY WITHIN 10 DAYS. If for any reason You are not satisfied with Your Policy, You may return it to Us within 10 days of the date You received it and the premium You paid will be promptly refunded.

This Policy is governed by the laws of North Carolina.

The availability and unavailability of membership in Inclusive Health and any benefits through the Plan are at all times subject to Federal law regulation and the agreement between the North Carolina Risk Pool and the U.S. Department of Health and Human Services and is dependent on continued availability of Federal funding.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If You are eligible for Medicare, review the Guide to Health Insurance for People with Medicare, which is available from us.

NOTE: Covered Services received outside of North Carolina will be reimbursed at the applicable Medicare reimbursement rate. You will be subject to costs in excess of Inclusive Health's covered payment.

Important Cancellation Information – Please read the section entitled Eligibility and Termination Provisions.

This Policy is a legal contract between the Policyholder and the Risk Pool.
READ YOUR POLICY CAREFULLY.

Executive Director

TABLE OF CONTENTS

SCHEDULE
BENEFIT PLAN FOR HIGH DEDUCTIBLE HEALTH PLAN 4500

This Schedule summarizes benefit information and the date these benefits take effect. Please read Your entire Policy to fully understand all terms, conditions, limitations and exclusions that apply.

Insurer: North Carolina Health Insurance Risk Pool, Inc.

Plan Administrator: CoreSource, Inc.
5200 77 Center Drive Suite 400
Charlotte, NC 28217-0718

Policy Effective Date: [date]

Policyholder/Covered Person: [name] Policy number: [#]

GENERAL POLICY LIMITS – These limits apply to all benefits unless stated otherwise in this Schedule. Any specific benefits not listed in this Schedule are also subject to these General Policy Limits.	
Lifetime Maximum Benefit:	$1,000,000 – All benefit payments apply to the Maximum Lifetime Benefit unless otherwise indicated.
Annual Deductible	$4,500

	Network Provider Benefit	**Non-Network Provider Benefit**
Coinsurance:	100% of Covered Expenses from a Network Provider after the Deductible is satisfied - The Coinsurance applies to all Covered Expenses unless otherwise indicated.	100% of Covered Expenses from a Non-Network Provider after the Deductible is satisfied - The Coinsurance applies to all Covered Charges unless otherwise indicated.
Annual Out-of-Pocket Maximum:	$4,500	$4,500
INPATIENT HOSPITAL SERVICES		
Inpatient Hospital Services	Subject to general policy limits stated above.	Subject to general policy limits stated above.
OUTPATIENT SERVICES		
Emergency Care	Subject to general policy limits stated above.	Subject to general policy limits stated above.
Outpatient Medical Services:	Subject to general policy limits stated above.	Subject to general policy limits stated above.
Physical Medicine (Chiropractic Care):	Subject to general policy limits stated above. In addition, Maximum of 30 visits per Calendar Year.	Subject to general policy limits stated above. In addition, Maximum of 30 visits per Calendar Year.

	Network Provider Benefit	Non-Network Provider Benefit
OUTPATIENT SERVICES cont.		
Physical Medicine (Physical, Occupational and Speech Therapies):	Subject to general policy limits stated above.	Subject to general policy limits stated above.
Urgent Care	Subject to general policy limits stated above.	Subject to general policy limits stated above.
HEALTH CARE PRACTITIONER SERVICES		
Office Visits	Subject to general policy limits stated above	Subject to general policy limits stated above
MENTAL HEALTH SERVICES		
Severe Mental Illness	Subject to general policy limits stated above.	Subject to general policy limits stated above.
Other Mental Illness	Subject to general policy limits stated above.	Subject to general policy limits stated above.
ORGAN TRANSPLANT SERVICES		
Organ Transplant Services	Subject to the general policy limits stated above when services are received from a network Center of Excellence Transplant Provider.	Lifetime maximum of $100,000 when services are received from a provider other than a network Center of Excellence Transplant Provider.
PREGNANCY SERVICES		
Maternity Benefits	Subject to general policy limits stated above.	Subject to general policy limits stated above.
PRESCRIPTION DRUG BENEFITS		
Generic Drugs	Subject to general policy limits stated above.	Subject to general policy limits stated above.
Brand Drugs	Subject to general policy limits stated above.	Subject to general policy limits stated above.
Specialty Drugs	Subject to general policy limits stated above.	Subject to general policy limits stated above.
Nicotine Replacement Therapy Drugs	Subject to general policy limits stated above.	Subject to general policy limits stated above.
PREVENTIVE CARE		
Routine Medical Care and Physical Examinations	Not subject to Deductible, Coinsurance or Out-of-Pocket limits.	Not subject to Deductible, Coinsurance or Out-of-Pocket limits.
Childhood Immunizations and Seasonal flu vaccination, H1N1 vaccination & Zostavax (Shingles) vaccination	Not subject to Deductible, Coinsurance or Out-of-Pocket limits.	Not subject to Deductible, Coinsurance or Out-of-Pocket limits.

	Network Provider Benefit	Non-Network Provider Benefit
Screening Tests	Not subject to Deductible, Coinsurance or Out-of-Pocket limits.	Not subject to Deductible, Coinsurance or Out-of-Pocket limits.
Obesity Assessment	Maximum of 4 visits per Calendar Year. Not subject to Coinsurance.	Maximum of 4 visits per Calendar Year. Not subject to Coinsurance.
SUBSTANCE ABUSE SERVICES		
Substance Abuse Services	Subject to general policy limits stated above.	Subject to general policy limits stated above.
SURGICAL SERVICES		
Surgical Services	Subject to the general policy limits stated above. In addition, the services of an assistant surgeon are limited to 50% of the benefit amount payable for the services of the primary surgeon.	Subject to the general policy limits stated above. In addition, the services of an assistant surgeon are limited to 50% of the benefit amount payable for the services of the primary surgeon.
OTHER BENEFITS		
Skilled Nursing Facility	Subject to general policy limits stated above. In addition, Maximum of 60 days of inpatient care per Calendar Year.	Subject to general policy limits stated above. In addition, Maximum of 60 days of inpatient care per Calendar Year.
Jaw, Face, and Head Bone and Joint Disorders	$3,500 Lifetime Maximum for non-surgical treatments. Surgical treatments payable as described in the Surgical Services benefit.	$3,500 Lifetime Maximum for non-surgical treatments. Surgical treatments payable as described in the Surgical Services benefit.
Bariatric Surgery Services	Subject to the general policy limits stated above when services are received from a network Center of Excellence Bariatric Surgery Provider.	No Coverage

HOW BENEFITS ARE PAID

We will pay benefits for Covered Expenses incurred for Covered Health Services, as described in the Schedule and the Covered Health Services sections. All benefits We pay will be subject to all conditions, limitations, and maximums of this Policy.

How to Access Your Benefits
An identification card (ID card) will be provided to You when You are accepted for coverage. Show Your ID card to Your provider every time You request health care services. Generally, any services You receive will be billed to Us by the provider. However, if You receive a service which will not be billed to Us by the provider, You must provide Us with notification of the claim and proof of loss in accordance with the Claims Payment section.

You are free to use any provider You choose. Generally, if You use a Network Provider, You will incur lower Coinsurance costs. If You use a Non-Network Provider, You may incur higher Coinsurance and Out-of-Pocket costs.

It is Your responsibility to determine if a provider is a Network Provider or a Non-Network Provider before any services are rendered. Please see the Schedule for specific benefit levels that apply to each type of provider.

How Benefits are Paid
We will determine if a service received by a Covered Person qualifies as a Covered Health Service. After determining that the service is a Covered Health Service, We will pay benefits as follows:

- We will determine the total amount of eligible Covered Expenses incurred related to a particular Covered Health Service;
- We will then review the eligible Covered Expenses incurred against any Policy or benefit maximums which may apply to a particular Covered Health Service;
- If You are required to pay a Copayment, We will subtract the amount of Your Copayment from the eligible Covered Expense amount;
- If You have not met Your Deductible, We will subtract any amounts You are required to pay as part of Your Deductible;
- We will then review Your Out-of-Pocket Limit. If You have not yet incurred enough Coinsurance expenses to equal the amount of the Out-of-Pocket Limit, We will subtract any Coinsurance amounts You must pay from the eligible Covered Expenses incurred;
- We will make payment for the remaining eligible Covered Expenses incurred to You or the provider of the service; or
- You will not be billed for any amount in excess of the negotiated rate for that service pursuant to the agreement between the provider and Us, unless services are received outside North Carolina. Covered Services received outside of North Carolina will be reimbursed at the applicable Medicare reimbursement rate. You will be subject to costs in excess of Our covered payment.

Deductible
The Deductible is the amount shown on the Schedule which the Covered Person must incur in Covered Expenses before We pay benefits. The Deductible applies on a Calendar Year basis.

Coinsurance
Coinsurance is the percentage of Covered Expenses We will pay toward the total expenses incurred for services. This amount is shown on the Schedule. Coinsurance may vary depending upon whether the service was provided by a Network or Non-Network Provider. You are responsible for the remaining percentage of Covered Expenses, and this amount does not apply to any responsibility You have for Copayments or Deductibles.

Out-of-Pocket Limit
Your Out-of-Pocket Limit is the amount, as shown on the Schedule, of Deductible and Coinsurance You must pay before We pay benefits at 100%.

Copayment
The Copayment is the amount shown on the Schedule which the Covered Person must pay directly to the Health Care Practitioner each time certain Covered Health Services are received.

Benefit Maximums
The amount We pay for some services are limited to a benefit maximum. We will not make benefit payments in excess of the benefit maximum for the Covered Expenses and time periods shown on the Schedule.

Lifetime Maximum Benefit
The lifetime maximum benefit shown on the Schedule is the maximum amount We will pay for Covered Expenses incurred by a Covered Person while this Policy is in effect.

Sample Benefit Payment Calculation
Below are samples illustrating how the benefit amount will be calculated:

HDHP 4500

- If a charge of $100 is incurred for a sick office visit to a Network Primary Care Provider, and You have not yet satisfied your annual deductible, benefits would be calculated as follows:

Amount charged by provider: $100

Allowed/negotiated amount, pursuant to Fee Schedule: . $80

Our payment to provider $0*

Amount billed to You $80*

**The provider will not balance bill You for charges in excess of the negotiated amount.*

2.) If a charge of $100 is incurred for a sick office visit to a Non-Network Provider, and You have not yet satisfied your annual deductible, benefits would be calculated as follows:

Amount charged by provider: $100

Allowed/negotiated amount, pursuant to Fee Schedule: . $80

Our payment to provider $0*

Amount billed to You $80*

**North Carolina providers are forbidden under state law from balance billing You for any amounts above the Inclusive Health allowed/negotiated rate. For services received from providers outside of North Carolina, however, You may be subject to being balance billed for charges in excess of the Inclusive Health allowed/negotiated rate.*

COVERED HEALTH SERVICES

We only pay benefits on Covered Expenses as explained in the How Benefits are Paid section. The services described below are Covered Health Services, and are payable as described in the Schedule.

Ambulance Services
Covered Health Services include local professional ground or air ambulance service:

- From the scene of a medical emergency to the nearest Hospital able to provide treatment of the Sickness or Injury; and
- From one health care facility to another as Medically Necessary for the continued treatment of the Covered Person, or to transport the Covered Person from a Non-Network facility to a Network facility.

Air ambulance service is covered only when ground ambulance service is medically inappropriate based on the distance or terrain to be traveled, and the medical condition of the Covered Person.

Clinical Trial Services
Covered Health Services include participation in phase II, phase III, and phase IV Clinical Trials for which You meet protocol requirements of the trials and provide informed consent.

Covered Expenses for Clinical Trials are limited to Medically Necessary costs associated with participation in the Clinical Trial, including those related to health care services typically provided absent a Clinical Trial, the diagnosis and treatment of complications, and Medically Necessary monitoring, are covered only to the extent that such costs have not been or are not funded by national agencies, commercial manufacturers, distributors, or other research sponsors of participants in Clinical Trials.

Covered Expenses for Clinical Trials do not include services provided solely to satisfy data collection and analysis needs, and those that are not provided for the direct clinical management of the patient.

Dental Benefits
Routine dental care is not covered under this Policy.

However, Covered Health Services include treatment of Injuries to a sound natural tooth, and excision of partially or completely unerupted impacted teeth.

Covered Health Services also include anesthesia and Hospital or Free-Standing Surgical Facility expenses where anesthesia is required in order to safely and effectively perform a dental procedure for Covered Persons who are under the age of nine; or who have serious mental or physical conditions; or significant behavior problems.

Diabetes Services
Covered Health Services include Medically Necessary services, including diabetic outpatient self-management training and educational services, and laboratory procedures used to treat diabetes. Diabetic outpatient self-management training and educational services shall be provided by a Health Care Practitioner. Medically Necessary equipment, supplies and medications will be covered under the Prescription Drug Benefit except for insulin pumps and insulin pump supplies which are covered as Durable Medical Equipment and not under the Prescription Drug Benefit.

Durable Medical Equipment
Covered Health Services include Durable Medical Equipment that is Medically Necessary and necessitated by the Covered Person's Injury or Sickness, and prescribed by a Health Care Practitioner as appropriate for use in the home.

Covered Expenses for Durable Medical Equipment are limited to the lesser of the rental cost or the purchase price, as decided by Us.

Emergency Care
Subject to the limits stated in the Schedule, Covered Health Services include Emergency Care provided by:

- A Hospital for emergency room and ancillary services; and
- An emergency room Health Care Practitioner.

