Exhibit 1

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF NORTH CAROLINA
Civil Action No. 1:19-cv-00272

MAXWELL KADEL; JASON FLECK; CONNOR THONEN-FLECK, by his next friends and parents, JASON FLECK and ALEXIS THONEN; JULIA MCKEOWN; MICHAEL D. BUNTING, JR.; C.B., by his next friends and parents, MICHAEL D. BUNTING, JR. and SHELLEY K. BUNTING; and SAM SILVAINE,	)
Plaintiffs,	)
v.	)
DALE FOLWELL, in his official capacity as State Treasurer of North Carolina; DEE JONES, in her official capacity as Executive Administrator of the North Carolina State Health Plan for Teachers and State Employees; UNIVERSITY OF NORTH CAROLINA AT CHAPEL HILL; NORTH CAROLINA STATE UNIVERSITY; UNIVERSITY OF NORTH CAROLINA AT GREENSBORO; and NORTH CAROLINA STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES,	)
Defendants.	)

OBJECTIONS AND RESPONSES OF DEFENDANTS DALE FOLWELL AND DEE JONES TO PLAINTIFFS' FIRST SET OF INTERROGATORIES

Dale Folwell and Dee Jones respond to the Plaintiffs' First Set of Interrogatories as follows:

The Plaintiffs have served eleven contention interrogatories upon the Defendants at the beginning of the discovery process. "[M]ost courts agree that due to the nature of contention interrogatories, they are more appropriately used after a substantial amount of discovery has been conducted—typically at the end of the discovery period." *Sigman v. CSX Corp.*, No. 3:15-CV-13328, 2016 WL 7444947, at *2 (S.D.W. Va. Dec. 27, 2016). As the parties move forward with discovery, the Defendants have every expectation these interrogatories will be supplemented. Currently, however, the Defendants are reviewing more than 11,000 documents that may be responsive to the Plaintiffs' request for production of documents. Until this process has moved forward somewhat, any answers below are necessarily preliminary. In addition, as discovery proceeds, there may be privileged and confidential information that is responsive to the Plaintiffs' request, although this cannot be fully discerned at this early stage.

1. Describe in detail the factual basis for each governmental interest that you contend supports the Exclusion.

The Defendants object that this interrogatory is overly broad, premature and calls for privileged and confidential information. The Defendants expect to supplement this answer as discovery proceeds. Health benefit coverage decisions for the State Health Plan must consider the actuarial soundness of the plan along with the health composition of Plan members. For an entity such as the State Health Plan, officials must also consider the effect of funding on plan premiums and the taxpayer subsidies. The decision whether to provide coverage for specific conditions also has a predictive component. Medical treatment sought must be cost-effective and likely to lead to a positive result for the member.

Upon information and belief, the coverage exclusions appear to have been considered at least three times by leadership of the State Health Plan. The Defendants are still conducting discovery as to the basis for the original decision to adopt the coverage exclusion in the 1990s. The Defendants are also still conducting discovery into the decision to suspend the coverage exclusion for the 2017 Plan Year, but, upon information and belief, this decision appears to have been made in order to comply with a 2016 federal regulation. While further discovery will provide clarity, at the time the one-year suspension ended, the

Defendants reviewed the ongoing litigation about the 2016 federal regulation and concluded that this regulation was no longer in effect.

2. Describe in detail the factual basis for each governmental interest that actually motivated the decision to no longer suspend the application of the Exclusion for calendar year 2018.

The Defendants object that this interrogatory is overly broad, premature and calls for privileged and confidential information. The Defendants expect to supplement this answer as discovery proceeds. The Defendants did not act to "no longer suspend the application of the Exclusion." While further discovery will provide clarity, at the time the one-year suspension of the coverage exclusion ended, the Defendants reviewed litigation involving the 2016 federal regulation and concluded that the regulation no longer required adoption of a second suspension by the Board of Trustees for the 2018 Plan year.

3. Describe in detail all evidence demonstrating that the government interests identified in Interrogatory 2 actually motivated the decision to no longer suspend the application of the Exclusion for calendar year 2018.

The Defendants object that this interrogatory is overly broad, premature and calls for privileged and confidential information. The Defendants expect to supplement this answer as discovery proceeds.

4. Identify each person involved in the decision to suspend the application of the Exclusion for the calendar year 2017.

The Defendants object that this interrogatory is overly broad, premature and calls for privileged and confidential information. The Defendants expect to supplement this answer as discovery proceeds.

Individuals who may have information about this suspension include:

Members of the Board of Trustees of the State Health Plan in 2016. These individuals include Paul Cunningham, Neal Alexander, Donald Martin, Warren Newton, Elizabeth Poole, David Rubin, Margaret Way, Bill Medlin, Charles Johnson, Andrew Heath, and Aaron McKethan.

Former North Carolina Treasurer Janet Cowell.

Employees and former employees of Treasurer Cowell and the State Health Plan. Lotta Crabtree, Mona Moon, Beth Horner, Chris Almberg, Mark Collins, Caroline Smart, Blake Thomas, and Patti Forest.

Exhibit 2

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF NORTH CAROLINA
Civil Action No. 1:19-cv-00272

MAXWELL KADEL; JASON FLECK; CONNOR THONEN-FLECK, by his next friends and parents, JASON FLECK and ALEXIS THONEN; JULIA MCKEOWN; MICHAEL D. BUNTING, JR.; C.B., by his next friends and parents, MICHAEL D. BUNTING, JR. and SHELLEY K. BUNTING; and SAM SILVAINE, Plaintiffs, v. DALE FOLWELL, in his official capacity as State Treasurer of North Carolina; DEE JONES, in her official capacity as Executive Administrator of the North Carolina State Health Plan for Teachers and State Employees; UNIVERSITY OF NORTH CAROLINA AT CHAPEL HILL; NORTH CAROLINA STATE UNIVERSITY; UNIVERSITY OF NORTH CAROLINA AT GREENSBORO; and NORTH CAROLINA STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES, Defendants.	)

AMENDED OBJECTIONS AND RESPONSES OF DEFENDANTS DALE FOLWELL AND DEE JONES TO PLAINTIFFS' AMENDED FIRST SET OF REQUESTS FOR ADMISSION

Dale Folwell and Dee Jones amend their response to the Plaintiffs' Amended First Set of Requests for Admission as follows:

In discussions between the parties, the Plaintiffs have agreed to modify, in part, their requests for admission to avoid any ambiguity over the definition of which procedures are, or are not, encompassed within the Plaintiffs' definition of Gender-Confirming Healthcare. With these modifications, Defendants Folwell and Jones have modified their responses to requests for admission #1 through #4, as reflected below.

Request for Admission #1

1. Admit that NCSHP partially or fully covers hormone therapy for some diagnoses.

Response

Admit.

Request for Admission #2

2. Admit that NCSHP partially or fully covers mammoplasty and/or breast reconstruction surgery for some diagnoses.

Response

Admit.

Request for Admission #3

3. Admit that NCSHP partially or fully covers vaginoplasty for some diagnoses.

Response

Admit.

Request for Admission #4

4. Admit that NCSHP partially or fully covers hysterectomy for some diagnoses.

Response:

Admit.

Dated this 29th day of September, 2020.

Respectfully submitted by,

/s/ James Benjamin Garner
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CERTIFICATE OF SERVICE

On September 29, 2020, I certify that I served this document via email on the following:

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/s/ John G. Knepper

Exhibit 3

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF NORTH CAROLINA
Civil Action No. 1:19-cv-00272

MAXWELL KADEL; JASON FLECK; CONNOR THONEN-FLECK, by his next friends and parents, JASON FLECK and ALEXIS THONEN; JULIA MCKEOWN; MICHAEL D. BUNTING, JR.; C.B., by his next friends and parents, MICHAEL D. BUNTING, JR. and SHELLEY K. BUNTING; and SAM SILVAINE, Plaintiffs, v. DALE FOLWELL, in his official capacity as State Treasurer of North Carolina; DEE JONES, in her official capacity as Executive Administrator of the North Carolina State Health Plan for Teachers and State Employees; UNIVERSITY OF NORTH CAROLINA AT CHAPEL HILL; NORTH CAROLINA STATE UNIVERSITY; UNIVERSITY OF NORTH CAROLINA AT GREENSBORO; and NORTH CAROLINA STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES, Defendants.	)

AMENDED RESPONSES AND OBJECTIONS OF DEFENDANTS DALE FOLWELL AND DEE JONES TO PLAINTIFFS' FIRST SET OF INTERROGATORIES

Consistent with the obligations of Federal Rule of Civil Procedure 26(e), Dale Folwell and Dee Jones amend their responses to Interrogatories 6, 7, 8, 9, & 10 of the Plaintiffs' First Set of Interrogatories as follows:

6. Identify each person involved in the decision to no longer suspend the application of the Exclusion for the calendar year 2018.

