NORTH CAROLINA'S SMALL EMPLOYER GROUP
STANDARD HMO HEALTH BENEFIT PLANS
BENEFITS AND EXCLUSIONS

STANDARD PLAN

PHYSICIANS SERVICES	
Office Visits	$15 co-pay per visit
Surgery during an office visit	Copay same as office visit
HOSPITAL SERVICES	
Inpatient (medical/surgical)	$250 co-pay per admission
Outpatient Surgery	$75 co-pay per episode
Other Outpatient Services	Covered in full
Emergency Room	$50 copay per visit, waived if admitted
Skilled Nursing Facility	$250 co-pay per admission with benefited limited to 100 days per calendar year.
PHYSICAL, OCCUPATIONAL AND SPEECH THERAPY	$15 co-pay per visit, limit up to 2 months treatment for conditions subject to significant improvement within the 2 months
LAB-PATHOLOGY TESTS (includes pap tests, psa tests and mammograms)	Covered in full
X-RAY RADIOLOGY	Covered in full
EYE EXAMS	Vision screening by PCP covered in full for children through age 17
AMBULANCE-EMERGENCY	$50 co-pay per use

PREVENTIVE SERVICES (includes routine physicals, well-baby, and well-child care)	~~Applicable physician co-pay~~ Covered in full to the extent the service is included in preventive services as required by the Affordable Care Act.
IMMUNIZATIONS	Covered in full and pursuant to the requirements of the Affordable Care Act.
PRE-NATAL & POST-NATAL OUTPATIENT VISITS	Covered in full
HOSPICE CARE	Covered in full
HOME HEALTH CARE (including physician house calls)	Covered in full
ALCOHOLISM/ SUBSTANCE ABUSE	
Inpatient	Medical detoxification - $250 co-pay per admission
Outpatient	Not covered
MENTAL HEALTH	
Inpatient	$250 co-pay per admission
Outpatient	$75 co-pay per visit
Inpatient/Outpatient Durational Limits [1]	30 combined inpatient/outpatient days per benefit year
Office Visit	$15 co-pay per visit
Office Visit Durational Limits [2]	30 office visits per year

OUTPATIENT PRESCRIPTION DRUG	50% co-pay per 30 day supply
DURABLE MEDICAL EQUIPMENT AND PROSTHESES	$400 co-pay per calendar year, then covered in full. Internally implanted prostheses covered in full.

NOTES

- A CHILD SHALL CEASE TO BE ELIGIBLE FOR COVERAGE AS A DEPENDENT AT AGE ~~19~~26 PURSUANT TO THE REQUIREMENTS OF THE AFFORDABLE CARE ACT~~, OR IF A FULL-TIME STUDENT IN AN ACCREDITED SCHOOL OR COLLEGE, AT AGE 25~~ . THIS DOES NOT APPLY TO A DEPENDENT CHILD WHO IS PHYSICALLY OR MENTALLY HANDICAPPED AND THEREFORE UNABLE TO SUPPORT HIM/HERSELF AND THE HANDICAP COMMENCED PRIOR TO THE DEPENDENT ATTAINING THE LIMITING AGE.

  EVERY STANDARD AND BASIC HEALTH BENEFIT PLAN THAT IS DELIVERED, ISSUED FOR DELIVERY, OR RENEWED ON OR AFTER OCTOBER 9, 2008 SHALL COMPLY WITH NCGS 58-51-25(b) AS ADOPTED IN SECTION 17 OF SESSION LAW 2009-382 WHICH ADOPTS BY REFERENCE PUBLIC LAW 110-381, ALSO KNOWN AS "MICHELLE'S LAW".

  NO STANDARD AND BASIC HEALTH BENEFIT PLAN (INCLUDING GRANDFATHERED PLANS) SHALL IMPOSE ANY PRE-EXISTING CONDITION EXCLUSION ON ANY ENROLLEE WHO IS UNDER 19 YEARS OF AGE, INCLUDING APPLICANTS FOR ENROLLMENT , FOR PLAN YEARS BEGINNING ON OR AFTER SEPTEMBER 23, 2010.

- EVERY STANDARD HMO HEALTH BENEFIT PLAN THAT IS IN FORCE, ISSUED, RENEWED, OR AMENDED ON OR AFTER JANUARY 1, 1998 SHALL PROVIDE COVERAGE FOR RECONSTRUCTIVE BREAST SURGERY RESULTING FROM A MASTECTOMY DUE TO BREAST CANCER OR DISEASE. THIS COVERAGE SHALL BE AT LEAST EQUAL TO THE COVERAGE REQUIRED BY NCGS 58-67-79, INCLUDING THE NOTIFICATION REQUIREMENTS.