If Emergency Care is obtained through a Non-Network Provider, We will pay benefits at the network level until the Covered Person can be safely transported to a Network Provider. If Emergency Care is subject to a Copayment as shown in the Schedule, the Copayment will be waived if the Covered Person is admitted as an inpatient during the Emergency Care visit.

Health Care Practitioner Services
Covered Health Services include professional fees charged by a Health Care Practitioner in dispensing Covered Health Services. Covered Health Care Practitioner services include:

- Covered Health Services received during an office visit (not subject to Deductible or Coinsurance when received from a Network Provider), including diagnostic x-ray and laboratory tests billed by the Network Provider as part of an office visit;
- Health Care Practitioner visits in an inpatient or outpatient setting as part of Covered Health Services;
- Health Care Practitioner services for administering or interpreting diagnostic x-ray and laboratory tests; and
- Allergy injections, testing and treatment.

Medical care received from a Specialist may be subject to a higher Copayment, as shown in the Schedule.

Professional fees related to surgery are covered as described in the Surgical Services benefit.

Hearing Aids
Covered Health Services include all Medically Necessary hearing aids and services ordered by a Health Care Practitioner, including:

- One hearing aid per hearing-impaired ear subject to a maximum of $2,500 per hearing aid every 36 months for Covered Persons under 22 years of age.
- Initial hearing aids and replacement hearing aids not more frequently than every 36 months.
- A new hearing aid when alterations to the existing hearing aid cannot adequately meet the needs of the Covered Person.
- Services, including the initial hearing aid evaluation, fitting, and adjustments, and supplies, including ear mold.

Home Health Care
Covered Health Services include services provided by a Home Health Care Provider, at the Covered Person's home, under a Home Health Care Plan. Up to four consecutive hours of Home Health Care services in a 24 hour period shall be considered as one Home Health Care visit. Covered Expenses for Home Health Care include the following:

- Part-time skilled nursing care;
- Physical therapy;
- Speech therapy;
- Medical supplies, drugs and medicines prescribed by a Health Care Practitioner;
- Laboratory services;
- Occupational therapy; and
- Respiratory therapy.

Covered Expenses for Home Health Care do not include full-time nursing care at home, meals delivered to the home, homemaker services, transportation, or services provided by a member of the Covered Person's immediate family or household.

Hospice Care
Covered Health Services include services provided to a Covered Person who is a Hospice Patient under a Hospice Care Program furnished in a Hospice Facility or in the Covered Person's home by a Hospice Care Agency. Covered Expenses include, but are not limited to:

- Room and board in a Hospice Facility, when it is for management of acute pain or for an acute phase of chronic symptom management;
- Part-time nursing care provided by or supervised by an R.N. for up to eight hours per day;
- Counseling for the Hospice Patient and the immediate family by a licensed clinical social worker or pastoral counselor;
- Medical social services for the Covered Person or immediate family including:
- Assessment of social, emotional and medical needs, and the home and family situation; and
- Identification of the community resources available;
- Psychological and dietary counseling;
- Physical therapy;
- Part-time home health aide services for up to eight hours in any one day; and
- Medical supplies, drugs, and medicines prescribed by a Health Care Practitioner.

Benefits will not be payable under this Hospice Care benefit unless a Health Care Practitioner certifies that the Covered Person is terminally ill with a life expectancy of six months or less.

Inpatient Hospital Services
Covered Health Services include the following services that are provided to a Covered Person while Confined as an inpatient in a Hospital for a Sickness or an Injury:

- Daily room and board in a semi-private room;
- Daily room and board in an intensive or critical care setting;
- Treatments such as dialysis, chemotherapy, inhalation therapy, or radiation therapy as ordered by a Health Care Practitioner;
- Other Medically Necessary Covered Health Services related to the Covered Person's Confinement, such as use of an operating room and recovery room; surgical instruments and supplies; administration of blood products; diagnostic imaging services; laboratory services; and drugs and medicines that are dispensed while Confined; or
- Services received from a Non-Network anesthesiologist, assistant surgeon, inpatient consulting physician, pathologist or radiologist will be paid at the Network Provider level when the surgeon is a Network Provider, and/or the Hospital where such services are rendered is a Network Provider.

Jaw, Face or Head Bone and Joint Disorders
Covered Health Services include services related to the Medically Necessary treatment of Temporomandibular Joint Disorder (TMJ) and for other procedures involving the bones or joints of the jaw, face or head. Medically Necessary treatment of TMJ may include splinting and use of intraoral prosthetic appliances to reposition the bones. Non-surgical treatments are subject to a $3,500 lifetime maximum benefit. Surgical treatments are covered as any other surgery under the Surgical Services benefit.

Lymphedema
Covered Health Services include Medically Necessary diagnosis, evaluation and treatment of lymphedema, including equipment, supplies, complex decongestive therapy, gradient compression garments, and self-management training and education. Treatment 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 the professional's scope of practice. Covered gradient compression garments are those that require a prescription, are custom-fit for the individual, and do not include disposable medical supplies such as over-the-counter compression or elastic knee-high or other stocking products.

Mental Health Services
Covered Health Services for Severe Mental Illness as defined in the Definitions section are the same as for any other Sickness under this Policy, and are not subject to any separate durational limits.

Newborn, Adopted, and Foster Children
Covered Health Services for a covered Newborn Child or newly adopted child or newly placed foster child who is eligible pursuant to the Eligibility for Newborn, Adopted and Foster Children provision, include the following:

- Injury or Sickness;
- Care and treatment for premature birth;
- Medically diagnosed birth defects and abnormalities; and
- Necessary care and treatment of cleft lip and cleft palate.

Organ Transplant Services
Covered Health Services include pre-transplant evaluation, transplant inclusive of any chemotherapy and associated services, post-discharge services, and treatment of complications after transplantation for the following types of transplants:

- Heart;
- Lung(s);
- Heart-lung;
- Liver;
- Kidney;
- Bone Marrow Transplant;
- Pancreas;
- Simultaneous pancreas/kidney;
- Intestine;
- Pancreas following kidney; and
- Any organ not listed above, if required by state or federal law.

Coverage is not provided for any organ transplant that We determine to be Experimental, Investigational, or for Research Purposes, unless performed as part of a covered Clinical Trial.

Corneal transplants and heart valve implants or replacements are not covered under this Organ Transplant Services benefit, but are covered as any other surgical procedure under this Policy.

The Covered Person may select any provider to perform transplant services. However, if the Covered Person selects a Non-Network Provider (a provider other than a Center of Excellence Transplant Provider), this organ transplant benefit will be subject to a $100,000 lifetime maximum.

Outpatient Services
Covered Health Services for Outpatient Services that are provided to a Covered Person include:

- Physical therapy; occupational therapy; speech therapy;
- Respiratory therapy and cardiac rehabilitation programs;
- Diagnostic Imaging services and laboratory services;
- Other Medically Necessary Covered Health Services received during the Outpatient visit including, but not limited to: use of an operating room and recovery room; surgical instruments and supplies; and drugs and medicines that are consumed during the Outpatient visit; and
- Services received from a Non-Network pathologist or radiologist for interpretation of an x-ray or to prepare a pathology report when the facility where such services are rendered is a Network Provider.

Physical Medicine
Covered Health Services include the following:

- Up to 30 visits per Calendar Year for chiropractic services.

Pregnancy Services
Covered Health Services include Medically Necessary services related to pregnancy and Complications of Pregnancy, to the same extent as any Sickness would be covered under this Policy.

Inpatient Hospital Services for the mother and the Newborn Child are covered for a minimum of 48 hours of Confinement following an uncomplicated vaginal delivery and a minimum of 96 hours of Confinement following an uncomplicated caesarean section delivery. If a shorter Hospital stay is agreed upon between the Covered Person and the Health Care Practitioner, Covered Health Services will include post-delivery follow-up care in the Covered Person's home, a Health Care Practitioner's office, a Hospital, a birthing center, an intermediate care facility, a federally qualified health center, a federally qualified rural health clinic, a state health department maternity clinic, or any other setting determined appropriate in accordance with federal regulations. Post-delivery follow-up care must be provided within 72 hours of discharge.

Inpatient Hospital Services and post-delivery follow-up care include routine care for the Newborn Child as well as the mother.

Prescription Drug Benefit
Covered drugs/supplies include the following:

- Drugs, medicines, or medications that under federal or state law may be dispensed only by Prescription from a Health Care Practitioner;
- Contraceptive drugs approved by the FDA;
- Insulin and other medications for the treatment of diabetes;
- Medically Necessary equipment and supplies for the treatment of diabetes, other than insulin pumps or insulin pump supplies for the treatment of diabetes which are covered under Durable Medical Equipment;
- Hypodermic needles or syringes prescribed for use with insulin or Self-Administered Injectable Drugs;
- Self-Administered Injectable Drugs approved by Us; and
- Spacers and/or peak flow meters for the treatment of asthma.

Covered Expenses for Prescription drugs include coverage of any drug that is approved by the FDA including drugs prescribed outside of their FDA labeled indication, provided that the drug has been proven effective and accepted for the treatment of the specific type of cancer in any one of the following established reference compendia:

- The National Comprehensive Cancer Network Drugs & Biologics Compendium;
- The Thomson Micromedex DrugDex;
- The Elsevier Gold Standard's Clinical Pharmacology
- Thomson Micromedex DrugPoints or Clinical Pharmacology; or
- Any other authoritative compendia as recognized periodically by the United States Secretary of Health and Human Services.

Covered Expenses for Prescription drugs do not include drugs that are Experimental, Investigational, or for Research Purposes, or any drug that the FDA has determined to be contraindicated for treatment of the specific type of cancer for which the drug has been prescribed.

Covered Expenses for Prescription drugs are subject to the Deductible, but not coinsurance. Any expenses incurred under provisions of this benefit, including Copayments, apply toward the Covered Person's Out-of-Pocket Limit. Co-payments for Prescription drugs will no longer apply when the Out-of-Pocket Limit has been attained. The Co-payment for Prescription drugs may vary, based on the classification of Prescription drug dispensed:

- Generic Drug;
- Preferred Brand Drug;
- Non-Preferred Brand Drug;
- Specialty Prescription Drug; or
- Nicotine Replacement Therapy Drug

You may obtain a current list of Prescription drugs by classification as described above by calling the telephone number on your ID card, or on the internet at www.medtrakrx.com.

You must obtain Prior Authorization from Us for certain Prescription drugs (referred to as Restricted Access Drugs), for the dosage, quantity and/or duration of a Prescription as appropriate for the Covered Person's age, diagnosis, and sex. The list of Prescription drugs requiring Prior Authorization is subject to periodic review and modification. You may obtain a current list by calling the telephone number on your ID card, or on the internet at www.medtrakrx.com.

Each Prescription drug or refill obtained at a retail Pharmacy is limited to a maximum of a 30-day or 90-day supply based on the FDA approved dosage and the prescriber's directions for use, regardless of manufacturers' packaging. 90-day supplies of prescription drugs or refills are subject to mail order copays.

Each Prescription drug or refill obtained through a Mail Order Pharmacy is limited to a maximum of a 90-day supply based on the FDA approved dosage and the prescriber's directions for use, regardless of manufacturer packaging.

You cannot refill a Prescription until 75% of the supply has been used, except under certain circumstances during a state of emergency or disaster.

Preventive Care

Covered Health Services include the preventive care services described below. Preventive care services are not subject to the Deductible or Coinsurance.

- A routine exam or annual physical exam performed by a Health Care Practitioner;
- Immunizations for Covered Persons under age 18, as recommended by the United States Preventive Services Task Force or the Advisory Committee on Immunization Practices on the date the service is incurred;
- Hearing screening for a newborn infant ordered by a Health Care Practitioner;
- Routine mammogram – one or more mammograms a year, as recommended by a Health Care Practitioner for a female Covered Person who is at risk for breast cancer; a baseline mammogram for a female Covered Person between the ages of 35 and 39; a mammogram every other year for a female Covered Person between the ages of 40 and 49, or more frequently as recommended by a Health Care Practitioner; and an annual mammogram for a female Covered Person 50 years of age or older. A woman is considered "at risk for breast cancer" if she has a personal history of breast cancer or biopsy-proven benign breast disease, if she has a mother, sister, or daughter who has or had breast cancer, or if she has not given birth prior to the age of 30;
- Examinations and laboratory tests for the screening for the early detection of cervical cancer, including conventional Pap smear screening, liquid-based cytology, and human papilloma virus detection methods for women with equivocal findings on cervical cytologic analysis that are subject to the approval of and have been approve by the FDA. Screening shall be in accordance with the most recently published American Cancer Society guidelines or guidelines adopted by the North Carolina Advisory Committee on Cancer Coordination and Control. This benefit includes the examination, the laboratory fee, and the interpretation of the laboratory results;
- Colorectal cancer screening for any nonsymptomatic Covered Person 50 years of age or less than 50 years of age and at high risk for colorectal cancer;
- Surveillance tests for a female Covered Person 25 years of age and older at risk for ovarian cancer. "At risk for ovarian cancer" means either: testing positive for a hereditary ovarian cancer syndrome, or having a family history with at least one first-degree relative with ovarian cancer, or a second relative, either first or second degree, with breast, ovarian, or nonpolyposis colorectal cancer. "Surveillance tests" mean annual screening using transvaginal ultrasound and rectovaginal pelvic examination. The same coinsurance and other limitations as apply to similar services covered under this Policy apply to this benefit;
    - Prostate Specific Antigen Test (PSA) or equivalent tests for a male Covered Person for the presence of prostate cancer; or
    - Osteoporosis screening for a Covered Person: 1) who is estrogen-deficient and at clinical risk of osteoporosis or low bone mass; 2) with radiographic osteopenia anywhere in the skeleton; 3) who is receiving long-term glucocorticoid (steroid) therapy; 4) with primary hyperparathyroidism; 5) who is being monitored to assess the response to or efficacy of commonly accepted osteoporosis drug therapies; 6) who has a history of low-trauma fractures; 7) with other conditions or on medical therapies known to cause osteoporosis or low bone mass.