The Defendants renew their objection that this interrogatory is overly broad and calls for privileged and confidential information.

The Board of Trustees for the State Health Plan did not make a decision to "no longer suspend the application of the Exclusion" in 2017. In December 2016, the Board of Trustees for the State Health Plan voted to suspend the coverage exclusion for the 2017 Plan year only. At the Board's meeting in September 2017, members of the public asked the Board to expand coverage under the 2018 plan to include gender transition treatment. No member of the Board made a motion to implement this request at either the September 2017 or November 2017 meetings. By operation of law, pursuant to the 2016 decision by the Board, the Plan's coverage exclusion was reinstated on January 1, 2018.

As a member of the Board of Trustees for the State Health Plan, Defendant Folwell will have information about the 2017 meetings of the Board of Trustees for the State Health Plan. Defendant Jones, who became the Administrator of the State Health Plan in June 2017, will also have relevant information from that point forward. Other individuals with relevant information would include members of the Board of Trustees in 2017: Peter Chauncey, Kim Hargett, Donald Martin, Aaron McKethan, Elizabeth Poole, David Rubin, Margaret Way, and Paul Cunningham, MD.

Employees of the Office of the State Treasurer who may have information about the 2017 process to determine benefits for the 2018 Plan year would include Andrew Norton (former Deputy General Counsel for the State Health Plan), Sam Hayes (former General Counsel for the Office of the State Treasurer), Chris Farr (Chief of Staff for the Office of the State Treasurer), and Frank Lester (Deputy Treasurer, Communications and Government Affairs for the Office of the State Treasurer).

Finally, to the extent the application of the exclusion beyond the 2017 plan year was discussed prior to Defendant Jones joining the Plan in June 2017, such discussions would have included Mona Moon (former Executive Administrator of the State Health Plan), Lotta Crabtree (former Deputy Executive Administrator and Deputy General Counsel for the State Health Plan), and Caroline Smart (Senior Director of Plan Integration for the State Health Plan).

7. For each person identified in response to Interrogatory 6, describe in detail that person's involvement in the decision to no longer suspend the application of the Exclusion for the calendar year 2018.

The Defendants object that this interrogatory is overly broad and calls for privileged and confidential information.

The State Health Plan's Board of Trustees makes decisions about the benefits offered by the Plan for each Plan year. The Board of Trustees did not decide to "no longer suspend the application of the Exclusion" after the 2017 Plan year. Rather, no member of the Board of Trustees brought forward a motion to suspend the coverage exclusion and thereby offer coverage for gender transition for the 2018 Plan year. The Board did not, therefore, vote on this issue. Each member of the Board of Trustees would have information about why he or she did not make a motion to expand the Plan's benefits as requested by members of the public.

Defendant Folwell, as the Chair of the Board of Trustees, approves the final agenda for each meeting of the Board of Trustees. Defendant Jones, as the Administrator of the State Health Plan, is responsible for developing each agenda and presenting it, along with supporting material, to Board members. Defendant Jones also supervises the Plan employees who notified members of the public about the opportunity to advocate for expanded Plan benefits at the September 2017 Board meeting. These Plan employees gathered material from individuals who wished to provide written information for Board members to review.

Andrew Norton provided legal advice to the Treasurer about the Plan's obligations under Section 1557 of the Affordable Care Act. As the General Counsel for the Office of the State Treasurer, Sam Hayes discussed this legal advice with Mr. Norton.

Ms. Farr and Mr. Lester do not have a direct policy role with regard to the State Health Plan. Ms. Farr was present at 2017 meetings involving Treasurer Folwell and State Health Plan employees as an observer, and Mr. Lester may have discussed policy matters as an advisor to Treasurer Folwell.

Ms. Moon, Ms. Crabtree, and Ms. Smart were responsible for managing plan benefits under the prior administration and may have discussed application of the exclusion beyond the 2017 plan year prior to the transition in the leadership of the State Health Plan.

8. Describe in detail the factual basis for the assertion in the "Statement from Treasurer Dale R. Folwell, CPA, on State Health Plan Coverage of Sex Change Operations," dated October 25, 2018 (Bates stamped KADEL 004060-61), that "[t]he legal and medical uncertainty of this elective, non-emergency procedure has never been greater."

specifically discussing the coverage exclusion with particular individuals, but he believes it is probable this was one of many issues he discussed informally.

10. For calendar year 2017, separately identify the cost of counseling and/or therapy, hormone-related therapy, and surgery for Gender-Confirming Healthcare.

The Defendants object that this interrogatory is overly broad and calls for privileged and confidential information. The Defendants further object to this interrogatory because "Gender-Confirming Healthcare" is not a medical term and because Plaintiffs' use and definition of the term "Gender-Confirming Healthcare" is otherwise vague, ambiguous, and confusing. The full extent of the benefits denominated as "gender-confirming healthcare" under the Plaintiffs' theory of the case is not known by the Defendants. The Defendants can only provide information related to expenses incurred by the State Health Plan in 2017.

Blue Cross and Blue Shield of North Carolina has identified $784,923.28 in billed claims during calendar year 2017 that would have been excluded had the coverage exclusion remained in effect. After reductions for the allowed amount for each charge, and exclusion of non-covered expenses, Blue Cross and Blue Shield reports that gender transition treatment resulted in medical charges of $504,406.04. Of these charges, the Plan paid $404,609.26, and other payers (the insured participant or, if applicable, a co-insurer of the participant) paid $99,796.78.

These figures do not include payments by the Plan's pharmacy benefit manager, CVS/Caremark, for medications related to gender transition. CVS/Caremark is still working to identify prescription costs that would have been excluded in 2017 had the coverage exclusion been in effect. The Plan will supplement its answer to this Interrogatory when this information is available.

These figures also do not include any costs incurred for coverage of State Health Plan members enrolled in a Medicare Advantage plan. For 2017, United Healthcare administered the State Health Plan's Medicare Advantage plans, which are fully insured plans. That is, the State Health Plan purchases this insurance coverage for eligible Plan members, but the State Health Plan does not have access to claim information.

Dated this 9th day of October, 2020.

Respectfully submitted by,

/s/ James Benjamin Garner
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VERIFICATION

I, Dale Folwell, state that I have read Plaintiffs' First Set of Interrogatories and my answers to those interrogatories, which are true to the best of my knowledge, information, and belief. I declare under penalty of perjury that the foregoing is true and correct.

VERIFICATION

I, Dee Jones, state that I have read Plaintiffs' First Set of Interrogatories and my answers to those interrogatories, which are true to the best of my knowledge, information, and belief. I declare under penalty of perjury that the foregoing is true and correct.

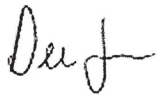

Exhibit 4

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF NORTH CAROLINA
Civil Action No. 1:19-cv-00272

MAXWELL KADEL; JASON FLECK; CONNOR THONEN-FLECK, by his next friends and parents, JASON FLECK and ALEXIS THONEN; JULIA MCKEOWN; MICHAEL D. BUNTING, JR.; C.B., by his next friends and parents, MICHAEL D. BUNTING, JR. and SHELLEY K. BUNTING; and SAM SILVAINE, Plaintiffs, v. DALE FOLWELL, in his official capacity as State Treasurer of North Carolina; DEE JONES, in her official capacity as Executive Administrator of the North Carolina State Health Plan for Teachers and State Employees; UNIVERSITY OF NORTH CAROLINA AT CHAPEL HILL; NORTH CAROLINA STATE UNIVERSITY; UNIVERSITY OF NORTH CAROLINA AT GREENSBORO; and NORTH CAROLINA STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES, Defendants.	)

OBJECTIONS AND RESPONSES OF DEFENDANTS DALE FOLWELL AND DEE JONES TO UNIVERSITY DEFENDANTS' FIRST SET OF REQUESTS FOR ADMISSION AND INTERROGATORIES

Dale Folwell and Dee Jones respond to the University Defendants' First Set of Requests for Admission and Interrogatories as follows:

REQUESTS FOR ADMISSION

1. Admit that pursuant to state law, the State Treasurer, the Executive Administrator, and the Board of Trustees of the State Health Plan must administer one or more group health plans for eligible State employees, eligible retired employees, and certain of their eligible dependents that are comprehensive in coverage.

ANSWER: The University Defendants' Request for Admission appears to restate, without change, state law codified at N.C. Gen. Stat. § 135-48.2(a). The Plan Defendants assume that this Request for Admission does not imply a particular interpretation of state law, only that the Plan Defendants admit that North Carolina law imposes such a requirement upon the Plan Defendants. With this clarification, this request is admitted.