- ~~EVERY BASIC HMO HEALTH BENEFIT PLAN SHALL PROVIDE COVERAGE FOR RECONSTRUCTIVE BREAST SURGERY RESULTING FROM A MASTECTOMY IN ACCORDANCE WITH THE FEDERAL WOMEN'S HEALTH AND CANCER RIGHTS ACT EFFECTIVE 10/21/98, INCLUDING REQUIREMENTS FOR NOTIFICATION OF BENEFITS.~~

- EVERY STANDARD HMO HEALTH BENEFIT PLAN THAT IS IN FORCE, ISSUED, RENEWED OR AMENDED ON OR AFTER JANUARY 1, 2000 SHALL PROVIDE COVERAGE FOR A QUALIFIED INDIVIDUAL FOR SCIENTIFICALLY PROVEN BONE MASS MEASUREMENT FOR THE DIAGNOSIS AND EVALUATION OF OSTEOPOROSIS OR LOW BONE MASS. THIS COVERAGE SHALL BE AT LEAST EQUAL TO THE COVERAGE REQUIRED BY NCGS 58-3-174 AND SHALL BE PROVIDED WITHOUT ANY COST SHARING AS PROVIDED UNDER THE AFFORDABLE CARE ACT.
- EVERY STANDARD HMO HEALTH BENEFIT PLAN THAT IS IN FORCE, ISSUED, RENEWED, OR AMENDED ON OR AFTER JANUARY 1, 2000 SHALL PROVIDE COVERAGE FOR PRESCRIBED CONTRACEPTIVE DRUGS AND DEVICES THAT PREVENT PREGNANCY. THIS COVERAGE SHALL BE AT LEAST EQUAL TO THE COVERAGE REQUIRED BY NCGS 58-3-176.
- MATERNITY CARE FOR INSURED EMPLOYEE/SUBSCRIBER/MEMBER AND COVERED SPOUSE ONLY; COMPLICATIONS OF PREGNANCY ARE COVERED FOR ALL INSUREDS. MATERNITY COVERAGE SHALL BE IN ACCORDANCE WITH NCGS 58-3-169 AND 58-3-170. INCLUDING INPATIENT CARE FOR THE MOTHER & HER NEWLY BORN CHILD FOR A MINIMUM OF 48 HOURS FOLLOWING VAGINAL DELIVERY AND 96 HOURS FOLLOWINGDELIVERY BY CESAREAN SECTION. THE HMO SHALL PROVIDE COVERAGE FOR TIMELY POST-DELIVERY CARE IF THE PHYSICIAN, IN CONSULTATION WITH THE MOTHER, DISCHARGES THE MOTHER AND HER CHILD PRIOR TO THE END OF THE MINIMUM STAYS.
- EVERY STANDARD HEALTH BENEFIT PLAN THAT IS DELIVERED, ISSUED FOR DELIVERY, OR RENEWED ON OR AFTER JULY 1, 2000 THAT ISSUES A PRESCRIPTION DRUG CARD, SHALL ISSUE TO ITS INSUREDS A UNIFORM PRESCRIPTION DRUG CARD PURSUANT TO NCGS 58-3-177.
- EVERY STANDARD HEALTH BENEFIT PLAN THAT IS DELIVERED, ISSUED FOR DELIVERY, OR RENEWED ON OR AFTER JANUARY 1, 2002 SHALL PROVIDE COVERAGE FOR COLORECTAL CANCER EXAMINATIONS AND LABORATORY TESTS. THIS COVERAGE SHALL BE AT LEAST EQUAL TO THE COVERAGE REQUIRED BY NCGS 58-3-179 AND SHALL BE PROVIDED WITHOUT ANY COST SHARING AS PROVIDED UNDER THE AFFORDABLE CARE ACT.
- EVERY STANDARD HEALTH BENEFIT PLAN THAT IS DELIVERED, ISSUED FOR DELIVERY, OR RENEWED ON OR AFTER JANUARY 1, 2004 SHALL PROVIDE COVERAGE FOR SURVEILLANCE TESTS FOR OVARIAN CANCER. THIS COVERAGE SHALL BE AT LEAST EQUAL TO THE COVERAGE REQUIRED BY NCGS 58-3-270.
- EVERY STANDARD HEALTH BENEFIT PLAN THAT IS DELIVERED, ISSUED FOR DELIVERY, OR RENEWED ON OR AFTER JULY 1, 2008 SHALL PROVIDE

COVERAGE FOR TREATMENT OF MENTAL ILLNESS THAT IS AT LEAST EQUAL TO THE COVERAGE REQUIRED BY NCGS 58-3-220.