- Adult vaccination administrative fees for: Seasonal flu vaccination, H1N1vaccination & Zostavax (Shingles) vaccination.

Reconstructive Surgery
Covered Health Services include the following:

- Reconstructive surgery resulting from:
  - An Injury or Sickness when functional impairment is present; or
  - Congenital disease or anomaly of a Covered Person who is less than 18 years old; and

The following services incident to a mastectomy:

- All stages and revisions of reconstructive breast surgery performed on the breast on which the mastectomy has been performed;
- All stages and revisions of reconstructive breast surgery performed on a non-diseased breast to achieve symmetrical appearance if reconstructive surgery on a diseased breast is performed; and
- Prostheses and physical complications from all stages of mastectomy, including lymphedemas.

Reconstructive surgery following a mastectomy is without regard to any lapse of time between the mastectomy and reconstruction.

Skilled Nursing Facility
Covered Health Services include daily room and board and general nursing services for each day of Confinement in a Skilled Nursing Facility, up to a maximum of 60 days of Confinement per Calendar Year. The Covered Person must be under the regular care of a Health Care Practitioner who has reviewed and approved the Confinement.

Substance Abuse Services
Covered Health Services include treatment of Substance Abuse.

Surgical Services
Covered Health Services include the following surgical services that are provided in a Hospital, a Hospital's Outpatient department, an Emergency Room, a Free-Standing Surgical Facility, an Urgent Care Facility or a Health Care Practitioner's office for a Sickness or an Injury:

- Professional services of a surgeon;
- Professional services of a Health Care Practitioner acting as an assistant surgeon during a surgical procedure, payable at up to 50% of the benefit amount payable for the services of the primary surgeon; and
- Services related to the administration of anesthesia.

Urgent Care
Covered Health Services include Urgent Care received in an Urgent Care Facility, as stated in the Schedule.

UTILIZATION MANAGEMENT

You are required to notify the Plan Administrator and obtain approval prior to obtaining certain services. Your benefits may be reduced or denied if You do not obtain Pre-Certification as required by this Section.

You may contact the Plan Administrator at:

1-800-480-6658

Pre-Certification
Pre-Certification is a screening process to determine if a proposed service is Medically Necessary.

The Plan Administrator will not reverse a Pre-Certification determination about a given service unless it can be shown that the determination was based on material misrepresentation about the Covered Person's health status that was knowingly made by the Covered Person or the provider.

Prior Authorization is required for certain Prescription drugs, referred to as Restricted Access Drugs. The list of Prescription drugs requiring Prior Authorization is subject to periodic review and modification. You may obtain a current list by calling the telephone number on your ID card, or on the internet at www.medtrakrx.com.

Services Requiring Pre-Certification
Pre-Certification is required for the following Covered Health Services:

- All acute care Inpatient admissions;
- All rehabilitation facility admissions;
- All subacute admissions;
- All long term acute care admissions;
- Home Health Care;
- Skilled Nursing Facility Confinement;
- Hospice Services;
- Organ Transplant Services;
- Clinical Trial Services;
- Inpatient Mental Health admissions;
- All Bariatric Surgery services; and
- All outpatient and inpatient chemotherapy.

Pre-Certification is required each time a Covered Person expects to incur an expense for one of the above-listed items.

Emergency Care
Pre-Certification is not required for Emergency Care. However, We request notification of Emergency Care as follows:

- Within 48 hours or the next business day after the initiation date of service for any Emergency Care for which the Covered Person is admitted for inpatient care in a Hospital or health care treatment facility.

You are covered for Emergency Medical Conditions and may receive Emergency Care without Pre-Certification, until the condition is stabilized.

In order to ensure that You receive proper care for Your condition, You should notify Us of Your condition and the services You are receiving.

If You do not notify Us of the services You are receiving, Your plan may not be required to cover medical services received after Your condition is stabilized.

Process and Timing of Pre-Certification Requests
You or Your provider must contact the Plan Administrator to request Pre-Certification. When services are to be received from a Network Provider, that provider is responsible for obtaining Pre-Certification. However, when services are to be received from a Non-Network Provider, You are responsible for obtaining Pre-Certification.

Pre-Certification requests must be received by phone as follows:

For Elective Services:

- At least 15 days prior to Confinement in a Hospital, Skilled Nursing Facility, or Hospice Facility;
- At least 15 days prior to Confinement in an Urgent Care;
- At least 30 days prior to the initial evaluation for Organ Transplant Services;
- At least 30 days prior to receiving Clinical Trial Services;
- At least 15 days prior to Inpatient Mental Health admission; or
- At least 15 days prior to the start of Home Health Care.

After the Covered Person's Health Care Practitioner has notified the Plan Administrator of the Covered Person's diagnosis and treatment plan, the Plan Administrator will advise You if Pre-Certification of the treatment plan is required. If Pre-Certification is necessary for a proposed treatment plan, the Plan Administrator will:

- Review services for determination of Medical Necessity and appropriateness; and
- Advise if continued review of the Covered Person's Confinement or services will be required throughout the course of treatment.

Effect on Benefits

If the Plan Administrator determines that a service is not Medically Necessary and denies Pre-Certification, no benefits will be paid for that service.

If You or Your provider fail to request Pre-Certification as required by the terms of this Policy, the Plan Administrator will make a retrospective determination of Medical Necessity as described in the Retrospective Review provision. If the service is determined to have been not Medically Necessary, no benefits will be paid for the service. If the service is determined to have been Medically Necessary, benefits will be paid in accordance with all Policy terms.

Notification and Time of Review
When Pre-Certification is required, notification of Pre-Certification decisions will be consistent with North Carolina law and the policies of the Insurer and the Plan Administrator. On receiving notification of proposed services, the Plan Administrator will obtain all pertinent information required to make a Pre-Certification decision, including pertinent clinical information. Requests for information will be limited to information that is necessary to Pre-Certify the service in question. If all required information is received with the request for Pre-Certification, the Plan Administrator will review all necessary information and will notify the Covered Person and the Health Care Practitioner of the determination within 3 days of receipt of the request.

If additional information is needed to consider the request, the Plan Administrator will request such information within 3 days of receipt of the request. The Covered Person or the Health Care Practitioner will have 45 days to provide the necessary documentation. The Plan Administrator will provide written or electronic notification of its decision within 3 days of receiving the additional information, or at the end of the 45 day time period, whichever is sooner. In the case of an adverse determination, written notification will be given to the Covered Person and the Health Care Practitioner within 24 hours or the next business day.

Concurrent Review
The Plan Administrator will conduct a concurrent review when a Covered Person has received Pre-Certification and during the course of the treatment plan, it is determined that additional services or an extended stay may be necessary. The Plan Administrator will obtain all pertinent information required to Pre-Certify the additional services or extended stay, including pertinent clinical information. Requests for information will be limited to information that is necessary to Pre-Certify the service in question.

On receipt of the request for the additional services or extended stay, the Plan Administrator will evaluate the services within the proposed treatment plan and determine if they are Medically Necessary and appropriate. The Plan Administrator will notify the Health Care Practitioner rendering the additional services within three (3) business days of making the determination.

In the event that the Plan Administrator denies Pre-Certification, written or electronic notification will be given to the Covered Person and the Health Care Practitioner within 24 hours of making the adverse determination. We will be responsible for all expenses incurred until the Covered Person is notified of the Plan Administrator's decision.

Retrospective Review
The Plan Administrator will conduct a retrospective review when a Covered Person did not request or receive Pre-Certification prior to receiving services. The Plan Administrator will obtain all pertinent information required to make a decision, including pertinent clinical information. Requests for information will be limited to information that is necessary to retrospectively certify the service in question.

Within 30 days of receipt of the necessary information, the Plan Administrator will evaluate the services and determine if they were Medically Necessary and appropriate, or in the case of Emergency Care to determine if the prudent layperson standard has been met. The Plan Administrator will notify the Health Care Practitioner rendering the additional services within five (5) business days of making the determination.

Second Surgical Opinion
Prior to having a non-Emergency surgical procedure, a second surgical opinion may be requested. A third surgical opinion may also be requested.

After receiving notification of a proposed surgical procedure through the Pre-Certification process, the Plan Administrator will notify You if a second surgical opinion is requested. Any requested second or third surgical opinion will be paid for by Us.

The Health Care Practitioners rendering the second and third surgical opinions must be approved by the Plan Administrator as qualified to render such a service, either through conference, specialist training or education, or similar criteria, and must not be affiliated in any way with each other or with the Health Care Practitioners who will perform the actual surgery.

Case Management Program
If you are suffering from a complex Sickness or Injury requiring ongoing medical care, You may be referred to the Case Management Program. The program provides a trained medical staff to work with You and/or the Health Care Practitioner.

A Case Management consultant will coordinate services, resources, and information with You and/or the Health Care Practitioner. Alternate forms of care, treatment, or facilities may be recommended as part of the program.

Prior Authorization for Prescription Drugs
Prior Authorization is required for certain Prescription drugs, referred to as Restricted Access drugs. The list of Prescription drugs requiring Prior Authorization is subject to periodic review and modification. You may obtain a current list by calling the telephone number on your ID card, or on the internet at www.medtrakrx.com.

The Prior Authorization requirement will be waived in certain circumstances. You or Your Health Care Practitioner acting on Your behalf may obtain, without penalty or additional cost-sharing beyond that provided for in this Policy, coverage for a Restricted Access Drug determined to be Medically Necessary and appropriate by Your Health Care Practitioner without Prior Authorization, after Your Participating Provider notifies the Plan Administrator:

- Either the alternatives to the Restricted Access Drug have been ineffective in the treatment of Your disease or condition, or such alternatives cause or are reasonably expected by the provider to cause a harmful or adverse clinical reaction; and
- Either the drug is prescribed in accordance with any applicable clinical protocol of the Plan Administrator for the prescribing of the drug, or the drug has been approved as an exception to the clinical protocol pursuant to the Plan Administrator's exception procedure.

The Prior Authorization requirement will also be waived if Your Health Care Practitioner certifies in writing that You have previously used an alternative non-Restricted Access Drug and the alternative drug or device has been detrimental to Your health or has been ineffective in treating the same condition and, in the opinion of the prescribing Health Care Practitioner, is likely to be detrimental to Your health or ineffective in treating the condition again. In such case We will provide coverage for the Restricted Access Drug without requiring Prior Authorization.

APPEALS OF NONCERTIFICATIONS

Informal Reconsideration

The Health Care Practitioner rendering the service can request informal reconsideration of Noncertification on the Covered Person's behalf. The reconsideration will be conducted between the Covered Person's provider and a medical doctor licensed to practice medicine in North Carolina designated by the Plan Administrator. If after informal reconsideration the Noncertification decision is upheld, a new notice of Noncertification will be provided. If the Plan Administrator is unable to render an informal reconsideration decision within 10 business days after the date of receipt of the request for informal reconsideration, the request will be treated as a request for an appeal.

Participation in this informal reconsideration process is not required, and the Covered Person may submit an appeal of a Noncertification at any time.

First Level Appeal of Medical Necessity Noncertification

The Covered Person (or their authorized representative), the provider or the facility rendering service has the right to request a first level appeal of a Medical Necessity Noncertification. A verbal or written request for an appeal must be received within one hundred eighty (180) days from receipt of the notification of the initial Medical Necessity Noncertification. The Covered Person (or their authorized representative), the provider or the facility rendering service may submit written materials for the appeal process.

Expedited Appeal Process

An expedited appeal of a Medical Necessity Noncertification may be requested only when a non-expedited appeal would reasonably appear to seriously jeopardize the life or health of a Covered Person or jeopardize the Covered Person's ability to regain maximum function. An expedited appeal determination will be provided as soon as possible, but not later than four (4) days after receipt of the appeal request and the necessary information.

Nonexpedited Appeal Process

Within three (3) business days after receipt of a request for a standard, nonexpedited appeal, the Covered Person (or their authorized representative) will be provided with the name, address and telephone number of the coordinator and information on how to submit written material. A nonexpedited appeal determination will be provided as soon as possible, but not later than thirty (30) days after receipt of the appeal request and the necessary information.

If the Noncertification determination is upheld on appeal (either expedited or nonexpedited appeal), written notification will include:

- The professional qualifications and licensure of the person(s) reviewing the appeal;
- A statement of the reviewers' understanding of the reason for the Covered Person's appeal;
- The reviewer's decision in clear terms and the medical rationale in sufficient detail for the Covered Person to respond further;
- A reference to the evidence or documentation that is the basis for the decision, including the clinical review criteria used in making the determination;
- A statement advising the Covered Person of the Covered Person's right to request a second level Grievance Review and information on whom to contact for this process; and
- Notice of the availability of assistance from the Managed Care Patient Assistance Program, including the telephone number and address of the Program.

Second Level Appeal Review

If the Covered Person or the Covered Person's representative is not satisfied with the appeal determination (either expedited or nonexpedited appeal), the Covered Person may submit a written request for a second level Grievance Review as described in the Grievance Procedures section.