2. Admit that the State Treasurer has the responsibility and duty to administer and operate the State Health Plan.

ANSWER: The University Defendants' Request for Admission appears to restate, without change, a portion of state law codified at N.C. Gen. Stat. § 135-48.30(a)(1). The Plan Defendants assume that this Request for Admission does not imply a particular interpretation of state law, only that the Plan Defendants admit that North Carolina law imposes such a requirement upon the Treasurer. With this clarification, this request is admitted.

3. Admit that the State Treasurer, the Executive Administrator, and the Board of Trustees of the State Health Plan are fiduciaries to the State Health Plan.

ANSWER: The University Defendants' Request for Admission appears to refer to the duties imposed by state law upon the Treasurer, the Executive Administrator of the Plan, and the Board of Trustees as codified at N.C. Gen. Stat. § 135-48.2(a). This request may also refer to N.C. Gen. Stat. § 147-69.7, which requires that the Treasurer act as a fiduciary for the funds under his management. The Plan Defendants assume that this Request for Admission does not imply a particular interpretation of state law, only that the Plan Defendants admit that North Carolina law imposes such a requirement upon the Treasurer. With this clarification, this request is admitted.

4. Admit that the State Treasurer has the power and duty to set benefits, premium rates, co-pays, deductibles, and coinsurance percentages and maximums, subject to approval by the Board of Trustees of the State Health Plan.

ANSWER: The University Defendants' Request for Admission appears to restate, without change, a portion of state law codified at N.C. Gen. Stat. § 135-48.30(a)(2). The Plan Defendants assume that this Request for Admission does not imply a particular interpretation of state law, only that the Plan Defendants admit that North Carolina law imposes such responsibility upon the Treasurer. With this clarification, this request is admitted.

5. Admit that state law requires that all eligible new University employees must be given the opportunity to enroll or decline enrollment in the State Health Plan for themselves and their dependents within 30 days from the date of employment or from first becoming eligible.

ANSWER: The University Defendants' Request for Admission appears to restate several discrete requirements of state law. Under N.C. Gen. Stat. § 135-48.43(a)(2), new employees apply for coverage "to be effective on the first day of the month following employment." The provision allowing employees to file their application for health insurance within 30 days after beginning employment is N.C. Gen. Stat. § 135.48.42(a). The authority for University employees to participate in the State Health Plan is N.C. Gen. Stat. § 135-48.40(b). The Plan Defendants assume that this Request for Admission does not imply a particular interpretation of state law, only that the Plan Defendants admit that enrollment in the State Health Plan operates in the manner described. The Plan Defendants further assume that this Request for Admission recognizes that, while 30 days is the requirement under state law, this same law incorporates such exceptions to this requirement as are required by federal law. N.C. Gen. Stat. § 135-48.42. With these clarifications, this request is admitted.

6. Admit that the North Carolina General Statutes do not authorize or empower the University of North Carolina or its constituent universities to purchase at Employer-Cost employee health insurance supplemental to, alternative to, or otherwise differing from to the coverage provided by the State Health Plan.

ANSWER: Denied. N.C. Gen. Stat. § 116-17.2 provides authority to the University Defendants for a "plan of flexible compensation to eligible employees of constituent

institutions for benefits available under Section 125 and related sections of the Internal Revenue Code of 1986 as amended." This authority exists when a benefit is not available under the State Health Plan. The Plan Defendants concede that treatment for gender dysphoria is not available under the State Health Plan, so the University Defendants can use this authority to provide such a benefit to Plaintiffs and others similarly situated. The opportunity to enroll in the State Health Plan is a part of the compensation package provided to state employees. The General Statutes of North Carolina permit the University Defendants to set compensation for employees, so long as this compensation does not provide benefits that are available under the State Health Plan. Treatment for gender dysphoria is not such a benefit, and the Plan Defendants assert that the University Defendants can use existing employment authorities to provide for payment for such services.

7. Admit that neither the University of North Carolina nor its constituent universities have any role or participation in determining plan design of the State Health Plan, the benefits offered, the amount of copays and deductibles, the amount of employer contributions to be paid to the State Health Plan for each covered State employee, or the amount of premiums to be paid by State employees to the State Health Plan for their coverage.

ANSWER: Denied. The University Defendants are both authorized and encouraged to participate in the consideration of State Health Plan benefits by the Board of Trustees at its meetings. Indeed, employees of the University Defendants have communicated to the Board of Trustees about expanding plan benefits, including the benefits at issue in this case. *See*, *e.g.*, PLAN DEF 49734 (Letter to Board of Trustees from Andy DeRoin, Program Coordinator for the GLBT Center at NC State University).

8. Admit that the neither the University of North Carolina nor its constituent universities have any discretion or ability to determine eligibility and coverage under the State Health Plan.

ANSWER: Denied. The University Defendants sweeping assertion that they lack "any discretion or ability" reflects a view that the University Defendants have no role in the benefit process. As noted in the response to Request for Admission #7, this is incorrect. To the extent that the University Defendants make the more limited assertion that plan benefits and plan premiums are determined by the State Treasurer, subject to approval by the Board of Trustees for the State Health Plan, this more limited assertion is admitted.

Exhibit 5

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF NORTH CAROLINA
Civil Action No. 1:19-cv-00272

MAXWELL KADEL, *et al.*,	)
Plaintiffs,	)
v.	)
DALE FOLWELL, in his official capacity as State Treasurer of North Carolina, *et al.*,	)
Defendants.	)

OBJECTIONS AND RESPONSES OF DEFENDANT NORTH CAROLINA STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES TO PLAINTIFFS' FIRST REQUESTS FOR ADMISSION, INTERROGATORIES, AND REQUESTS FOR PRODUCTION OF DOCUMENTS AND THINGS

The North Carolina State Health Plan for Teachers and State Employees responds to the Plaintiffs as follows:

REQUESTS FOR ADMISSION

1. Admit that NCSHP receives federal financial assistance from the U.S. Department of Health and Human Services, including any of its component agencies.

Response: The Plaintiffs' request does not include a definition of "federal financial assistance," which is a legal term used in § 1557 (42 U.S.C. 18116). The U.S. Department of Health and Human Services has interpreted this phrase twice, in 2016 and in 2020. The validity of these rulemakings is before other federal courts. Whether, and to what extent, the Plan receives federal financial assistance within the meaning of § 1557 is not discernable at this time.

With that qualification, the Plan admits that it receives quarterly payments under the Retiree Drug Subsidy from the U.S. Department of Health and Human Services.

2. Admit that NCSHP partially or fully covers hormone therapy for some diagnoses not related to Gender-Confirming Healthcare.

Response: The Defendant objects to this request because "Gender-Confirming Healthcare" is not a medical term and because Plaintiffs' use and definition of the term "Gender-Confirming Healthcare" is vague, ambiguous, and confusing. This term is also not a legal term or a term of art used by the Plan when determining whether a healthcare provider will be reimbursed for the cost of covered benefits. At this time, the specific benefits denominated as "gender-confirming healthcare" under the Plaintiffs' theory of the case is not known by the Defendant, and the Plaintiffs' definition in this request includes "any healthcare, physical, mental, or otherwise, administered or prescribed for the treatment of gender dysphoria, related diagnoses, or gender transition." Subject to and without waiving the foregoing objections, after reasonable inquiry, the information known or that can be reasonably obtained by Defendant is insufficient to enable Defendant to admit or deny this request from the Plaintiffs.

With greater particularity, the Plan admits that, under some circumstances, it covers prescription testosterone products for certain FDA-approved treatments. These FDA-approved uses are treatment of chromosomal males diagnosed with primary hypogonadism (congenital or acquired) and hypogonadotropic hypogonadism (congenital or acquired). The Plan also covers "brief treatment with conservative doses" of testosterone for "carefully selected [chromosomal] males with clearly delayed puberty." Finally, under certain circumstances, the Plan covers prescription testosterone for chromosomal females diagnosed with breast cancer.

The Plan admits that, under some circumstances, it covers prescription Supprelin for the FDA-approved treatment of the diagnosis of central precocious puberty in chromosomal females up to age 12 and chromosomal males up to age 13.

The Plan admits that, under some circumstances, it covers prescription Triptodur for the FDA-approved treatment of the diagnosis of central precocious puberty in chromosomal females up to age 12 and chromosomal males up to age 13.