- EVERY BASIC AND STANDARD HMO HEALTH BENEFIT PLAN (OTHER THAN GRANDFATHERED PLANS) SHALL PROVIDE COVERAGE WITHOUT COST SHARING FOR PREVENTIVE HEALTH SERVICES AS REQUIRED UNDER THE AFFORDABLE CARE ACT.

- AS OF PLAN YEARS BEGINNING ON OR AFTER SEPTEMBER 23, 2010, INSURERS SHALL NOT RESCIND COVERAGE UNDER A BASIC OR STANDARD HMO HEALTH BENEFIT PLAN (INCLUDING GRANDFATHERED PLANS) WITH RESPECT TO AN INDIVIDUAL (INCLUDING THE GROUP TO WHICH THE INDIVIDUAL BELONGS) ONCE THE INDIVIDUAL IS COVERED UNLESS THE INDIVIDUAL (OR A PERSON SEEKING COVERAGE ON BEHALF OF THE INDIVIDUAL) PERFOMS AN ACT, PRACTICE, OR OMMISSION THAT CONSTITUTES FRAUD, OR MAKES AN INTENTIONAL MISREPRESENTATION OF MATERIAL FACT.

- AS OF PLAN YEARS BEGINNING ON OR AFTER SEPTEMBER 23, 2010, IF A BASIC OR STANDARD HMO HEALTH BENEFIT PLAN (OTHER THAN GRANDFATHERED PLANS) REQUIRES AN INDIVIDUAL TO DESIGNATE A PRIMARY CARE PHYSICIAN, THE PLAN SHALL COMPLY WITH THE REQUIREMENTS OF THE AFFORDABLE CARE ACT WITH REGARD TO CHOICE OF HEALTH CARE PROFESSIONAL.

- AS OF PLAN YEARS BEGINNING ON OR AFTER SEPTEMBER 23, 2010, BASIC AND STANDARD HMO HEALTH BENEFIT PLANS (EXCEPT A GRANDFATHERED PLAN) SHALL PROVIDE PATIENT ACCESS TO OBSTETRICAL AND GYNECOLOGICAL CARE AS PROVIDED IN THE AFFORDABLE CARE ACT.

- AS OF PLAN YEARS BEGINNING ON OR AFTER SEPTEMBER 23, 2010, BASIC AND STANDARD HMO HEALTH BENEFIT PLANS (OTHER THAN GRANDFATHERED PLANS) SHALL PROVIDE COVERAGE FOR EMERGENCY SERVICES AS PROVIDED UNDER THE AFFORDABLE CARE ACT ***AND*** IN ACCORDANCE WITH G.S. 58-3-190 TO THE EXTENT THAT THE STATE STATUTE IS MORE FAVORABLE TO INSURED MEMBERS THAN THE FEDERAL STANDARD.
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EXCLUSIONS

Charges for the following are considered non-covered charges. They cannot be used in satisfying any deductibles or out-of-pocket maximums, nor are they included in any calculation of benefits payable.

1. Services or supplies for the treatment of an Occupational Injury or Sickness which 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;

2. Care or treatment of an injury that is intentionally self-inflicted, while sane or insane, unless otherwise required to be covered by Federal law ;

   Federal law requires that if a group plan generally provides benefits for a type of injury, the plan may not deny benefits otherwise provided for the treatment of the injury because of the manner by which the injury is incurred if the injury is attributed to an underlying medical condition (including both physical and mental health conditions) or the injury is attributed to an act of domestic violence.

3. Treatment for cosmetic purposes, other than for prompt repair of an accidental injury or reconstructive surgery following removal of tumor; [3]

4. Travel, except transportation by local professional ambulance to nearest health care facility qualified to treat injury or disease;

5. Private room accommodations to extent charges are in excess of the institution's most common semi-private room charge;

6. Services or articles provided which are not within scope or licensure or certificate of the provider;

7. Services or articles for custodial, convalescent or intermediate level care, or care designed primarily to assist in activities of daily living;

8. Eyeglasses, contacted lenses, hearing aids, or the fitting of any of these~~;~~, except to the extent that such services/devices are included as "preventive health services" under the Affordable Care Act;

9. Services performed by member of family of covered individual or family of covered individual's spouse, or by person who normally resides in covered individual's home;

10. Care incurred while individual is not covered;

11. Immunizations and medical examinations or tests of any kind not related to treatment of covered injury or disease, to the extent coverage is not specifically defined elsewhere, except to the extent that such services are included as "preventive health services" under the Affordable Care Act;