GRIEVANCE PROCEDURES

A Grievance is a written complaint submitted by the Covered Person, or the Covered Person's representative or Health Care Practitioner, regarding the following:

- The Insurer's or the Plan Administrator's decisions, policies, or actions related to the availability, delivery, or quality of health care services. This does not include questions of coverage where this Policy specifically excludes a particular service;
- Claims payment or handling, or reimbursement for services;
  - The contractual relationship between a Covered Person and Us; or
  - The outcome of an appeal of a Noncertification.
  - Eligibility and membership/Enrollment in the Federal Pool or application denials.

The Grievance process described in this section does not apply to Noncertifications or denial of coverage rendered solely on the basis of a clearly stated Policy exclusion of a specific service.

The Grievance procedure is voluntary on the part of the Covered Person. A Grievance or appeal may be initiated and/or proposed by You or a person acting on Your behalf such as a relative or other representative, including Your provider. Grievances or complaints should be submitted in writing to the Plan Administrator at:

CoreSource, Inc.
5200 77 Center Drive, Ste 400
Charlotte, NC 28217

The Plan Administrator must receive a written Grievance or complaint within 180 days from the date of the event or action that precipitated the Grievance.

The North Carolina Department of Insurance is available to assist You with insurance-related problems and questions. You may reach the Department at:

North Carolina Department of Insurance
1201 Mail Service Center
Raleigh, NC 27699-1201
1-800-546-5664

Assistance is available from the Managed Care Patient Assistance Program (MCPAP). You may reach MCPAP at:

Managed Care Patient Assistance Program

Health Insurance Smart NC
North Carolina Department of Insurance
1201 Mail Service Center
Raleigh, NC 27699-1201
Toll Free: 1-877-885-0231

Informal Consideration

The Plan Administrator has 3 business days to acknowledge in writing receipt of a complaint or an appeal, and 10 business days to complete the review to the satisfaction of the Covered Person. If the complaint is not resolved to the Covered Person's satisfaction during this time period, the appeal will be considered a grievance and will be subject to the formal Grievance Review procedures described in this section, beginning with a first level Grievance Review.

Level I Grievance Review

The Plan Administrator will acknowledge the Covered Person's grievance within three business days (10 business days for grievances concerning quality of clinical care), providing the Covered Person with the name, address, and telephone number of the coordinator handling the grievance. The Covered Person will not be permitted to attend the first level Grievance review, but will be permitted to submit written material for consideration. Written acknowledgement to the Covered Person will include information about how to submit written material needed for review. The Plan Administrator will provide the Covered Person and the Covered Person's Health Care Practitioner, if applicable, with a written decision in clear terms within 30 days of receipt of the grievance.

The written decision issued in a first level Grievance will contain:

- The professional qualifications and licensure of the person or persons reviewing the Grievance;
- The reviewers' understanding of why the Grievance was filed;
- All issues in the appeal must be addressed;
- The reviewer's decision in clear terms and the contractual basis or medical rationale for the denial in sufficient detail to allow the insured to respond;
- A reference to the evidence or documentation used as the basis for the decision;
- Statement advising the insured of his or her right to request a second level Grievance and that they may attend the second level Grievance review meeting; and
- Notice of the availability of assistance from the Managed Care Patient Assistance Program, including the telephone number and address of the Program.

For Grievances concerning the quality of clinical care delivered by the Covered Person's provider, the Plan Administrator shall acknowledge the Grievance within 10 business days. The acknowledgement shall advise the Covered Person that:

- The Grievance will be referred to the Plan Administrator's quality assurance committee for review and consideration or any appropriate action against the provider; and
- State law does not allow for a second level Grievance review for Grievances concerning quality of care.

Level II Grievance Review

If the Covered Person or the Covered Person's representative are not satisfied with the results of the first level Grievance Review, or with a Utilization Management appeal decision, the Covered Person may submit a written request for a second level Grievance to Us at:

North Carolina Health Insurance Risk Pool, Inc.
3739 National Drive, Suite 228
Raleigh, NC 27612

The request for a second level Grievance Review must be received by Us within 180 days from the date of receipt of the first level Grievance Review results or the Utilization Management appeal decision. We will acknowledge receipt of the appeal within 10 business days, providing the Covered Person with the name, address, and telephone number of the person designated to coordinate the review. A second level Grievance Review meeting will be scheduled no later than 45 days after receipt of the request. Notification of the meeting will be provided to the Covered Person at least 15 days prior to the meeting date, with a summary of the Covered Person's rights under this second level Grievance Review, including:

- The right to request and receive all information relevant to the case;
- The right to attend the second level Grievance review, ask questions of the review panel, and to submit supporting materials before and at the meeting;
- The date, time and place of the meeting;
- The right to present his or her case to the review panel;
- The right to be assisted or represented by a person of his or her choice, such person may be without limitation to: a provider, family member, employer representative, or attorney. (If the covered person chooses to be represented by an attorney, an attorney may also represent the Insurer.); and

– The right to a full review not conditioned on appearing at the review meeting.

The review panel must not be an employee of the Insurer or its Administrator. If the review involves a non-certification or a clinical issue the panel must be composed of providers who have appropriate expertise, including at least one clinical peer. We will issue a written decision to the Covered Person and if applicable, the provider, within seven business days after completing the review meeting. The decision shall include:

- The professional qualifications and licensure of the members of the review panel;
- Statement of the review panel's understanding of the Grievance and all pertinent facts;
- The review panel's recommendation and the rationale behind the recommendation;
- In the review of a Noncertification or other clinical matter, a description or reference to the evidence or documentation considered in making the recommendation;
- A written statement of the clinical rationale, including the clinical review criteria, used by the review panel to make the recommendation;
- The rationale for Our decision if it differs from the review panel's recommendation;
- A statement that the decision is Our final determination in the matter. If the review concerned a Noncertification and Our decision on the second level Grievance review is to uphold the initial Noncertification, a statement advising the Covered Person of the right to request an external review and a description of the procedure for submitting a request for external review to the Commissioner of Insurance;
- Notice of the availability of the Commissioner's office for assistance, including the telephone number and address of the Commissioner's office; and
- Notice of the availability of the Managed Care Patient Assistance Program for assistance, including the telephone and address of the PAP office.

Expedited Level II Grievance

An expedited second level Grievance review may be requested when a non-expedited appeal would reasonably appear to seriously jeopardize the life or health of a Covered Person or jeopardize the Covered Person's ability to regain maximum function, whether or not the initial review was expedited. When a Covered person is eligible for an expedited second level Grievance review, all provisions regarding second level Grievance review shall apply, except that We shall conduct the review proceeding and communicate Our decision within four days after receiving all necessary information. The review meeting may take place by way of a telephone conference call or through the exchange of written information.

EXTERNAL REVIEW

North Carolina law provides for review of Noncertification decisions by an external, Independent Review Organization (IRO). 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. You or someone You have authorized to represent You may request an external review. We will notify You in writing of Your right to request an external review each time You:

- Receive a Noncertification decision; or
- Receive an appeal decision upholding a Noncertification decision; or
- Receive a second level Grievance review decision upholding the original Noncertification.

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

- That Your request is about a Medical Necessity determination that resulted in a Noncertification decision;
- That You had coverage with the Risk Pool in effect when the Noncertification decision was issued;
- That the service for which the Noncertification was issued appears to be a covered service under Your policy; and
- That You have exhausted Our internal review process.

External review is performed on a standard and expedited timetable, depending on which is requested and on whether medical circumstances meet the criteria for expedited review. For a standard external review, You will be considered to have exhausted the internal review process if You have:

- Completed Our appeal and second level Grievance review and received a written second level determination from Us;
- Filed a second level Grievance and except to the extent that You have requested or agreed to a delay, have not received Our written decision within 60 days of the date You submitted the request; or
- Received notification that We have agreed to waive the requirement to exhaust the internal appeal and/or second level Grievance process.

If Your request for a standard external review is related to a retrospective Noncertification (a Noncertification which occurs after You have received the services in question), You will not be eligible to request a standard review until You have completed Our internal review process and received a written final determination from Us.

If You wish to request a standard external review, You (or Your representative) must make this request to NCDOI within 120 days of receiving Our written notice of final determination that the services in question are not approved. 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 may need to be reviewed for the purpose of reaching a decision on the external review.

Within 10 business days of receipt of Your request for a standard external review, the NCDOI will notify You and Your provider of whether Your request is complete and whether it is 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 date of Our written notice of final determination. If the NCDOI accepts Your request, the acceptance notice will include:

- The name and contact information for the Independent Review Organization (IRO) assigned to Your case;
- A copy of the information about Your case that We have provided to the NCDOI;
- Notice that We will provide You with a copy of the documents and information considered in making the denial decision (which will also be sent to the IRO); and
- Notification that You may submit additional written information and supporting documentation relevant to the initial Noncertification to the assigned IRO within 7 days of the date of the acceptance notice.

If You choose to provide any additional information to the IRO, You must also provide that same information to Us at the same time using the same means of communication (e.g., You must fax the information to Us if You faxed it to the IRO). When faxing information to Us send it to 1-919-783-5767. If You choose to mail Your information, send it to:

North Carolina Health Insurance Risk Pool, Inc.
External Review
3739 National Drive, Suite 228
Raleigh, NC 27612

Please note that You may also provide this additional information to the NCDOI within the 7-day deadline rather than sending it directly to the IRO and Us. The NCDOI will forward this information to the IRO and Us within two business days of receiving Your additional information.

The IRO will send You written notice of its determination within 45 days of the date the NCDOI received Your standard external review request. If the IRO's decision is to reverse the Noncertification, We will reverse the Noncertification decision within 3 business days of receiving notice of the IRO's decision, and provide coverage for the requested service or supply that was the subject of the Noncertification decision. If You are no longer covered by this Policy at the time We receive notice of the IRO's decision to reverse the Noncertification, We 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.

An expedited external review of a Noncertification decision may be available if You have a medical condition where the time required to complete either an expedited internal appeal or second level Grievance review or a standard external review would reasonably be expected to seriously jeopardize Your life or health or would jeopardize Your ability to regain maximum function. If You meet this requirement, You may make a written request to the NCDOI for an expedited review after You:

- Receive a Noncertification decision from Us AND file a request with Us for an expedited appeal;
- Receive an appeal decision upholding a Noncertification decision AND file a request with Us for an expedited second level Grievance review; or
- Receive a second level Grievance review decision upholding the original Noncertification.

You may also make a request for an expedited external review if You receive an adverse second level Grievance review decision concerning a Noncertification of an admission, availability of care, continued stay or Emergency Care, but have not been discharged from the inpatient facility.

In consultation with a medical professional, the NCDOI will review Your request and determine whether it qualifies for expedited review. You and Your provider will be notified within 3 business days if Your request is accepted for expedited external review. If Your request is not accepted for expedited review, the NCDOI may: (1) accept the case for standard external review if Our internal review process was already completed, or (2) require the completion of Our internal review process before You may make another request for an external review with the NCDOI. An expedited external review is not available for retrospective Noncertifications.

The IRO will communicate its decision to You within 4 business days of the date the NCDOI received Your request for an expedited external review. If the IRO's decision is to reverse the Noncertification, We will, within one business day of receiving notice of the IRO's decision, reverse the Noncertification decision for the requested service or supply that is the subject of the Noncertification decision. If You are no longer covered by Us at the time We receive notice of the IRO's decision to reverse the Noncertification, We 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 Us 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 decision for which You have already received an External Review decision.

For further information about External Review or to request an External Review, contact the NCDOI at:

By Mail:
NC Department of Insurance
Healthcare Review Program
1201 Mail Service Center
Raleigh, NC 27699-1201
(fax) 1-919-807-6865

In Person:
N Department of Insurance
Health Insurance Smart NC
430 N. Salisbury Street, Suite 1018
Raleigh, NC 27603
(Toll-free in NC) 1-877-885-0231
(Out of NC) 1-919-807-6860
www.ncdoi.com for External Review information and Request Form

The Healthcare Review Program is available to provide consumer counseling on utilization review and internal appeals and grievance issues.

CLAIMS PAYMENT

Notifying Us of Your Claim
Generally, any services the Covered Person receives will be billed to Us by the provider.

If the Covered Person receives a service which will not be billed to Us by the provider, the Covered Person must send Us or Our authorized representative a letter with the Covered Person's name, the service received and the Policy number. He or she should mail the letter to Our address shown on this Policy.

We must receive a letter from the Covered Person or the provider informing Us of the claim within 30 days of the date the service was received.

Notice given by or on behalf of the Covered Person or the beneficiary to Us at P.O. Box 2920, Clinton, IA, 52733, or to Our authorized agent, with information sufficient to identify the Covered Person, shall be deemed notice to Us.

Claim Forms
Upon receipt of a notice of claim, We will furnish to the claimant such forms as are usually furnished by Us for filing proofs of loss. If such forms are not furnished within 15 days after the giving of notice the claimant shall be deemed to have complied with the requirements of this Policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

Proofs of Loss
Written proof of loss must be furnished to Us at Our office in the case of a claim for loss for which this Policy provides any periodic payment contingent upon continuing loss within 180 days after the termination of the period for which We are liable, and in case of a claim for any other loss within 180 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the Covered Person, later than one year from the time proof is otherwise required.

Physical Examinations and Autopsy
We, at Our own expense, shall have the right and opportunity to have the Covered Person examined when and as often as it may reasonably require during the pendency of a claim hereunder, and to make an autopsy in case of death where it is not forbidden by law.

Adjudication of the Claim
Once We receive all the necessary information, We will determine if Policy benefits are available, and if they are, We will pay any amounts due under this Policy in the timeframes required by state law or by provider contract. We may pay all or a portion of any benefit provided for Covered Expenses to the provider unless You or the Covered Person have notified Us in writing by the time the claim form is submitted.