Upon information and belief after reasonable inquiry, the Plan admits that it covers prescriptions for estrogen for beneficiaries. After reasonable inquiry and upon information and belief, the Plan's coverage for prescription estrogen does not depend on the member's diagnosis. Therefore, after reasonable inquiry and upon information and belief, the Plan cannot admit or deny whether it covers the prescription of estrogen for diagnoses related to—or not related to—gender-confirming healthcare.

3. Admit that NCSHP partially or fully covers mammoplasty and/or breast reconstruction surgery for some diagnoses not related to Gender-Confirming Healthcare.

Response: The Defendant objects to this request because "Gender-Confirming Healthcare" is not a medical term and because Plaintiffs' use and definition of the term "Gender-Confirming Healthcare" is vague, ambiguous, and confusing. This term is also not a legal term or a term of art used by the Plan when determining whether a healthcare provider will be reimbursed for the cost of covered benefits. At this time, the specific benefits denominated as "gender-confirming healthcare" under the Plaintiffs' theory of the case is not known by the Defendant, and the Plaintiffs' definition in this request includes "any healthcare, physical, mental, or otherwise, administered or prescribed for the treatment of gender dysphoria, related diagnoses, or gender transition." Subject to and without waiving the foregoing objections, after reasonable inquiry, the information known or that can be reasonably obtained by Defendant is insufficient to enable Defendant to admit or deny this request as provided by the Plaintiffs.

Upon information and belief, the Plan admits that it covers mastectomies as a treatment for individuals diagnosed with breast cancer. Further, the Plan notes that under the federal Women's Health and Cancer Rights Act of 1998, certain health plans that provide coverage for a mastectomy must also cover breast reconstruction for that beneficiary. 29 U.S.C. 1185b. The Plan has not identified any statement or other decision to opt out of this federal requirement. Therefore, upon information and belief, the Plan admits that it covers breast reconstruction consistent with the Women's Health and Cancer Rights Act.

4. Admit that NCSHP partially or fully covers vaginoplasty for some diagnoses not related to Gender-Confirming Healthcare.

Response: The Defendant objects to this request because "Gender-Confirming Healthcare" is not a medical term and because Plaintiffs' use and definition of the term "Gender-Confirming Healthcare" is vague, ambiguous, and confusing. This term is also not a legal term or a term of art used by the Plan when determining whether a healthcare provider will be reimbursed for the cost of covered benefits. At this time, the specific benefits denominated as "gender-confirming healthcare" under the Plaintiffs' theory of the case is not known by the Defendant, and the Plaintiffs' definition in this request includes "any healthcare, physical, mental, or otherwise, administered or prescribed for the treatment of gender dysphoria, related diagnoses, or gender transition." Subject to and without waiving the foregoing objections, after reasonable inquiry, the information known or that can be reasonably obtained by Defendant is insufficient to enable Defendant to admit or deny this request as provided by the Plaintiffs.

5. Admit that NCSHP partially or fully covers hysterectomy for some diagnoses not related to Gender-Confirming Healthcare.

Response: The Defendant objects to this request because "Gender-Confirming Healthcare" is not a medical term and because Plaintiffs' use and definition of the term "Gender-Confirming Healthcare" is vague, ambiguous, and confusing. This term is also not a legal term or a term of art used by the Plan when determining whether a healthcare provider will be reimbursed for the cost of covered benefits. At this time, the specific benefits denominated as "gender-confirming healthcare" under the Plaintiffs' theory of the case is not known by the Defendant, and the Plaintiffs' definition in this request includes "any healthcare, physical, mental, or otherwise, administered or prescribed for the treatment of gender dysphoria, related diagnoses, or gender transition." Subject to and without waiving the foregoing objections, after reasonable inquiry, the information known or that can be reasonably obtained by Defendant is insufficient to enable Defendant to admit or deny this request as provided by the Plaintiffs.

6. Admit that the cost of Gender-Confirming Healthcare for calendar year 2017 did not exceed the cost estimate provided by Segal Consulting in its "Transgender Cost Estimate" memorandum addressed to Mona Moon, dated November 29, 2016 (Bates stamped KADEL 000036-37).

Response: The Defendant objects to this request because "Gender-Confirming Healthcare" is not a medical term and because Plaintiffs' use and definition of the term "Gender-Confirming Healthcare" is vague, ambiguous, and confusing. This term is also not a legal term or a term of art used by the Plan when determining whether a healthcare provider will be reimbursed for cost of a covered benefit. At this time, the specific benefits denominated as "gender-confirming healthcare" under the Plaintiffs' theory of the case is not known by the Defendant, and the Plaintiffs' definition in this request includes "any healthcare, physical, mental, or otherwise, administered or prescribed for the treatment of gender dysphoria, related diagnoses, or gender transition." Subject to and without waiving the foregoing objections, after reasonable inquiry, the information known or that can be reasonably obtained by Defendant is insufficient to enable Defendant to admit or deny this request as provided by the Plaintiffs.

Further, the Segal Consulting memorandum does not define the "cost of treatment," which it notes was "provided at a very high level" by Blue Cross and Blue Shield of North Carolina. The Plan's experience has been that Blue Cross and Blue Shield of North Carolina is unwilling to disclose publicly the specific per-procedure costs it has negotiated with providers. Therefore, it is unclear whether the Segal cost estimates refer to (1) the payment requests from medical providers; (2) the allowed payments authorized after discounts negotiated with the medical providers; or (3) the amount paid by the State Health Plan after other deductibles and co-insurance payments are applied. Finally, Segal Consulting provided a range of potential cost: between $344,013 and $862,292. There is not a single "cost estimate" value.

In addition, the Defendant cannot identify the costs incurred for coverage of State Health Plan members enrolled in a Medicare Advantage plan. For 2017, United Healthcare administered the State Health Plan's Medicare Advantage plans, which are fully insured plans. That is, the State Health Plan purchases this insurance coverage for eligible Plan members, but the State Health Plan does not have access to claim information.

Information provided from Blue Cross and Blue Shield of North Carolina for the 2017 Plan year indicates that $784,923.28 was billed to the State Health Plan for medical treatment that BCBS indicated would have been excluded had the coverage exclusion remained in effect. After reductions, the Plan incurred $504,406.04 in allowed expenses. After Plan participants or other insurers paid their portion, the Plan paid $404,609.26.

7. Admit that Gender-Confirming Healthcare can be medically necessary treatment for gender dysphoria in at least some patients.

Response: The Defendant objects to this request because "Gender-Confirming Healthcare" is not a medical term and because Plaintiffs' use and definition of the term "Gender-Confirming Healthcare" is vague, ambiguous, and confusing. This term is also not a legal term or a term of art used by the Plan when determining whether a healthcare provider will be reimbursed for cost of a covered benefit. At this time, the specific benefits denominated as "gender-confirming healthcare" under the Plaintiffs' theory of the case is not known by the Defendant, and the Plaintiffs' definition in this request includes "any healthcare, physical, mental, or otherwise, administered or prescribed for the treatment of gender dysphoria, related diagnoses, or gender transition." Subject to and without waiving the foregoing objections, after reasonable inquiry, the information known or that can be reasonably obtained by Defendant is insufficient to enable Defendant to admit or deny this request as provided by the Plaintiffs. Defendant further objects to this request because the term "medically necessary treatment" is vague, ambiguous, and confusing.

After reasonable inquiry, the Defendant is unable to admit or deny the Plaintiffs' request for admission. The Defendant cannot admit or deny a hypothetical question about medical treatment for an unknown patient with an unknown medical history and unknown medical needs. The Plaintiffs' request provides no information about whether biological disorders of sex development are present or the individual has only a psychiatric diagnosis of gender dysphoria. Moreover, the term "medically necessary" is used by insurance companies to determine whether medical treatment (and insurance coverage) should be provided. That is, whether a treatment is "medically necessary" is decided before treatment occurs. Medical necessity determinations do not necessarily correlate to or guarantee effective outcomes.

8. Admit that NCSHP acts as an agent for North Carolina government employers who participate in NCSHP.

Response: The Defendant objects to this request because the term "agent" is vague, ambiguous, and confusing. Further, it is unclear whether Plaintiffs' request seeks an admission regarding the undefined term "agent" as it appears in Title VII (42 U.S.C. 2000e(b)) or "agent" as defined and interpreted in some other legal context. Subject to the foregoing objections, denied.

9. Admit that NCSHP acts as a joint employer with participating North Carolina government employers.

Response: The Defendant objects to this request because the term "joint employer" is vague, ambiguous, and confusing. Further, it is unclear whether Plaintiffs' request seeks an admission with regard to the Fourth Circuit's caselaw regarding the liability of joint employers under Title VII (*see*, *e.g.*, *Butler v. Drive Auto. Indus. of Am., Inc.*, 793 F.3d 404 (4th Cir. 2015)) or as defined and interpreted in some other legal context. Subject to the foregoing objections, denied.