12. Expenses that are not medically necessary, required for treatment, and recommended and approved by the attending physician;

13. Injury or sickness caused by war or armed international conflict;

14. Services given by person not specified elsewhere as licensed providers of health care;

15. Dental care and dental x-rays, including shortening of the mandible or maxillae for cosmetic purposes, correction of malocclusion and any dental treatment involved in temporomandibular joint (TMJ) pain dysfunction syndrome , except to the extent that such services are included as "preventive health services" under the Affordable Care Act;

16. Services for which the covered person is not legally obligated to pay;

17. Dietary control, exercise programs, education programs , except to the extent that such services are included as "preventive health services" under the Affordable Care Act;

18. Sexual re-assignment surgery and related services;

19. Treatment for infertility, including artificial insemination, unless required by federal statute;

20. Speech therapy except for treatment that is expected to restore speech to an individual who has lost existing speech function as a result of injury or disease;

21. Services and supplies which schools must provide;

22. Reversal of voluntary infertility;

23. Services and supplies for analysis and adjustments of spinal sublaxation, diagnosis and treatment by manipulation of the skeletal structure, or for muscle stimulation by any means (except treatment of fractures and dislocations of the extremities);

24. Court ordered services which are not deemed medically necessary;

25. Blood and blood products;

26. Experimental and Investigation Services: Any treatment, procedure, drug or drug usage, facility or facility usage, or supplies where either (a) the service is not recognized in accordance with generally accepted medical standards as being safe and effective for treatment of condition in question regardless of whether the service is authorized by law for use in testing or other studies, or (b) the service requires approval by any governmental authority and such authority has not been granted prior to service being rendered; [4]

27. Routine foot care;

28. Treatment of Temporomandibular Joint Dysfunction (TMJ) and Craniomandibular Pain Syndrome (CPS), except surgical services for TMJ and CMS are covered, but only if medically necessary and there is clearly demonstrable radiographic evidence of joint abnormality due to disease or injury;

29. Private Duty Nursing in the home;

30. Custodial or sanitarium or rest cures;

31. Physical examinations and other services required for obtaining or maintaining employment, insurance or government licensing;

32. Care in the connection with a pre-existing condition, except in the case of a late-enrollee, for not more than 12 months; however, the plan shall provide credit for creditable coverage in accordance with NCGS 58-68-30(a)(3). Children under age 19 shall not be subject to any pre-existing condition exclusion as provided in the Affordable Care Act.[5]

33. Organ Transplants, except human organ transplants which would be approved by Medicare if the individual were covered;[6]

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[1] Except when services are provided for Bipolar Disorder, Major Depressive Disorder, Obsessive Compulsive Disorder, Paranoid and Other Psychotic Disorder, Schizoaffective Disorder, Schizophrenia, Post-Traumatic Stress Disorder, Anorexia Nervosa, and Bulimia, which shall not be subject to any durational limitations. Applicable to the Standard HMO benefit plan only.

[2] Except when services are provided for Bipolar Disorder, Major Depressive Disorder, Obsessive Compulsive Disorder, Paranoid and Other Psychotic Disorder, Schizoaffective Disorder, Schizophrenia, Post-Traumatic Stress Disorder, Anorexia Nervosa, and Bulimia, which shall not be subject to any durational limitations. Applicable to the Standard HMO benefit plan only.

[3] Except, treatment to correct congenital defects and anomalies of newborn, adopted and foster children shall not be excluded; for the Standard plan, pursuant to NCGS 58-50-155(a2) and NCGS 58-67-79, reconstructive breast surgery resulting from a mastectomy as a result of breast cancer or breast disease shall not be excluded; and for the Basic plan, reconstructive breast surgery resulting from a mastectomy shall be covered in accordance with the federal Women's Health and Cancer Rights Act effective October 21, 1998. This includes compliance with the applicable notice requirements.

[4] Except certain drugs prescribed to treat cancer shall be covered in accordance with NCGS 58-50-156 and 58-67-78 for the Standard plan only. **Note amendment to the compendia referenced in G.S. 58-67-78 as found in Session Law 2009-170 effective June 26, 2009.**

[5] Every Standard or Basic HMO Health Benefit Plan that is issued, renewed, or amended on or after July 1, 1997 shall not impose any preexisting condition exclusion relating to pregnancy as a preexisting condition.

[6] Health services and associated expenses for organ and tissue transplants are excluded except those specifically stated in guidelines for transplantation Health Services. Any solid organ transplant otherwise covered under the plan which is performed as a treatment for cancer. Transplantation of two (2) or more organs simultaneously (except kidney/pancreas and health/lung).