Within 30 calendar days after receipt of a claim, We will send electronic or paper mail to the Provider or Covered Person who filed the claim that includes one or more of the following:

- Payment of the claim;
- Notice of denial of the claim;
- Notice that the information provided with the claim as proof of loss is inadequate;
- Notice that the claim is not submitted on the form required by Us or by applicable law;
- Notice that information pursuant to the Nonduplication of Benefits provision is needed to pay the claim; or
- Notice that the claim is pending based on nonpayment of premiums.

If the claim is denied in whole or in part, the notice shall include all of the specific good faith reasons for the denial along with payment of any uncontested part within 30 days of receipt of the claim. Upon receipt of additional information requested in its notice, the Plan Administrator shall process and pay or deny the claim within 30 days after receiving the additional information. If We do not receive the additional information

requested within 90 days, We shall deny the claim and send notice to the Provider or Covered Person who filed the claim that the claim was denied and will be reopened if the additional information requested is received within one year of the denial notice.

Claim payments not made within 30 calendar days of receipt of a claim are subject to eighteen percent (18%) annual interest. Claims must be filed within 180 days of the date of service or discharge to assure payment.

If the Covered Person is deceased, payment will be made, at Our option, to Your designated beneficiary or to Your estate.

Any payment made by Us in good faith will fully discharge Us of any liability to the extent of such payment.

Nonduplication of Benefits

This Policy shall be payor of last resort of benefits whenever any other benefit or source of third-party payment is available. Benefits otherwise payable under this Policy shall be reduced by all amounts paid or payable through any other medical care benefits and by all hospital and medical expenses paid or payable under any workers' compensation coverage, notwithstanding any provision of law to the contrary, automobile medical payment, or liability insurance, whether provided on the basis of fault or no-fault, and by any hospital or medical benefits paid or payable under or provided pursuant to any State or federal law or program.

Errors In Claim Payment

If a claim was paid in error to You or a provider, We have the right to recover Our payments. We may correct this payment error by an adjustment to any amount applied to the Deductible or Out-of-Pocket Limit. Errors may include such actions as claims paid which are not actually covered under the Policy, claims paid where such payment is greater than the amount allowed under the Policy, or claims paid based on fraud or an intentional misrepresentation.

We may seek recovery of Our payments made in error from any person(s) to, for, or with respect to whom such payments were made. We alone shall determine from whom We shall seek recovery.

For information on Our process, see the "Recovery Rights" section.

ELIGIBILITY AND TERMINATION PROVISIONS

In accordance with North Carolina state law, eligibility for coverage provided by this Policy is determined by the statutory eligibility requirements for coverage provided by the Risk Pool. An individual who is and continues to be a Resident of North Carolina is eligible for coverage under this Policy by providing evidence of any of the following:

1. Citizenship or legal residency in the United States.
2. Residency in North Carolina.
3. Has not been covered under creditable coverage for a continuous 6 month period of time prior to the date on which such individual is applying for coverage in the high risk pool program.
4. Meets the pre-existing condition requirement established for a qualified high risk pool as evidenced by one of the following:
   a. A notice of rejection or refusal to issue substantially similar health insurance coverage for health reasons by an insurer. A rejection or refusal by an insurer offering only stop-loss, excess loss, or reinsurance coverage with respect to the applicant is not sufficient evidence of eligibility.
   b. An offer to issue health insurance coverage only with a conditional rider that limits coverage for the individual's high-risk medical condition.
   c. A diagnosis of the individual with one of the medical or health conditions listed by the Board in accordance with this section. An individual diagnosed with one or more of these conditions is eligible for Pool coverage without applying for other health insurance coverage.

Loss of Eligibility

You are not eligible for coverage provided by this Policy or another Policy offered by the Risk Pool if any of the following apply:

1. You have had creditable coverage during the 6 month period prior to the date on which You apply to coverage to Inclusive Health.
2. You are determined to be enrolled in the State Medical Assistance Plan or in Medicare;
3. You are an inmate or resident of a public institution, unless You are also a Federally Defined Eligible Individual;
4. Your premiums are paid for or reimbursed under any government-sponsored program or by any government agency or health care provider, except as an otherwise qualifying full-time employee, or dependent thereof, of a government agency or health care provider.

If You become ineligible as described above at any time after Your Effective Date, Your Policy will terminate as described in the Policy Termination provision.

This Policy renews automatically each year upon the Anniversary of the Policy at the option of the Policyholder, except as provided in this section.

Policy Termination

This Policy and the coverage it provides will terminate on the earliest of the following:

1. On the date You are no longer a Resident of North Carolina;
2. At the end of the month in which You request termination of this Policy in writing, or if later, the date such notice is received by Us;
3. On the date of Your death;
4. At midnight, 12:00 EST, on the date that North Carolina law requires cancellation of this Risk Pool Policy;
5. On the date that the Lifetime Maximum Benefit is reached;
6. 30 days after We make an inquiry concerning Your eligibility or Residence to which You do not reply;
7. On the premium due date if premium is not paid when due, subject to the Grace Period provision;

8. On the date there is fraud or material misrepresentation made by or with the knowledge of the Covered Person in applying for this coverage or filing a claim for benefits, subject to the Time Limit on Certain Defenses provision;
9. At the end of the month for which Risk Pool premium has been paid, following the date that You cease to meet the eligibility requirements of the Risk Pool, as described in the Loss of Eligibility provision;
10. On the date that We cease to offer this particular type of policy in North Carolina, as allowed by state law and subject to Our provision of 90 days advance written notice of such termination to You and the beneficiary. In such case You will have the opportunity at the time of termination to purchase any other policy We offer in North Carolina; or
11. On the date that We cease to do business in the individual insurance market in North Carolina, as allowed by state law and subject to our provision of 180 days advance written notice of such termination to You and the beneficiary.

We will provide you with a certification of Creditable Coverage at the time You cease to be covered under this Policy. A certification of Creditable Coverage is a written certification of the period of Creditable Coverage under a health plan and any waiting period and affiliation period imposed with respect to the individual for any coverage under that plan. You may also request a certification of Creditable Coverage from Us within 24 months after the date of termination.

EXCLUSIONS

Below is a list of exclusions on Policy benefits. While the exclusions are listed by section, please review the entire document, as there may be multiple exclusions applying to a particular service. These exclusions apply even if a Health Care Practitioner has performed or prescribed a medical service. This does not prevent Your Health Care Practitioner from providing or performing the service; however, the service will not be a Covered Expense.

EXCLUSIONS

Benefits are not payable under this Policy for any of the following:

- Services that are not Covered Expense(s), except for Emergency Care to the extent necessary to stabilize the Covered Person's condition;
- Services incurred before the Effective Date or after the termination date;
- Services not Medically Necessary for diagnosis and treatment of an Injury or Sickness;
- Any service, treatment, or drug which is Experimental, Investigational, or for Research Purposes, except as outlined within the Utilization Management section and definitions;
- Services exceeding the amount of benefits available for a particular service; or
- Services provided when this Policy is past premium due date, and payment is not received.

Causation Exclusions

Benefits are not payable under this Policy for any loss:

- Caused by or related to war or any act of war, whether declared or undeclared;
- Caused by or related to participation in the military service of any country or international organization, including non-military units supporting such forces; or
- Due to commission of or attempt to commit a felony.

Service Exclusions

Benefits are not payable under this Policy for any of the following:

- Cosmetic Services or any complication therefrom, unless specifically described in the Benefits section;
- Custodial Care and Maintenance Care;
- Infertility Services;
- Pregnancy and well baby expenses, unless specifically provided in this Policy;
- Sterilization, including tubal ligation and vasectomy, and reversal of sterilization;
- Abortion services, except in connection with covered Complications of Pregnancy or if the life of the expectant mother would be at risk or when the pregnancy is the result of rape or incest;
- Gender reassignment or sexual dysfunction;
- Eye refractive disorders, eyeglass frames and lenses or contact lenses, radial keratotomy, laser or lasik and any other surgery to correct myopia, hyperopia or stigmatic error, vision therapy, or orthoptic treatment (eye exercises), unless specifically described in this Policy;
- Routine hearing or eye exams, unless specifically described in this Policy or for covered newborn hearing screening;
- Dental services, appliances or supplies for treatment of the teeth, gums, jaws or alveolar processes including, but not limited to, any oral or periodontal surgery and preoperative and postoperative care, implants and related procedures, orthodontic procedures, and any dental services related to an Injury or Sickness unless otherwise covered as described in the Dental Benefits provision or the Jaw, Face or Head Bone and Joint Disorders provision;
- Therapy and testing for treatment of allergies not approved by the American Academy of Allergy and Immunology or the Department of Health and Human Services or any of its offices or agencies;
- Nutritional counseling, except as part of a covered diabetes self-management training program or Obesity Assessment examination;
- Treatment of nicotine habit or addiction, including, but not limited to, nicotine patches, hypnosis, smoking cessation classes or tapes, unless specifically provided or covered under the Prescription Drug benefit or as part of a program sponsored by Us;
- Educational or vocational therapy, services, and schools including, but not limited to, videos and books;
- Foot care services including, but not limited to:
- Treatment of weak, strained, flat, unstable or unbalanced feet;

- Treatment of superficial lesions of the feet, such as corns, calluses or hyperkeratosis;
- Tarsalgia, metatarsalgia or bunion treatment, except surgery which involves exposure of bones, tendons or ligaments;
- Treatment of toenails, except removal of nail matrix; and
- Arch supports, heel wedges, lifts, the fitting or provision of foot orthotics or orthopedic shoes, except as an integral part of a brace;
- Hearing aids, unless specifically described in this Policy, hair prosthesis, hair transplants or implants, and wigs;
- Sleep therapy or services rendered in a premenstrual syndrome clinic or holistic medicine clinic;
- Alternative Medicine;
- Marital counseling, unless Medically Necessary and provided by a Health Care Practitioner;
- Immunizations required for foreign travel for Covered Persons of any age, unless otherwise covered in this Policy;
- Genetic testing, counseling or services;
- Routine physical examination for occupation, employment, school, travel, the purchase of insurance, or premarital tests / examinations;
- Services received in an emergency room unless required because of Emergency Care; or
- Services or supplies for the treatment of an occupational Sickness or Injury for which benefits are paid under the North Carolina Workers' Compensation Act, only to the extent such services or supplies are the liability of the employee, employer or workers' compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act.
- Care falling under the definition of Experimental, Investigative and for Research Purposes, except such care that is part of an approved Clinical Trial.
- Coverage of medical services provided to individuals other than to the named insured covered by the Plan.

Service Enhancement Exclusions
Benefits are not payable under this Policy for any of the following:

- Private duty nursing;
- Services rendered by a standby Health Care Practitioner or assistant surgeon, unless Medically Necessary;
- Lodging accommodations or transportation, except as described in this Policy; and
- Charges for services that are primarily and customarily used for a non-medical purpose or used for environmental control or enhancement (whether or not prescribed by a Health Care Practitioner) including, but not limited to:
- Common household items such as air conditioners, air purifiers, vacuum cleaners, waterbeds, hypoallergenic mattresses or exercise equipment;
- Personal comfort items such as cervical pillows, gravity lumbar reduction chairs, swimming pools, whirlpools, or spas;
- Professional medical equipment such as blood pressure kits, breast pumps, PUVA lights, and stethoscopes, except as covered under the Diabetes Services benefit;
- Charges for health clubs or health spas, aerobic and strength conditioning, work-hardening programs, and all related material and products for these programs;
- Personal computers and related equipment or other similar items or equipment; or
- Communication devices, except after surgical removal of the larynx or a diagnosis of permanent lack of function of the larynx.

Durable Medical Equipment Exclusions
Durable Medical Equipment benefits are not payable for:

- Duplicate or similar rentals of Durable Medical Equipment, as determined by Us.

Health Care Practitioner and Health Care Treatment Facility Exclusions
Benefits are not payable under this Policy for any services:

5. Not authorized, furnished or prescribed by a Health Care Practitioner or health care treatment facility;
6. For which no charge is made, or for which the Covered Person would not be required to pay if he/she did not have this insurance, unless charges are received from and reimbursable to the United States government or any of its agencies as required by law;
7. Furnished by or payable under any plan or law through a government or any political subdivision, unless prohibited by law;
8. Furnished while a Covered Person is Confined in a Hospital or institution owned or operated by the United States government or any of its agencies for any service-connected Sickness or Injury;
9. Which are not rendered or not substantiated in the medical records;
10. Provided by a family member or person who resides with Covered Person;
11. That are performed in association with a service that is not covered under this Policy, except for Emergency Care to the extent necessary to stabilize the Covered Person's condition;
12. Billed above or inconsistent with a standard billing method appropriate to the service provided, and in accordance with Our claims payment guidelines; and
13. Performed prior to the Effective Date or after the termination date.

Home Health Exclusions
Home Health Care benefits are not payable for any of the following:

- Charges for mileage or travel time to and from the Covered Person's home;
- Wage or shift differentials for Home Health Care Providers;
- Charges for supervision of Home Health Care Providers; or
- Charges for services of a home health aide.

Hospice Exclusions
Hospice Care benefits are not payable for any of the following:

- Private duty nursing when Confined in a Hospice Facility;
- Services relating to a Confinement not required for acute pain control or other treatment for an acute phase of chronic symptom management;
- Funeral arrangements;
- Financial or legal counseling, including estate planning or drafting of a will;
- Homemaker or caretaker services, including:
  - Sitter or companion services;
  - Housecleaning; and
  - Household maintenance;
  - Services of a social worker other than a licensed clinical social worker;
  - Services by volunteers or persons who do not regularly charge for their services; and
    - Bereavement counseling services.