10. Admit that participating North Carolina government employers delegate control over employee health benefits to NCSHP.

Response: The Defendant objects to this request because the term "delegate[s] control" is vague, ambiguous, and confusing. Subject to the foregoing objections, denied.

11. Admit that NCSHP has significant control over the terms of coverage in the health plans offered through NCSHP, including but not limited to control over the exclusions in those health plans.

Response: The Defendant objects to this request because the term "significant control" is vague, ambiguous, and confusing. The Defendant denies that the Plan has control over all coverage exclusions involving benefits in the health plans offered through the Plan. Some coverage exclusions are mandated by North Carolina law. Further, the request for admission does not address the more general limits on coverage created by the General Assembly's appropriations as well as the cap on the employer premium that can be charged by the Plan. The Defendant notes that certain federal requirements also influence coverage available under the Plan. Subject to these qualifications, the Defendant admits that, under North Carolina General Statute 135-48.30(a)(2), the Treasurer—subject to the approval of the Plan Board of Trustees—has the power and duty to set benefits, premium rates, co-pays, deductibles, and coinsurance percentages and maximums.

12. Admit that NCSHP determines the terms of coverage in the health plans offered through NCSHP.

Response: The Defendant objects to this request to the extent that the phrase "terms of coverage" is vague, ambiguous, and confusing. The Defendant has an understanding of how this phrase is used within its operations, but it is unclear whether the Plaintiffs share this definition or have a different one.

The Defendant denies that the Plan determines the terms of coverage of the Plan, without qualification. This request for admission does not address the limits on coverage created by the General Assembly's appropriations or the cap on the premium that can be charged to employers by the Plan. The Defendant notes that certain federal laws also influence the coverage available under the Plan.

In addition, the Plan has contracted with Blue Cross and Blue Shield of North Carolina to act as the Plan's third-party administrator and CVS/Caremark to act as the Plan's Pharmacy Benefit Manager. Both contractors are responsible for administering the Plan benefits as described in the Plan Benefit Book. Upon information and belief, to the extent that the Plan Benefit Book is silent about whether a specific procedure or medication is covered, the third-party administrator generally defaults to the terms of coverage used by that contractor in other plans. After reasonable inquiry and upon information and belief, however, the Plan cannot admit or deny whether this is the case for all treatment for all diagnoses.

Finally, the Plan does not determine the terms of coverage for the Medicare Advantage Plan offered to the Plan's Medicare-eligible employees and retirees. These Plans (which have been provided since 2016 by Humana or United Healthcare, depending on the Plan year), are fully insured health plans. To the extent that the Plan makes a decision about the terms of coverage for Medicare Advantage participants, that determination takes place in the selection of a particular insurance company as the Medicare Advantage plan provider.

Subject to these qualifications, the Defendant admits that, under North Carolina General Statute 135-48.30(a)(2), the Treasurer—subject to the approval of the Plan Board of Trustees—has the power and duty to set benefits, premium rates, co-pays, deductibles, and coinsurance percentages and maximums.

13. Admit that NCSHP determines the services that are excluded from coverage through NCSHP's health plans.

Response: The Defendant objects to this request to the extent that the phrase "terms of coverage" is vague, ambiguous, and confusing. The Defendant has an understanding of how this phrase is used within its operations, but it is unclear whether the Plaintiffs share this definition or have a different one.

The Defendant denies that the Plan determines all coverage exclusions involving Plan benefits. Some coverage exclusions are mandated by North Carolina law. Further, the request for admission does not address the more general limits on coverage created by the General Assembly's appropriations as well as the cap on the premium that can be charged by the Plan. The Defendant notes that federal requirements also influence the coverage available under the Plan.

In addition, the Plan has contracted with Blue Cross and Blue Shield of North Carolina to act as the Plan's third-party administrator and CVS/Caremark to act as the Plan's Pharmacy Benefit Manager. Both contractors are responsible for administering the Plan benefits as described in the Plan Benefit Book. Upon information and belief, to the extent that the Plan Benefit Book is silent about whether a specific procedure or medication is covered, the third-party administrator generally defaults to the terms of coverage used by that contractor in other plans. After reasonable inquiry and upon information and belief, however, the Plan cannot admit or deny whether this is the case for the treatment of all diagnoses applicable to all diagnoses.

Finally, the Plan does not determine the terms of coverage for the Medicare Advantage Plan offered to the Plan's Medicare-eligible employees and retirees. These Plans (which have been provided since 2016 by Humana or United Healthcare, depending on the Plan year), are fully insured health plans. To the extent that the Plan makes a decision about the terms of coverage for Medicare Advantage participants, that determination takes place in the selection of a particular insurance company as the Medicare Advantage plan provider.

Subject to these qualifications, the Defendant admits that, under North Carolina General Statute 135-48.30(a)(2), the Treasurer—subject to the approval of the Plan Board of Trustees—has the power and duty to set benefits, premium rates, co-pays, deductibles, and coinsurance percentages and maximums.

14. Admit that NCSHP is responsible for administering the insurance coverage offered to participating employees.

Response: The Defendant objects to the request because the phrase "administering" is vague, ambiguous, and confusing, and the phrase could be interpreted to include actions that are not conducted by the Plan. This includes face-to-face interactions with new employees, which is administered by the employers of each new employee. Further, significant administrative responsibilities are carried out by Plan contractors, including Blue Cross and Blue Shield of North Carolina (the Plan's Third-Party Administrator), CVS/Caremark (the Plan's Pharmacy Benefit Manager), and the Plan's fully-insured

Medicare Advantage plan administrator (currently Humana beginning January 1, 2021, previously United Healthcare).

Subject to these qualifications, the Plan admits that North Carolina law requires the Plan to administer one or more group health plans that are comprehensive in coverage. N.C. Gen Stat. § 135-48.2(a).

INTERROGATORIES

1. Describe in detail any sources of federal funding Defendant NCSHP has received since 2014, including but not limited to any grants, contracts, or other forms of federal financial assistance.

Response: The Defendant objects that this interrogatory is overly broad and burdensome. The Plan receives funding each year through the Retiree Drug Subsidy. The Plan receives no other federal funding.

2. Describe in detail the fiscal sustainability of NCSHP including the basis for Treasurer Folwell's estimates that NCSHP has a $28 billion unfunded liability, and any policies (those adopted and not yet adopted) to address this unfunded liability.

Response: The Defendant objects that this interrogatory is overly broad, burdensome, and to the extent that it purports to seek the views of a separate defendant, Treasurer Folwell, it is misdirected.

For several decades, while retirees from North Carolina state and local government were eligible for health care coverage under the Plan, there was no money set aside to pay for the cost of this health care. The State Health Plan is funded by annual appropriations by the North Carolina General Assembly. In recent years, the North Carolina General Assembly has appropriated for an increase in health care costs of about 4% on average over the fiscal biennium. At the same time, the annual rate of inflation for health care costs has been significantly higher (approximately 7% annually) than that appropriation or the rate of inflation for the economy as a whole.

The most recent estimate of the Plan's unfunded liability by The Segal Group, which conducts an annual actuarial evaluation, is $27.7 billion as of June 30, 2020. The Plan, and its leadership, have been actively seeking to reduce this overall liability since 2017. Some policy initiatives have required the approval of the General Assembly, but the policies listed below have been sought and supported by the Plan and its leadership.

High-profile policies or decisions to improve the Plan's long-term sustainability that have been proposed, adopted, or implemented since 2017 have included:

(a) Increased use of a Medicare Advantage plan for Medicare-eligible retirees. In the open enrollment in October 2017, the Plan automatically enrolled eligible retirees in its Medicare Advantage plan, rather than asking these members to select a health plan option. Members still have the ability to leave the Medicare Advantage plan and choose a different Plan option, but this policy decision has resulted in approximately $35 million in savings. In addition, the Plan has moved to a competitive bidding process for the Medicare Advantage Plan. In 2020, Humana was selected. In January 2021, the Plan transitioned its retirees to the Humana plan from the United Healthcare plan. This change is expected to generate $590 million in savings over three years.

(b) Elimination of the subsidy for retiree health care benefits for members hired after January 1, 2021. This reform was enacted by the General Assembly in 2017.

(c) Competitive bidding for Third-Party Administration services for the Plan. In 2020, the Plan awarded a new contract to Blue Cross and Blue Shield of North Carolina for its administrative support to the Plan. Under this new contract, the Plan estimates administrative cost savings of at least $20 million per year.