Organ Transplant Services Exclusions
Organ Transplant benefits are not payable for any of the following:

- Transplants which are Experimental, Investigational, or for Research Purposes, unless part of a covered Clinical Trial;
- Transplants for which there is insufficient data or experience to determine whether the procedure is clinically acceptable;
- Transplants for which We are not contacted for Pre-Certification;
- Transplants for which We do not approve coverage, based on Our established criteria;
- The expense relates to the transplantation of any non-human organ or tissue, unless otherwise stated in this Policy;

- A denied transplant. This includes the pre-transplant evaluation, the transplant procedure, follow up care, immunosuppressive drugs, and complications of such transplant; or
- Expenses related to the storage of umbilical cord blood and stem cells unless the storage is an integral part of a covered Bone Marrow Transplant approved by Us.

Prescription Drug Exclusions
Prescription Drug benefits are not payable for any of the following:

- Medications, drugs, or hormones to stimulate growth, unless there is a laboratory confirmed diagnosis of growth hormone deficiency;
- Any non-Prescription supplement, herbs, minerals, vitamins, nutritional supplements, dietary products, fluoride except pediatric multi-vitamins with fluoride;
- Any drug, medicine, or device not approved by the FDA unless part of an approved Clinical Trial;
- Drugs which are not recommended and not deemed necessary by a Health Care Practitioner;
- Any Outpatient Prescription drug prescribed for a Sickness or Injury not covered under this Policy;
- Any drug prescribed for intended use other than for:

Indications approved by the FDA;
Recognized off-label indications through peer-reviewed medical literature; or
Drugs prescribed in conjunction with an approved Clinical Trial

- The administration of covered medication(s) unless approved by Us;
- Therapeutic devices or appliances, including:

Hypodermic needles and syringes except needles and syringes for use with insulin, and Self-Administered Injectable Drugs approved by Us;
Support garments;
Test reagents;
Mechanical pumps for delivery of medications; or
Other non-medical substances;

- Anabolic steroids;
- Anorectic or any drug used for the purpose of weight control;
- Abortifacients (drugs used to induce abortions);
- Any drug used for cosmetic purposes, including but not limited to:

Tretinoin, e.g. Retin-A, except if the Covered Person is under the age of 45 or is diagnosed as having adult acne;
Dermatologicals or hair growth stimulants; or
Pigmenting or de-pigmenting agents, e.g. Solaquin;

- Any drug or medicine that is:

Lawfully obtainable without a Prescription (over the counter drugs), except insulin; or
Available in Prescription strength without a Prescription;

- Compounded drugs in any dosage form except when prescribed for pediatric use for children up to 19 years of age;
- Progesterone crystals or powder in any compounded dosage form;
- Infertility Services including medications;
- Any drug prescribed for impotence and/or sexual dysfunction, e.g. Viagra;
- Any drug, medicine, or medication that is consumed or injected at the place where the Prescription is given or dispensed by the Health Care Practitioner;
- Treatment for Onychomycosis (nail fungus);
- Prescriptions that are to be taken by or administered to the Covered Person, in whole or in part, while he or she is a patient in a facility where drugs are ordinarily provided by the facility on an inpatient basis. Inpatient facilities include, but are not limited to:

Hospital;
Rest home;
Sanitarium;
Skilled Nursing Facility;
Convalescent Hospital; or
Hospice Facility;

Injectable drugs, unless coverage is approved by Us. Injectable drugs include but are not limited to:
Blood;
Blood plasma; or
Self-Administered Injectable Drugs for which coverage is not approved by Us;

- Prescription refills:
  In excess of the number specified by the Health Care Practitioner; or
  Dispensed more than one year from the date of the original order;
- Any portion of a Prescription or refill that exceeds a 30-day supply (or a 90-day supply for a Prescription or refill that is received from a Mail Order Pharmacy);
- Any drug for which Prior Authorization is required, as determined by Us, and not obtained, subject to the exceptions in the Prior Authorization provision in the Utilization Management section;
- Any drug for which a charge is customarily not made;
- Any portion of a Prescription or refill that:
  Exceeds the amount or duration specified in Our Prior Authorization;
  Is dispensed to a Covered Person whose age is outside the drug specific age limits defined by Us; or
- Any drug, medicine, or medication received by the Covered Person:
  Before becoming covered under this benefit; or
  After the date the Covered Person's coverage under this benefit has ended;
- Any costs related to the mailing, sending or delivery of Prescription drugs;
- Any intentional misuse of this benefit, including Prescriptions purchased for consumption by someone other than the Covered Person;
- Prescription or refill for drugs, medicines, or medications that are lost, stolen, spilled, spoiled, or damaged;
- Any drug or biological that has received designation as an Orphan Drug, unless approved by Us;
- More than one Prescription for the same drug or therapeutic equivalent medication prescribed by one or more Health Care Practitioners and dispensed by one or more Pharmacies until at least 75% of the previous Prescription has been used or should have been used by the Covered Person, unless the drug or therapeutic equivalent medication is a maintenance medication purchased through a Mail Order Pharmacy, in which case 66% of the previous Prescription must have been used or should have been used by the Covered Person (based on the dosage schedule prescribed by the Health Care Practitioner); or
- Any Co-payments or Coinsurance related to Out-of-Pocket expenses the Covered Person paid for a Prescription that has been filled, regardless of whether the Prescription is revoked or changed due to adverse reaction or change in dosage or Prescription.

Preventive Care Exclusions
Preventive Care benefits are not payable for any of the following:

- Eye examination for the purpose of prescribing corrective lenses;
- Hearing tests, except for covered newborn hearing screening;
- Dental examinations;
- An employment physical or exam for the purpose of obtaining insurance; or
- Immunizations other than those specified in this Policy.

PREMIUM PAYMENT

You must pay the required premium to Us as it becomes due. If You don't pay Your premium on time, We will terminate this Policy.

The first premium is due with the enrollment application. Subsequent premiums are due on the first day of each premium period. Premium period means monthly, quarterly, semi-annually, or annually as selected by You. All premiums are payable to Us through an EFT (Electronic Fund Transfer).

Grace Period
You have 31 days from the premium due date to remit the required funds. If premium is not paid, We will terminate the Policy as of the last day of the premium period for which premium was paid.

Changes to Your Premium
Premium is subject to change annually at the time of renewal.

We will provide written notice at least 45 days prior to the Effective Date of any premium change.

Return of Premium
If, upon review of Your application, You are found to be ineligible for the coverage provided by this Policy, any premium received will be returned to You and the Policy will be void from the Effective Date.

Your unearned premium if there is any, will be returned to You at the end of the month in which You request termination of this Policy in writing, or if later, the end of the month during which such notice is received by Us:

If it becomes necessary for You to terminate your Inclusive Health Policy, You are responsible for notifying us promptly.

If You elect to voluntarily cancel your Inclusive Health Coverage, We must receive written notification by the 20th of the month prior to the day You are requesting Your coverage to end.

Requests must be submitted in writing and include Your name and member identification number.

Mail Requests to PO BOX 2302, Mt. Clemens MI or fax to: 586-296-3112.

CHANGES TO THE POLICY

If a change is required by a state or federal law or government division, We can make the change at any time without notice to You.

We can also make changes to Your Policy on the premium due date or upon separate notice, provided We send You a written explanation of the change, 31 days prior to its effect. All such changes will be made in accordance with state law. Your continued payment of premium will stand as proof of Your agreement to the change.

Once You become enrolled in the Risk Pool, the Benefit Plan Option that You select will remain in effect until the annual renewal date of Your Policy. You can only make a change in your Benefit Plan Option during Your annual Open Enrollment period which is the 30 day period that begins 45 days prior to Your annual renewal date.

GENERAL PROVISIONS

Entire Contract
The rules governing Our agreement to provide You with health insurance in exchange for Your premium payment is based upon several written documents: the Policy, riders, amendments, endorsements and the application.

Time Limit on Certain Defenses
After two years from the date of issue or reinstatement of this Policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void this Policy or deny a claim for loss incurred or disability commencing after the expiration of such two-year period.

Assignment of Benefits
Assignment of benefits may be made only with Our consent. An assignment is not binding until We receive and acknowledge in writing the original or copy of the assignment before payment of the benefit. We do not guarantee the legal validity or effect of such assignment.

Conformity With State Statutes
Any provisions which are in conflict with the laws of the state of North Carolina are amended to conform to the minimum requirements of those laws.

Legal Actions
No action at law or in equity may be brought to recover benefits under this Policy less than 60 days before nor more than 3 years after written proof of loss was required to be furnished.

Our Relationship With Providers
We and health care providers, both Network and Non-Network Providers, are at all times acting independently. We do not make any medical decisions, nor prescribe treatment options, regardless of any coverage determinations We make under this Policy.

RECOVERY RIGHTS

Your Obligation to Assist in the Recovery Process
As explained in the "Claims Payment" section, We have the right to collect Our payments made in error.

Recovery Rights
If the Covered Person's claim against the other insurer is denied or partially paid, We will process such claim according to the terms and conditions of this Policy. If payment is made by Us on the Covered Person's behalf, You agree that any reimbursement the Covered Person receives from the other insurer for medical expenses We pay will be returned to Us.

Workers' Compensation
If benefits are paid by Us and We determine that the benefits were for treatment of an occupational Injury or Sickness that is paid under the North Carolina Workers' Compensation Act, We have the right to recover against the Covered Person. Our right to recover extends to benefits We pay for services or supplies that are the liability of the employee, employer or workers' compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act.

The Covered Person hereby agrees that, in consideration for the coverage provided by the Policy, We will be notified of any Workers' Compensation claim the Covered Person makes, and that the Covered Person agrees to reimburse Us as described above.

DEFINITIONS

The following are definitions of terms as they are used in this Policy.

Alternative Medicine means an approach to medical diagnosis, treatment, or therapy that has been developed or is practiced not using the scientific methods generally accepted in the United States of America. Alternative Medicine includes, but is not limited to, acupressure, acupuncture, aromatherapy, ayurveda, biofeedback, chelation therapy, faith healing, guided mental imagery, herbal medicine, holistic medicine, homeopathy, hypnosis, macrobiotics, massage therapy, meditation, naturopathy, ozone therapy, reflexotherapy, relaxation response, rolfing, shiatsu, and yoga.

Benefit Plan Option – One of the following Risk Pool coverage options authorized by the Risk Pool Board of Directors:

- $1,000 Calendar Year Deductible PPO;
- $2,500 Calendar Year Deductible PPO;
- $3,500 Calendar Year Deductible PPO; or
- $4,500 Calendar Year High Deductible Health Plan (HDHP).

Bone Marrow Transplant means the transplant of human blood precursor cells which are administered to a patient following high-dose, ablative or myelosuppresive chemotherapy. Such cells may be derived from bone marrow, circulating blood, or a combination of bone marrow and circulating blood obtained from the patient in an autologous transplant or from a matched related or unrelated donor or umbilical cord blood. If chemotherapy is an integral part of the treatment involving a covered organ transplant of bone marrow, the term Bone Marrow Transplant includes the harvesting, the transplantation, and the chemotherapy components.

Calendar Year means the period of time beginning on January 1st of any year and ending on December 31st of the same year. The first Calendar Year begins for a Covered Person on the date benefits under this Policy first become effective for that Covered Person and ends on the following December 31st.

Center of Excellence Transplant Provider means those organ transplant providers on the Centers of Excellence list made available to Covered Persons by calling Us at 1-866-665-2117.

Clinical Trial means phase II, phase III, and phase IV patient research studies designed to evaluate new treatments, including Prescription drugs, and that:

- Involve the treatment of life-threatening medical conditions;
- Are medically indicated and preferable for that patient compared to available noninvestigational treatment alternatives; and
- Have clinical and preclinical data that shows the trial will likely be more effective for that patient than available noninvestigational alternatives.

Covered Clinical Trials must also meet the following requirements:

Must involve determinations by treating physicians, relevant scientific data, and opinions of experts in relevant medical specialties;

Must be trials approved by centers or cooperative groups that are funded by the National Institutes of Health, the FDA, the Centers for Disease Control, the Agency for Health Care Research and Quality, the Department of Defense, or the Department of Veterans Affairs; and

Must be conducted in a setting and by personnel that maintain a high level of expertise because of their training, experience, and volume of patients.

Coinsurance means the percentage of Covered Expenses that will be paid by Us, as shown on the Schedule. The remaining percentage of Covered Expenses is the responsibility of the Covered Person, in addition to any Copayments and Deductible. This amount is shown on the Schedule.

Complications of Pregnancy means conditions with diagnoses which are distinct from pregnancy, but adversely affected by pregnancy or caused by pregnancy, such as:

- Acute nephritis;
- Nephrosis;
- Cardiac decompensation;
- Hyperemesis gravidarum;
- Puerperal infection;
- Pre eclampsia (toxemia);
- Eclampsia;
- Abruptio placenta;
- Placenta previa;
- Missed or threatened abortion;
- Ectopic pregnancy;
- Endometritis;
- Hydatiform mole;
- Chorionic carcinoma;
- Pre-term labor;
- Non-elective Caesarean section;
- Spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible; or
- Gestational diabetes.

Complication of Pregnancy does not include:

- False labor;
- Occasional spotting;
- Rest prescribed during the period of pregnancy;
- Elective abortion;
- Conditions associated with the management of a difficult pregnancy, but which do not constitute distinct Complication of Pregnancy; or
- Elective Cesarean section.