(d) The Clear Pricing Project. The Plan has aggressively sought to link Plan payments for health care services to the Medicare payment rate for the same services. While this policy has not been fully adopted by all providers, the Plan created the "N.C. State Health Plan Network" effective January 1, 2020. Plan beneficiaries who select a provider from this network will have no co-pay for primary care visits and the co-pay for visits to specialist providers is also reduced. In return, the providers in this network agreed to be reimbursed for services at the Medicare rate plus approximately 60%.

(e) Since 2017, the Plan has generally avoided increasing benefits for Plan participants. The minutes of the Board of Trustees reflect all instances in which adjustments to coverage were made after a routine review of current benefit offerings or specific medical recommendations for clinically effective treatments. A review of the Plan's coverage benefits since 2017 demonstrates that Plan benefits have remained relatively static, year-over-year.

3. Describe in detail the factual basis for each governmental interest that you contend supports the Exclusion.

Response: The Defendants object that this interrogatory is overly broad, burdensome, and calls for privileged and confidential information.

Decisions about new benefits for the Plan, and the permanent removal of an exclusion that has the effect of creating a new benefit, are reviewed within the overall goals of the Board of Trustees and the Plan leadership. In 2016, the Treasurer identified goals for the Plan: reducing the Plan's unfunded liability, providing a more affordable family

premium for participants, and providing transparency to taxpayers about spending decisions.

In 2018, when the Board of Trustees declined to adopt the benefit proposed by the Plaintiffs, the Treasurer put forward several government interests. The Plan asserts that each reason justifies the decision not to permanently eliminate the existing coverage exclusion.

First, as noted by the Treasurer, legal uncertainty surrounds the federal requirement that the Plan eliminate its coverage exclusion. In December 2016, the Plan was advised that a federal regulation mandated elimination of the coverage exclusion as a condition of federal funding. This regulatory requirement was enjoined by a federal court later that same month, and, upon information and belief, that injunction remains in effect in 2021. In 2020, the Department of Health and Human Services amended its regulations and removed the federal requirement. Legal challenges to this 2020 regulation are also currently pending. At this time, it is unclear whether the 2016 regulation, the 2020 regulation or no regulation speaks to the coverage exclusion.

Second, as the Treasurer noted, medical uncertainty exists about the treatments sought by the Plaintiffs. The Plan remains unaware of any objective test to identify individuals suffering from gender dysphoria who will benefit from the hormonal and surgical treatments sought by the Plaintiffs. For minors, the Plan is unaware of any methodology to reliably distinguish between children for whom gender dysphoria will resolve without hormonal therapy or surgical intervention and those for whom it will not. (The Plan does not limit counseling or other mental health care for individuals suffering from gender dysphoria. Upon information and belief, the coverage exclusion affects only pharmacological and surgical treatment of gender dysphoria. Services such as counseling for a patient with gender dysphoria are limited only by the generally applicable Plan restrictions on mental health services.)

The Plan lacks a definite understanding of which prescription drugs, and which surgeries, the Plaintiffs believe should be covered for treatment of gender dysphoria. As noted in the Defendant's expert reports, the FDA has not approved any drugs for treatment of gender dysphoria.

The Plan has not identified any valid, reliable, peer-reviewed longitudinal studies that support the efficacy of the Plaintiffs' desired treatments. The Plan notes that during the pendency of this case, the American Journal of Psychiatry issued a correction to an article that claimed to find such evidence. The correction, after review by third-party experts, indicates that article's statistical analysis does not support its hypothesis that surgical intervention for transgender individuals reduces the need for mental health care.

In 2021, clinics in the United Kingdom, Sweden, and Finland ceased hormonal and surgical intervention for minors with gender dysphoria.

Finally, the Treasurer stated that he did not support addition of this benefit when many other plan participants have sought, but have not received, coverage for services that they desire. The members of the Board of Trustees have spoken to their understanding that they have a duty to use the Plan's limited resources in a manner that provides the best use of health care payments for the overall health of the Plan population. In the context of the Plan's overall fiscal condition, the Plan has been unable to identify a reasonable metric to distinguish the benefits sought by Plaintiffs from other uncovered medical treatments that affect small groups within the overall Plan's population.

4. For calendar year 2017, separately identify the cost of counseling and/or therapy, hormone-related therapy, and surgery for Gender-Confirming Healthcare.

Response: The Defendant objects that this interrogatory is overly broad, burdensome, and calls for privileged and confidential information. The Defendant further objects to this interrogatory because "Gender-Confirming Healthcare" is not a medical term and because Plaintiffs' use and definition of the term "Gender-Confirming Healthcare" is vague, ambiguous, and confusing. The full extent of the benefits denominated as "gender-confirming healthcare" under the Plaintiffs' theory of the case remains unknown. The Defendant can only provide information related to expenses incurred by the State Health Plan in 2017, recognizing that this information was gathered by third parties and provided to Plan employees.

Blue Cross and Blue Shield of North Carolina identified $784,923.28 in billed claims during calendar year 2017 that would have been excluded had the coverage exclusion remained in effect. After reductions for the allowed amount for each charge, and exclusion of non-covered expenses, Blue Cross and Blue Shield reports that gender transition treatment resulted in medical charges of incurred $504,406.04 in allowed expenses. After Plan participants or other insurers paid their portion, the Plan paid $404,609.26, and other payers (the insured participant or, if applicable, a co-insurer of the participant) paid $99,796.78.

These figures do not include payments by the Plan's pharmacy benefit manager, CVS/Caremark, for medications related to gender transition. After reasonable inquiry, the Plan has not been able to identify a reliable estimate of the cost of prescription drugs that were potentially covered in 2017 but were not covered after the suspension of the coverage exclusion lapsed.

Finally, the Plan does not have access to information about the costs incurred by State Health Plan members enrolled in a Medicare Advantage plan. The State Health Plan's

Medicare Advantage plan is fully insured. That is, the State Health Plan purchases insurance coverage for Medicare-eligible retirees and pays the premium for these Plan members. Humana, the current insurance provider (as well as United Healthcare, the prior provider) ensures that premiums are sufficient to cover expected claims. Moreover, the private insurance company, not the Plan, is responsible for payment if these premiums are insufficient. The State Health Plan therefore does not have access to claim information.

5. For calendar year 2017, separately identify the cost of counseling and/or therapy, hormone-related therapy, and surgery not relating to Gender-Confirming Healthcare.

Response: The Defendants object that this interrogatory is overly broad, burdensome, and calls for privileged and confidential information. The Defendants further object to this interrogatory because "Gender-Confirming Healthcare" is not a medical term and because Plaintiffs' use and definition of the term "Gender-Confirming Healthcare" is vague, ambiguous, and confusing. The full extent of the benefits denominated as "gender-confirming healthcare" under the Plaintiffs' theory of the case is not known by the Defendants.

Because, after reasonable inquiry, the Plan has not been able to develop a precise estimate of the cost of Gender-Confirming Healthcare, the Defendant cannot accurately provide the cost information that the Plaintiffs seek.

6. Describe in detail NCSHP's role in determining components of state employees' compensation, terms, conditions, or privileges of employment.

Response: The Defendants object that this interrogatory is overly broad, burdensome, and calls for privileged and confidential information.

The decision by an employee to participate in the Plan is voluntary and is available to all full-time employees on an equal basis. (The same premium is charged to each member who selects a specific coverage option.)

The Plan does not determine the compensation, terms, conditions, or privileges of employment for state employees, other than the approximately fifty employees of the Plan itself. Other full-time state employees, and the employees of non-state entities such as school districts and local governments, are offered the opportunity to participate in the State Health Plan by their employers. As noted in the Response to Request for Admission No. 13 (above), the North Carolina General Assembly determines the maximum amount that the Plan can charge to employers as a premium for coverage of an employee. Under North Carolina General Statute 135-48.30(a)(2), the Treasurer—subject to the approval of the Board of Trustees—sets benefits, premium rates, co-pays, deductibles, and coinsurance percentages and maximums when not otherwise set by law.

7. Describe in detail NCSHP's role in providing benefits in the form of health care coverage to state employees.

Response: The Defendant objects that this interrogatory is overly broad, burdensome and calls for privileged and confidential information.

The Plaintiffs' interrogatory misstates the role of the Plan and the health care coverage it provides. The Plan offers four coverage options to eligible participants. Enrollment is voluntary in the 80/20 Plan, the 70/30 Plan, the High Deductible Health Plan, or the Medicare Advantage Plan (for eligible retirees).

The North Carolina General Assembly appropriates funds and imposes, among other requirements and limitations, a maximum premium that may be charged to the employer for provision of health coverage to a Plan participant. In the immediate day-to-day operation of the plans listed above, the Plan staff ensure that state employees receive timely communication about the Plan, that Plan contractors implement the Plan policies, and that the resources allocated to the Plan are sufficient to meet current expected costs and ensure the statutorily-required reserve balance for unpaid claims. On a more long-term basis, the Plan and its staff are responsible for planning to ensure that the Plan remains financially sustainable within the larger context of significant health care inflation.

8. Describe in detail NCSHP's role in determining the terms of coverage in the health plans offered through NCSHP, including but not limited to the extent of control over the terms of those health plans and their exclusions.

Response: The Defendants object that this interrogatory is overly broad, burdensome, and calls for privileged and confidential information. As noted above, the General Assembly has statutorily mandated specific coverage exclusions. In addition, certain coverage requirements are imposed by federal law. The Treasurer and the Board of Trustees are responsible for ensuring that the remaining benefits provided by the Plan are financially sustainable in the short-term and into the future.

9. Describe in detail participating North Carolina government employers' delegation of control over employee health benefits to NCSHP.

Response: The Defendants object that this interrogatory is overly broad, burdensome, and calls for privileged and confidential information. The Plan disagrees with the Plaintiffs' view that North Carolina government employers have delegated control of employee health benefits to the Plan. Enrollment in the Plan is not required for state or local government employees. Enrollment in the Plan, at the determined premium costs, is an option that is made available to these individuals.

VERIFICATION

I, Dee Jones, state that I have read Plaintiffs' First Set of Interrogatories to the North Carolina State Health Plan for Teachers and State Employees and the answers to those interrogatories, which are true to the best of my knowledge, information, and belief. I declare under penalty of perjury that the foregoing is true and correct.

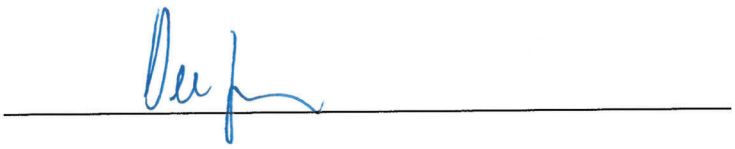

Exhibit 6

UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF NORTH CAROLINA
WINSTON-SALEM DIVISION
FILE No. 1:19-CV-00272-LCB-LPA

MAXWELL KADEL, *et al.* Plaintiffs, v. DALE FOLWELL, in his official capacity as State Treasurer of North Carolina, *et al.*, Defendants.	)	**DEFENDANT N. C. DEPARTMENT OF PUBLIC SAFETY'S RESPONSES TO PLAINTIFF'S FIRST SET OF INTERROGATORIES**

NOW COMES Defendant the North Carolina Department of Public Safety, and hereby respond to Plaintiff's First Set of Interrogatories, pursuant to Rules 26 and 33 of the Federal Rules of Civil Procedure as follows:

GENERAL RESPONSE AND OBJECTIONS

Each of The Department's responses, in addition to any specifically stated objections, is subject to and incorporates the following general responses and objections. The assertion of the same, similar, or additional objections or a partial response to any individual request does not waive any of The Department's general responses and objections.

1. The Department objects to every Interrogatory that calls for privileged information, including, without limitation, information protected by the attorney-client privilege.

2. The Department objects to every Interrogatory that calls for information prepared in anticipation of litigation or for trial absent a showing of substantial need by the Plaintiff

3. The Department objects to every Interrogatory that calls for information containing or reflecting the mental impressions, conclusions, opinions and/or legal theories of any

148-74. The records of prisoners in the custody of the Department of Public Safety ("DPS"), Division of Adult Correction ("DAC") are confidential and are not subject to inspection by the public or the inmate or those acting on behalf of the inmate. *Goble v. Bounds*, 13 N.C. App. 579, 186 S.E.2d 638, *aff'd* 281 N.C. 307, 188 S.E.2d 347 (1972). Except as otherwise noted, all documents referenced herein or provided herein are not in The Department possession or control, but have been provided to the undersigned Assistant Attorneys General at the direction of the Secretary for the limited purpose of the defense of this action under the Defense of State Employees Act, N.C.G.S. § 143-300.2 et seq. All such documents remain classified, confidential, privileged and under the control and direction of the Secretary.

1. Describe in detail all reasons for which Defendant has not made available employee healthcare coverage that is different from or supplemental to the NCSHP and which does not contain an Exclusion.

   ANSWER: It's the State Treasury Department's responsibility to provide the same coverage to all state employees.

2. Identify any person who is directly responsible for ensuring or coordinating the provision of NCSHP benefits to the employees of Defendant.

   ANSWER: Defendant objects to use of the phrase "ensuring or coordinating the provision of NCSHP benefits to the employees" as vague, not defined and imprecise. Without waiving, and subject to the foregoing objection, Defendant states that upon hiring, and annually during the open enrollment period, Health Benefit Representatives provide the benefits information to the employees to give them the information they need to determine if they would like to join the SHP.

3. Describe in detail all processes by which Defendant:

   a. registers its employees for coverage under the NCSHP, and maintain and end such registrations; and

      ANSWER: Upon hiring, and annually during the open enrollment period, Health Benefit Representatives provide the information to the employees to give them the information they need to determine if they

would like to join the SHP. Employees can enroll online through the Integrated HR payroll system. (formerly known as Beacon)

b. is involved, if at all, with employees' coverage under NCSHP. This includes, but is not limited to, any claims made for coverage under the NCSHP, processing employees' and Defendant's contributions to NCSHP, dealing with employees' under- or over-payments to NCSHP, and/or entering settlement agreements with employees regarding health benefits covered under NCSHP.

ANSWER: DPS would only be involved if an employee loses coverage of the State Health Plan due to non-payment of the employee's premium. This would only occur if an employee goes on leave without pay and there is no monthly paycheck from which the employee's monthly premium is able to be deducted. If the employee wants the coverage to be reinstated before the annual enrollment period, DPS will work with the employee to submit an exception request to the State Health Plan. The State Health Plan is responsible for approving the exception request and reinstating the coverage. DPS has no authority to reinstate the coverage.

4. Identify which steps, if any, in your answer to Interrogatory No. 3, require involvement by personnel of NCSHP and/or the Office of the State Treasurer.

ANSWER: DPS would work with the State Health Plan which is a part of the State Treasurer's Office to submit the exception request as described in 3b and await for the approval or denial to be made by the State Health Plan.

5. Identify any person with whom you consulted and any documents you reviewed in order to provide your answer to Interrogatory Nos. 1, 2, 3, and 4.

ANSWER: Charlene Shabazz Charlene Shabazz, CPM, SPHR, SHRM-SCP
HR Deputy Director for Safety, Health, WC, Benefits, Time/Leave and IBHS
NC Department of Public Safety

6. To the extent that you deny any Request for Admission, describe in detail the bases for each denial; and identify any person with whom you needed to consult and any documents you needed to review in order to provide your answer.

ANSWER: NCDPS did not deny any of the Requests for Admissions. See response to Request for Admission No. 4 for the response regarding the inability to admit or deny.

This the 18th day of June, 2021.

JOSHUA H. STEIN
ATTORNEY GENERAL

/s/ *Alan McInnes*
Alan McInnes
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Exhibit 7

UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF NORTH CAROLINA
WINSTON-SALEM DIVISION
FILE No. 1:19-CV-00272-LCB-LPA

MAXWELL KADEL, *et al.* Plaintiffs, v. DALE FOLWELL, in his official capacity as State Treasurer of North Carolina, *et al.*, Defendants.	)	**DEFENDANT N. C. DEPARTMENT OF PUBLIC SAFETY'S RESPONSES TO PLAINTIFF'S FIRST SET OF INTERROGATORIES**

NOW COMES Defendant the North Carolina Department of Public Safety, and hereby respond to Plaintiff's First Requests for Admission, pursuant to Rules 26 and 36 of the Federal Rules of Civil Procedure as follows:

REQUESTS FOR ADMISSION

1. Admit that Defendant is engaged in industry affecting commerce, has fifteen or more employees for each working day of twenty or more calendar weeks, and is not a corporation wholly owned by the United States, an Indian Tribe, or the District of Columbia.

   RESPONSE: Admitted.

2. Admit that Defendant contributes funding to NCSHP to help cover the health insurance cost of at least some of its employees.

   RESPONSE: Admitted. NCDPS pays $521.96 per month per employee.

This the 18th day of June, 2021.