Confined/Confinement means the status of being a resident patient in a Hospital or health care treatment facility receiving inpatient services.

Successive Confinements are considered to be one Confinement if they are due to the same Injury or Sickness, and are separated by fewer than 30 consecutive days when a Covered Person is not Confined.

Copayment means a specified dollar amount, shown on the Schedule, to be paid by You or a Covered Person to a provider toward Covered Expenses of certain benefits specified in this Policy.

Cosmetic Service means a service performed to reshape normal structures of the body in order to improve a Covered Person's appearance or self-esteem. Treatment of a congenital defect or birth abnormality of a Covered Person under the age of 18 is not considered a Cosmetic Service.

Covered Expense means the amount on which We will base Our payment for Covered Health Services, incurred by a Covered Person, determined based on the following:

- When Covered Health Services are received from Network Providers, Covered Expenses are Our contracted fee with that provider; or
- When Covered Health Services are received from Non-Network Providers, Covered Expenses are based on Medicare fees for Covered Health Services covered by Medicare. For Covered Health Services not covered by Medicare, Covered Expenses shall be based on Our fee schedule.

Covered Expenses are determined in accordance with Our reimbursement policy guidelines. We develop our reimbursement policy guidelines, in our discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association;
- As reported by generally recognized professionals or publications;
- As used for Medicare; or
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determination that we accept.

Covered Health Service means a Medically Necessary health care service or supply which is:

- Provided for the purpose of preventing, diagnosing or treating a Sickness or Injury;
- Identified as such in the Covered Health Services section of this Policy; and
- Not excluded under the Exclusions section.

Covered Person means a person who is eligible for benefits under this Policy and is named in the Schedule.

Custodial Care means services given to a Covered Person if:

- The Covered Person needs services that include, but are not limited to, assistance with dressing, bathing, preparation and feeding of special diets, walking, supervision of medication which is ordinarily self administered, getting in and out of bed, maintaining continence; or
- The services are required to primarily maintain, and not likely to improve, the Covered Person's condition.

Services may still be considered Custodial Care by Us even if:

- The Covered Person is under the care of a Health Care Practitioner;
- The services are prescribed by a Health Care Practitioner to support or maintain the Covered Person's condition;
- Services are being provided by a registered nurse (R.N.) or licensed practical nurse (L.P.N.);
- Services involve the use of skills which can be taught to a layperson; or
- The Covered Person does not require the technical skills of a licensed nurse at all times.

Creditable Coverage means coverage under the following:

- An employee welfare benefit plan to the extent that the plan provides medical care (including items and services paid for as medical care) to employees (including both current and former employees) or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise;
- Health insurance coverage without regard to whether the coverage is offered in the group market, the individual market, or otherwise;
- Medicare (Part A or Part B);
- Medicaid;
- Military sponsored health care (CHAMPUS and/orTricare);
- A medical care program of Indian Health Service or of a tribal organization;
- A state health benefit risk pool;
- Federal Employee Health Benefit Plan (FEHBP);
- A public health plan, as defined by federal regulations;
    - A health plan under the Peace Corps Act;
    - The North Carolina Health Insurance Program for Children, or any successor program; or
    - Short-term limited-duration health insurance coverage.

Creditable Coverage does <u>not</u> include coverage consisting solely of coverage of Excepted Benefits.

Deductible means the amount of Covered Expense that a Covered Person must incur in a Calendar Year and is responsible to pay before We pay certain benefits. Deductibles are shown in the Schedule.

Durable Medical Equipment means equipment that is:

- Able to withstand repeated use;
- Customarily used to serve a medical purpose; and
- Not generally useful to a person except to treat an Injury or Sickness.

Effective Date means the date coverage under this Policy begins for a Covered Person. The Effective Date appears on the cover page of this Policy.

Emergency Care means any service, supply, treatment or medication provided to screen for or treat an Emergency Medical Condition until the condition is stabilized.

Emergency Care does not mean any service for the convenience of the Covered Person or the provider of treatment or services.

Emergency Medical Condition means an Injury or Sickness manifesting itself by acute symptoms of sufficient severity (including severe pain) such 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:

- Placing the health of that individual (or with respect to a pregnant woman the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment of bodily functions; or
- Serious dysfunction of any bodily organ or part.

Excepted Benefits means:

– The following benefits:
Coverage only for accident or disability income insurance or any combination of these;
Coverage issued as a supplement to liability insurance;
Liability insurance, including general liability insurance and automobile liability insurance;
Workers' compensation or similar insurance;
Automobile medical payment insurance;
Credit-only insurance;
Coverage for on-site medical clinics; or
Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.
– The following benefits if offered separately:
Limited scope dental or vision benefits;
Benefits for long-term care, nursing care, home health care, community-based care, or any combination of these; or
Other similar, limited benefits as are specified in federal regulations.
– The following benefits if offered as independent, noncoordinated benefits:
Coverage only for a specified disease or illness; or
Hospital indemnity or other fixed indemnity insurance.
– The following benefits if offered as a separate insurance policy:
Medicare supplemental health insurance;
CHAMPUS or Tricare supplement coverage; or
Similar supplemental coverage provided under a group health insurance plan.

Experimental, Investigational or for Research Purposes means a drug, biological product, device, treatment, or procedure that meets any one of the following criteria, as determined by Us:

- Cannot be lawfully marketed without the final approval of the FDA and which lacks such final FDA approval for the use or proposed use, unless:

Found to be accepted for that use in the most recently published edition of the United States Pharmacopoeia-Drug Information for Healthcare Professional (USP-DI) or in the most recently published edition of the American Hospital Formulary Service (AHFS) Drug Information;

Identified as safe, widely used, and generally accepted as effective for that use as reported in nationally recognized peer reviewed medical literature published in the English language as of the date of service; or

Is mandated by state law;

- Is a device required to receive Premarket Approval (PMA) or 510K approval by the FDA, but has not received a PMA or 510K approval;
- Is not identified as safe, widely used, and generally accepted as effective for the proposed use as reported in nationally recognized peer reviewed medical literature published in the English language as of the date of service;
- Is subject of a phase I clinical trial or a treatment protocol comparable to a phase I trial, or any trial that is not a covered Clinical Trial under this Policy;
- Is identified as not covered by the Centers for Medicare and Medicaid Services Coverage Issues Manual, except as required by state or federal law.

Drugs, biological products, devices, treatments, or procedures are not considered Experimental, Investigational or for Research Purposes if they are part of a covered Clinical Trial under this Policy.

FDA means the Federal Food and Drug Administration.

Federally Defined Eligible Individual means an individual who qualifies for coverage by the Risk Pool under the Health Insurance Portability and Accountability Act as follows:

- For whom, as of the date on which the individual seeks coverage under this Policy, the aggregate of the periods of Creditable Coverage is 18 or more months and whose most recent prior Creditable Coverage was under an ERISA group health plan, governmental plan, or church plan (or health insurance coverage offered in connection with any such plan);
- Who is not eligible for coverage under a group health plan, part A or part B of title XVIII of the Social Security Act, or a State plan under title XIX of the Act (or any successor program), and does not have other health insurance coverage;
- With respect to whom the most recent Creditable Coverage was not terminated based on nonpayment of premium or fraud;
- If the individual had been offered the option of continuation coverage under a federal COBRA continuation provision or state continuation provision, who elected the coverage; and
- Who, if the individual elected the continuation coverage, has exhausted the continuation coverage under the provision or program.

You must submit a certificate of Creditable Coverage or other form of acceptable proof of prior coverage in order to be approved by Us for eligibility as a Federally Defined Eligible Individual.

Free-Standing Surgical Facility means any licensed public or private establishment which has permanent facilities that are equipped and operated primarily for the purpose of performing outpatient surgery. It does not provide services or accommodations for patients to stay overnight.

Generic Prescription Drug means a Prescription drug that is not protected by a patent or a trademark registration and which the prescribing Health Care Practitioner has either prescribed by its generic name or has approved its use as a substitute for a drug protected by a patent or a trademark registration. It is chemically the same as and usually costs less than the Brand Name Prescription Drug for which it is being substituted.

Health Care Practitioner means a practitioner, professionally licensed by the appropriate state agency to diagnose or treat an Injury or Sickness, and who provides services within the scope of that license. A Health Care Practitioner's services are not covered if the practitioner resides in the Covered Person's home or is a family member.

Home Health Care Plan means a plan of health care established with a Home Health Care Provider. The home health care plan must consist of:

- Care by or under the supervision of a registered nurse (R.N.);
- Physical, speech, occupational, and respiratory therapy; or
- Medical appliances and equipment, if expenses incurred for such supplies would have been Covered Expenses during a Confinement.

A Health Care Practitioner must:

- Review and approve the home health care plan;
- Certify and verify that the home health care plan is required in lieu of Confinement or a continued Confinement; and
- Not be related to the Home Health Care Provider by ownership or contract.

Home Health Care Provider means an agency licensed by the proper authority as a home health agency, or Medicare approved as a home health agency and provides 24-hour-a-day, 7-day-a-week service supervised by a Health Care Practitioner.

Hospice Care Agency means an agency which:

- Has the primary purpose of providing hospice services to Hospice Patients;
    - Is licensed and operated according to the laws of the state in which it is located; and
- Meets the following requirements:
  Has obtained any required certificate of need;
  Provides 24-hour-a-day, 7-day-a-week service, supervised by a Health Care Practitioner;
  Has a full-time administrator;
  Keeps written records of services provided to each patient;
  Has a coordinator who:
  Is a R.N.; and
  Has four years of full-time clinical experience, of which at least two were involved in caring for terminally ill patients; and
  Has a licensed social service coordinator.

Hospice Care Program means a written plan of hospice care which:

- Is established and reviewed by:
  The Health Care Practitioner attending to the person; and
  The Hospice Care Agency; and
- Provides:
  Palliative care and supportive care to Hospice Patients;
  Supportive care to the families of Hospice Patients;
  An assessment of the Hospice Patient's medical and social needs; and
  A description of the care to meet those needs.

Hospice Facility means a licensed facility or part of a facility which:

- Principally provides hospice care;
- Keeps medical records of each patient;
- Has an ongoing quality assurance program;
- Has a Health Care Practitioner on call at all times;
- Provides 24-hour-a-day skilled nursing services under the direction of an R.N.; and
- Has a full-time administrator.

Hospice Patient means a terminally ill person with six months or less to live, as certified by a Health Care Practitioner.

Hospital means a facility that provides acute care for a Sickness or Injury on an inpatient basis, and meets the following requirements:

- Maintains permanent full-time facilities for bed care of resident patients;
- Has a Health Care Practitioner in regular attendance;
- Provides continuous 24-hour-a-day nursing services;
- Is primarily engaged in providing diagnostic and therapeutic facilities for medical or surgical care of sick or injured persons;
- Is legally operated in the jurisdiction where located; and
- Has surgical facilities on its premises or has a contractual agreement for surgical services with an institution having a valid license to provide such surgical services.

Hospital does not include a place or institution which is principally for the treatment of mental disorders, alcohol or chemical dependency. Hospital does not include an institution which is principally a rest home, group home, nursing home, convalescent home, home for the aged, or a residential treatment center.

Infertility Services mean any treatment or artificial means, supplies, medications, or services given to achieve pregnancy or to achieve or maintain ovulation. This includes, but is not limited to:

- Artificial insemination;
- In-vitro fertilization;
- GIFT;
- ZIFT;
- Tubal ovum transfer;
- Embryo freezing or transfer;
- Sperm storage or banking;
- Ovum storage or banking;
- Embryo or zygote banking; and
- Any assisted reproductive techniques or cloning methods.

Injury means bodily harm resulting from an accidental event, independent of disease or bodily infirmity.

Insurer means the North Carolina Health Insurance Risk Pool, Inc. d/b/a Inclusive Health – Federal Option.

Maintenance Care means any service or activity which seeks to prevent disease, prolong life, or promote health of a Covered Person who has reached the maximum level of improvement, or whose condition is resolved or stable.

Medically Necessary/Medical Necessity means 1) provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease and is not Experimental, Investigational, or for Research Purposes, nor for cosmetic purposes; 2) necessary for and appropriate to the diagnosis, treatment, cure or relief of a health condition, illness, injury, disease, or its symptom; 3) within generally accepted standards of medical care in the community; 4) not solely for the convenience of the Covered Person, the Covered Person's family, or the Health Care Practitioner.

For Medically Necessary services, the cost-effectiveness of alternative services or supplies may be compared when determining which of the services or supplies will be covered.

Network Provider means a Hospital or other facility, Pharmacy, Health Care Practitioner, or other provider who is designated as such and has signed an agreement with Us, or who has been designated by Us to provide services to Covered Persons. For purposes of the organ transplant benefit, a Network Provider is a Center of Excellence Transplant Provider. Any provider who provides covered Emergency Care will be considered a Network Provider, regardless of the status or affiliation of the provider.

Newborn Child means a child who is less than 32 days old.

Nicotine Replacement Therapy Drug means a Prescription drug that is prescribed for treatment of nicotine addiction.

Noncertification means a determination by the Plan Administrator or Us that an admission, availability of care, continued stay, or other health care service has been reviewed and, based upon the information provided, does not meet the requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness, or does not meet the prudent layperson standard for coverage of Emergency Care, and the requested service is therefore denied, reduced, or terminated. A Noncertification is not a decision rendered solely on the basis that this Policy does not provide benefits for the service in question, if the exclusion of the specific service requested is clearly stated in this Policy. A Noncertification includes decisions about a Covered Person's condition to determine whether a requested treatment is Experimental, Investigational, or for Research Purposes, or a Cosmetic Service, and the extent of coverage is affected by that decision.

Non-Network Provider means a Hospital or other facility, Pharmacy, Health Care Practitioner, or other provider who has not signed an agreement with Us or who has not been designated by Us to provide services to Covered Persons. For purposes of the organ transplant benefit, a Non-Network Provider is a provider other than a Center of Excellence Transplant Provider.

Non-Preferred Brand Prescription Drug means a Prescription drug that is not included in Our list of preferred Prescription drugs.

Obesity Assessment means a medical examination by a Health Care Practitioner to evaluate an individual for obesity.

Open Enrollment – The designated 30 day period each year in which you may elect to transfer from one Benefit Plan Option to another that begins **45** days prior to Your annual renewal date.

Orphan Drug means a drug or biological compound used for the diagnosis, treatment, or prevention of rare diseases or conditions, which:

- Affects less than 200,000 persons in the United States; or
    - Affects more than 200,000 persons in the United States, however, there is no reasonable expectation that the cost of developing the drug and making it available in the United States will be recovered from the sale of that drug in the United States.

Other Mental Illness means mental disorders as diagnosed and defined in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, or a subsequent edition published by the American Psychiatric Association, except for the following:

- Severe Mental Illness as defined;
- Those mental disorders coded in the DSM-IV or subsequent edition as substance-related disorders (291.0 through 292.2 and 303.0 through 305.9);
- Those coded as sexual dysfunctions not due to organic disease (302.70 through 302.79); and
- Those coded as 'V' codes.

Outpatient Services means medical services that are rendered to a Covered Person while they are not confined as a registered inpatient. Outpatient services include, but are not limited to, services provided in:

- A Health Care Practitioner's office;
- A Hospital outpatient setting;
- A Free-Standing Surgical Facility;
- A licensed birthing center; or
- An independent laboratory or clinic.

Out-of-Pocket Limit means the total of Deductibles and Coinsurance a Covered Person pays for certain services before We begin paying at 100%. The Out-of-Pocket Limit is stated in the Schedule.

Palliative Care means care given to a Covered Person to relieve, ease, or alleviate, but not to cure, an Injury or Sickness.

Pharmacist means a person who is licensed to prepare, compound, and dispense medication and who is practicing within the scope of his or her license.

Pharmacy means a licensed establishment where Prescription medications are dispensed by a Pharmacist.

Plan Administrator means a third party administrator contracted by Us to perform the administration required under this Policy. The Plan Administrator is identified on the Schedule.

Policy means this document, together with Your application and any amendments, riders, or endorsements which describe the agreement between You and Us.

Policyholder means the person to whom this Policy is issued and whose name is shown on the Schedule.

Pre-Certification means the prior approval for a Covered Health Service given by Us or the Plan Administrator. Pre-Certification review will determine if the proposed service is a Covered Expense.

Pre-Existing Condition means any condition for which medical advice, care or treatment was recommended or received during the 12-month period immediately preceding the Covered Person's Effective Date.

Preferred Brand Prescription Drug means a Prescription drug that is included in Our list of preferred Prescription drugs.

Preferred Provider Network means a network or group of Health Care Practitioners, health care treatment facilities, Hospitals, and other health care providers who have signed an agreement with Us to furnish services at a negotiated fee for Covered Persons under this Policy.

Prescription means a direct order for the preparation and use of a drug, medicine, or medication. The drug, medicine, or medication must be obtainable only by Prescription.

The Prescription must be given by a Health Care Practitioner to a Pharmacist for the benefit of and use by a Covered Person for the treatment of an Injury or Sickness. The Prescription may be given to the Pharmacist verbally, electronically, or in writing by the Health Care Practitioner.

The Prescription must include:

- The name of the Covered Person for whom the Prescription is intended;
- The type and quantity of the drug, medicine, or medication prescribed, and the directions for its use;
- The date the Prescription was prescribed; and
- The name and address of the prescribing Health Care Practitioner.

Primary Care means a Health Care Practitioner whose primary area of practice is family medicine, internal medicine, obstetrics/gynecology, or pediatrics.

Prior Authorization means the required prior approval from Us for the coverage of certain Prescription drugs, medicines, or medications (referred to as Restricted Access Drugs), including the dosage, quantity and duration, as appropriate for the Covered Person's age, diagnosis, and sex. The list of Prescription drugs requiring Prior Authorization is subject to periodic review and modification. You may obtain a current list by calling the telephone number on your ID card, or on the internet at www.medtrakrx.com.

Resident means an individual who has legal status in the United States and who is and continues to be a resident of North Carolina.

Restricted Access Drug means those covered Prescription drugs or devices for which reimbursement is conditioned on obtaining Prior Approval to prescribe the drug or device or on the provider prescribing one or more alternative drugs or devices before prescribing the drug or device in question.

Self-Administered Injectable Drug means an FDA approved medication which a person may administer to himself/herself by means of intramuscular, intravenous, or subcutaneous injection (excluding insulin, epinephrine, sumatriptan, and glucagon), and intended for use by the Covered Person.

Severe Mental Illness means any of the following disorders, as diagnosed and defined in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, or a subsequent edition published by the American Psychiatric Association:

- Bipolar disorder;
- Major depressive disorder;
- Obsessive-compulsive disorder;
- Paranoid and other psychotic disorder;
- Schizoaffective disorder;
- Schizophrenia;
- Post-traumatic stress disorder;
- Anorexia nervosa; or
- Bulimia.

Sickness means a disturbance in function or structure of the Covered Person's body which causes physical signs or symptoms which, if left untreated, will result in a deterioration of the health state of the structure or system(s) of the Covered Person's body.

Skilled Nursing Facility means only an institution licensed as a Skilled Nursing Facility and lawfully operated in the jurisdiction where located. It must maintain and provide:

- Permanent and full-time bed care facilities for resident patients;
- A Health Care Practitioner's services at all times;
- 24-hour-a-day skilled nursing services under the full-time supervision of a Health Care Practitioner or Registered Nurse (R.N.);
- A daily record for each patient;
- Continuous skilled nursing care for sick or injured persons during their convalescence; and
- A utilization review plan in effect.

A Skilled Nursing Facility is not, except by incident, a rest home, a home for the care of the aged, or engaged in the care and treatment of chemical or alcohol dependency.

Specialist means a Health Care Practitioner who is qualified by means of advanced clinical training or postgraduate education to limit practice to a narrow spectrum of health care. A Specialist does not include a Health Care Practitioner whose primary area of practice is family medicine, internal medicine, obstetrics/gynecology, or pediatrics.

Specialty Prescription Drug means any Prescription drug classified by Us as one which requires special dosing or administering, which is typically prescribed by a Specialist, and which is more expensive than most medications.

Substance Abuse means abuse of, addiction to, or dependence on drugs, chemicals or alcohol as defined in the edition of the International Classification of Diseases (ICD) that is published at the time a claim is received by Us.

Urgent Care means treatment, services or supplies provided for a Sickness or an Injury that:

- Develops suddenly and unexpectedly outside of a Health Care Practitioner's normal business hours; and
- Requires immediate treatment, but is not of sufficient severity to be considered Emergency Care.

Urgent Care Facility means a facility that is attached to a Hospital, but separate from the Emergency Room, or a separate facility that provides Urgent Care on an Outpatient basis. A Health Care Practitioner's office is not considered to be an Urgent Care Facility even if services are provided after normal business hours. Room and board and overnight services are not covered. This type of facility must meet all of the following requirements:

- Be licensed by the state in accordance with the laws for the specific services being provided in that facility;
- Be staffed by an on duty physician during operating hours;
- Provide services to stabilize patients who need Emergency Treatment and arrange immediate transportation to an Emergency Room; and
- Provide immediate access to appropriate in-house laboratory and imaging services.

We, **Us**, or **Our** refers to the North Carolina Health Insurance Risk Pool, Inc. d/b/a Inclusive Health – Federal Option as shown on the cover page of this Policy.

You or **Your** means the Policyholder.

North Carolina Health Insurance Risk Pool, Inc.
d/b/a Inclusive Health – Federal Option
Notice of Privacy Practices

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

YOUR PRIVACY RIGHTS, OUR RESPONSIBILITIES

Inclusive Health collects and maintains health information about you and is required by law to protect the privacy of your health information and to provide you with this Notice of Privacy Practices. This *Notice* describes how Inclusive Health may use and share your health information and explains your privacy rights. Inclusive Health will use or disclose your health information only as described in this *Notice.* We do, however, reserve the right to change our privacy practices and the terms of this *Notice* and to make new notice provisions effective for all health information that we maintain. We will not change our privacy practices before you are sent a revised *Notice* unless the change is required by law.

When you applied for coverage with Inclusive Health, your application included information such as your name, address, birth date, phone number, social security number, Medicare number (if applicable) and health insurance policy information. It may also have included information about your health condition. When your health care provider sends a claim to Inclusive Health for payment, the claim includes your diagnosis and the medical treatment and supplies you received. For certain medical treatments, your health care provider must send additional medical information such as a doctor's statements, x-rays or lab test results.

If at any time, you have questions or concerns about the information in this *Notice* or about our agency's privacy policies, procedures or practices; you may contact Inclusive Health at 1-866-665-2117.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION WITHOUT AUTHORIZATION

There are some services Inclusive Health provides through contracts with other agencies such as CoreSource, Inc., the Administrator for Inclusive Health, and through private contractors that process your health care provider claims. When services are contracted, Inclusive Health must share enough information about you with their contractors so that they can perform the job that Inclusive Health has asked them to do.
To further protect your health information, Inclusive Health will only disclose your health information after making sure in writing that its contractors will safeguard your information the same way that Inclusive Health does.

This agency may use or disclose your health information to provide Inclusive Health services to you for:

Payment For Services: Inclusive Health may use or disclose your health information to its contractors who provide payment services for Inclusive Health. (EXAMPLE: In order for your health care provider's claim to be considered, the contractor who processes claims for payment must have enough health information about you to verify and consider the services you received).

Treatment: To determine if your treatment is medically necessary and is covered under Inclusive Health, we may use or disclose your health information to other health care professionals. These professionals have specific medical expertise so that they can give an opinion on your treatment as being medically necessary.

Health Care Operations: Inclusive Health may use or disclose your protected health information to perform a variety of business activities that we call "health care operations." These operations ensure that you receive quality car, that charges are appropriate for the service that you received, and, where applicable, that your

health care provider is paid promptly. (EXAMPLE: We may contract with a private company to review the care and services our participants have received to ensure that quality care was provided.) Other "operations" that may require your protected health information to be shared are to:

Review and evaluate the skills, qualifications and performance of health care providers that are providing services to you.

Provide training programs for students, trainees, professional and non-professional staff to allow them to use, under supervision, the skills they have learned.

Provide information to certifying and licensing agencies so that their staff may fulfill professional requirements.

Plan our agency's future operations.

Enhance investigations conducted by Inclusive Health or its contractors whenever a participant files a Grievance or protests a particular issue.

Provide information to other health plans and federal agencies to determine if you are enrolled as their member or covered by their plan or agency.

Other Circumstances: Inclusive Health may cooperate with other government agencies and outside organizations that conduct health oversight activities for the purposes allowed under federal law. Inclusive Health may also comply with court orders, subpoenas, administrative orders, lawsuits related to administration of Medicaid.

Contacting You: Inclusive Health may contact you personally to keep you informed, such as appointment reminders or other treatment opportunities, when necessary or available, under certain selected public agency benefit programs.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION THAT REQUIRES YOUR AUTHORIZATION

Inclusive Health will not use, communicate or disclose your protected health information without your authorization except as allowed in the circumstances mentioned above. For all other uses or disclosures, we will ask you to sign a written authorization to allow us to share or request your protected health information. You may cancel such authorization by notifying us.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

Inclusive Health members have certain rights about their protected health care information.

YOU HAVE THE RIGHT TO:

Receive a copy of this Notice: You may request a paper copy of this notice. You may also obtain a copy of this *Notice* by accessing Inclusive Health's web site at www.inclusivehealth.org.

Request confidential communications: You have a right to request that Inclusive Health communicate with you in a certain way or at a certain location, such as calling you at work rather than at home.

Inspect and copy: At a reasonable fee, you have a right to request in writing to see and obtain a copy of your records within 30 days. There are some exceptions to this right such as impending court actions. If this right is denied, you will be notified in writing of the reason for denial and your right to request review of the denial.

Request amendment: You have a right to request in writing, portions of your Inclusive Health records be corrected when you feel information is incorrect or incomplete. We may deny your request if the information was not created by us or if we believe the information is accurate. You may then file a statement of disagreement that will be included in any future disclosures.

A listing of disclosures: You have the right to request in writing and receive a written list of certain disclosures of your protected health information made after the effective date of this policy. Exceptions from this list include those disclosures regarding treatment, payment or other health care operations or disclosures allowed by certain laws, or disclosures authorized by you.

Request restrictions on uses and disclosures of your protected health information: You have a right to request restrictions on the information Inclusive Health uses or discloses about you. Inclusive Health is not required to agree to your requested restriction, but it will consider your request and the possibility of accommodating it.

Complaints: If you feel we have violated your privacy rights, you may contact us. If you file a complaint, we will not take any action against you or retaliate in any way.

COMPLAINT ADDRESS

Inclusive Health – Federal Option
5200 77 Center Drive, Suite 400
Charlotte, NC 28217-0718

Toll Free: 1-866-665-2117

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