JOSHUA H. STEIN
ATTORNEY GENERAL

/s/ *Alan McInnes*

Alan McInnes
Assistant Attorney General
N.C. State Bar No. 20938
N.C. Department of Justice
Public Safety Section
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Exhibit 8

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

State Health Plan for Teachers and State Employees

Traditional 70/30 PPO Plan

Benefits Booklet

January 1 – December 31, 2016

BlueCross BlueShield of North Carolina

NCHEALTH Smart
An initiative of the State Health Plan

Revised: August 3, 2016

Hospital			
Inpatient Medical Detoxification	**X**		**X**
Psychiatric Residential Treatment Center		**X**	**X**
Chemical Dependency Residential Treatment Center		**X**	**X**
Psychiatric Partial Hospitalization Program		**X**	**X**
Chemical Dependency Partial Hospitalization Program		**X**	**X**
Psychiatric Intensive Outpatient Program		**X**	**X**
Chemical Dependency Intensive Outpatient Program		**X**	**X**

**Continuing treatment certifications must be requested by the last date of any previously certified period. Otherwise, certification decisions by the* Mental Health Case Manager *are effective as of the date the request for certification is received by the* Mental Health Case Manager.

*The following notice applies only when you are responsible for obtaining *certification*. NOTICE: Your actual expenses for *covered services* may exceed the stated *coinsurance* percentage or *copayment* amount because actual *provider* charges may not be used to determine the plan's and *member's* payment obligations. For *out-of-network* benefits, you may be required to pay for charges over the *allowed amount* in addition to any *copayment* or *coinsurance* amount. In addition, certain services require *prior review* and *certification*. You are responsible for obtaining or having your *provider* obtain *certification* on your behalf if you go to an *out-of-network*, or out-of-state *provider*. Failure to obtain *certification* will result in a full denial of benefits.

Mental Health and Chemical Dependency Services Exclusions and Limitations

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

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

- Received after the coverage termination date, regardless of when the treated condition occurred, and regardless of whether the care is a continuation of care received prior to the termination
- For telephone consultations or web-based, online or other electronic evaluations, charges for failure to keep a scheduled visit, charges for completion of a claim form, charges for obtaining medical records, and late payment charges
- *Incurred* more than 18 months prior to the *member's* submission of a claim
- For *cosmetic* purposes for any reason, including but not limited to excess skin from the abdomen, arms or thighs, except as specifically covered by your health benefit plan
- For camisoles, or other clothing, post-mastectomy
- For any services that would not be necessary if a non-covered service had not been received, except for *emergency services* in the case of an *emergency*
- For benefits that are provided by any governmental unit except as required by law
- For services that are ordered by a court that are otherwise excluded from benefits under this health benefit plan
- For care that the *provider* cannot legally provide or legally charge or is outside the scope of license or *certification*
- Provided and billed by a licensed health care professional who is in training
- For any services provided and billed by a lactation consultant
- For breast pumps
- Available to a *member* without charge and/or care given to a *member* by a *provider* who is in a *member's* immediate family
- For any condition suffered as a result of any act of war or while on active or reserve military duty
- In excess of the *allowed amount* for services usually provided by one *doctor*, when those services are provided by multiple *doctors*
- For palliative, *cosmetic* or *routine foot care*
- For dental care, dentures, dental implants, oral orthotic devices, palatal expanders and orthodontics except as specifically covered by the Plan
- *Dental services* provided in a *hospital*, except when a hazardous condition exists at the same time or covered oral *surgery* services are required at the same time as a result of a bodily injury
- For any treatment or regimen, medical or surgical, for the purpose of reducing or controlling the weight of a *member* or for treatment of obesity, except for nutritional visits or surgical treatment of morbid obesity, or as specifically covered by your health benefit plan
- Bariatric surgery, except when provided at a Blue Distinction Center (BDC).
- Wigs, hair pieces and hair implants for any reason
- Received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust or similar person or group
- For prescribed *sexual dysfunction* medications
- Treatment or studies leading to or in connection with sex changes or modifications and related care
- Music therapy, remedial reading, recreational or activity therapy, alternative therapy services, all forms of special education and supplies or equipment used similarly
- Hypnosis except when used for control of acute or chronic pain
- Acupuncture and acupressure
- *Surgery* for psychological or emotional reasons
- Travel, whether or not recommended or prescribed by a *doctor* or other licensed health care professional, except as specifically covered by your health benefit plan
- For heating pads, hot water bottles, ice packs and personal hygiene and convenience items such as, but not limited to, devices and equipment used for environmental control, incontinence products (including briefs, diapers, underwear, underpads), and urinary incontinence devices (including bed wetting devices) and equipment
- For devices and equipment used for environmental accommodation requiring vehicle and/or building modifications such as, but not limited to, positioning seats, chair lifts, stair lifts, home elevators, and ramps

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

State Health Plan for Teachers and State Employees

TRADITIONAL 70/30 PPO PLAN BENEFITS BOOKLET

January 1 – December 31, 2017

BlueCross BlueShield of North Carolina

October 1, 2016

COVERED SERVICES

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

Also keep in mind as you read this section:

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

Office Services

Care you receive from a *doctor*, physician's assistant, nurse practitioner or nurse midwife as part of an *office visit* or house call is covered with a *copayment*, except as otherwise noted in this benefits booklet. Some *providers* may get *ancillary services*, such as laboratory services, medical equipment, supplies or *specialty medications* from third parties. In these cases, you may be billed directly by the *ancillary provider*. Benefit payments for these services will be based on the type of *ancillary provider*, its network status, and how the services are billed.

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

A *copayment* will not apply if you only receive services such as allergy shots or other injections and are not charged for an *office visit*.

Office Services Exclusions

Services not covered when billed as an office service include:

- Services in free-standing surgical facilities, independent laboratories, therapy facilities or *outpatient hospital* departments
- Certain self-injectable *prescription medications* that can be self-administered. The list of these excluded medications may change from time to time. See our website at **www.shpnc.org** or call *State Health Plan* Customer Service for a list of these medications excluded in the office. Also see "*Pharmacy* Benefits" for information about purchasing *prescription medications* at the pharmacy.

➢ *Office Visit* Services

Prior authorization by your *Mental Health Case Manager* is not required for mental health and *substance abuse office visit* services. The following professional services are covered when provided in an office setting:

- Evaluation and diagnosis
- Preventive *office visits*
- *Medically necessary* biofeedback and neuropsychological testing
- Individual and family counseling
- Group therapy
- *Medically necessary* services for the treatment of gender dysphoria

➢ *Outpatient* Services

Covered *outpatient* treatment services when provided in a mental health or *substance abuse* treatment facility include:

- Each service listed in the section under *office visit* services
- Partial-day/night hospitalization services (minimum of four hours per day and 20 hours per week)
- Intensive *Outpatient* Program Services (less than four hours per day and minimum of nine hours per week)
- Certain *in-network* and *out-of-network outpatient* services, such as partial hospitalization and intensive therapy, require *prior authorization* and *certification* or services will not be covered. The timeframe for receiving *prior authorization* and treatment *certification* are set forth in the table below. The list of services that require *prior authorization* may change from time to time

➢ *Inpatient* Services

Covered *inpatient* treatment services also include:

- Each service listed under *office visit* services
- Semi-private room and board
- Detoxification to treat *substance abuse*

Prior Authorization must be requested and *certification* must be obtained in advance for *inpatient* services or services will not be covered, except for *emergencies*. *In-network providers* in North Carolina are responsible for requesting *prior review* and obtaining *certification*. If *prior review* is not requested and *certification* is not obtained for covered *out-of-network inpatient* admissions, services will be denied.

➢ *Residential Treatment Facility Services*

Prior authorization must be requested and *certification* must be obtained in advance for mental health and *substance abuse* services received in a *residential treatment facility*. *In-network providers* in North Carolina are responsible for requesting *prior authorization* and obtaining *certification*. If *prior authorization* is not requested and *certification* is not obtained for covered *out-of-network residential treatment facility* services, services will be denied.

➢ Applied Behavior Analysis

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

- The *member* is younger than age 26
- Diagnosed with Autism Spectrum Disorder by a licensed physician (MD or DO) or a licensed doctoral level clinical psychologist (PhD or PsyD) utilizing results from a face-to-face evaluation and a clinically recognized, validated tool endorsed by the *Mental Health Case Manager*
- Treatment is determined by the *Mental Health Case Manager* to be *medically necessary*

Other than those listed in the second bullet above, no *other providers* are eligible for reimbursement of the diagnostic evaluation. Licensure of the MD, DO, PhD or PsyD must be in the state in which the diagnostic evaluation is performed.

The diagnostic evaluation does not require prior approval. However, the results of the diagnostic evaluation may be requested by the *Mental Health Case Manager* when authorization for ABA (Applied Behavior Analysis) is requested.

Clinically recognized, validated tools endorsed by the *Mental Health Case Manager* can be found at **http://www.cdc.gov/ncbddd/autism/screening.html**.

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

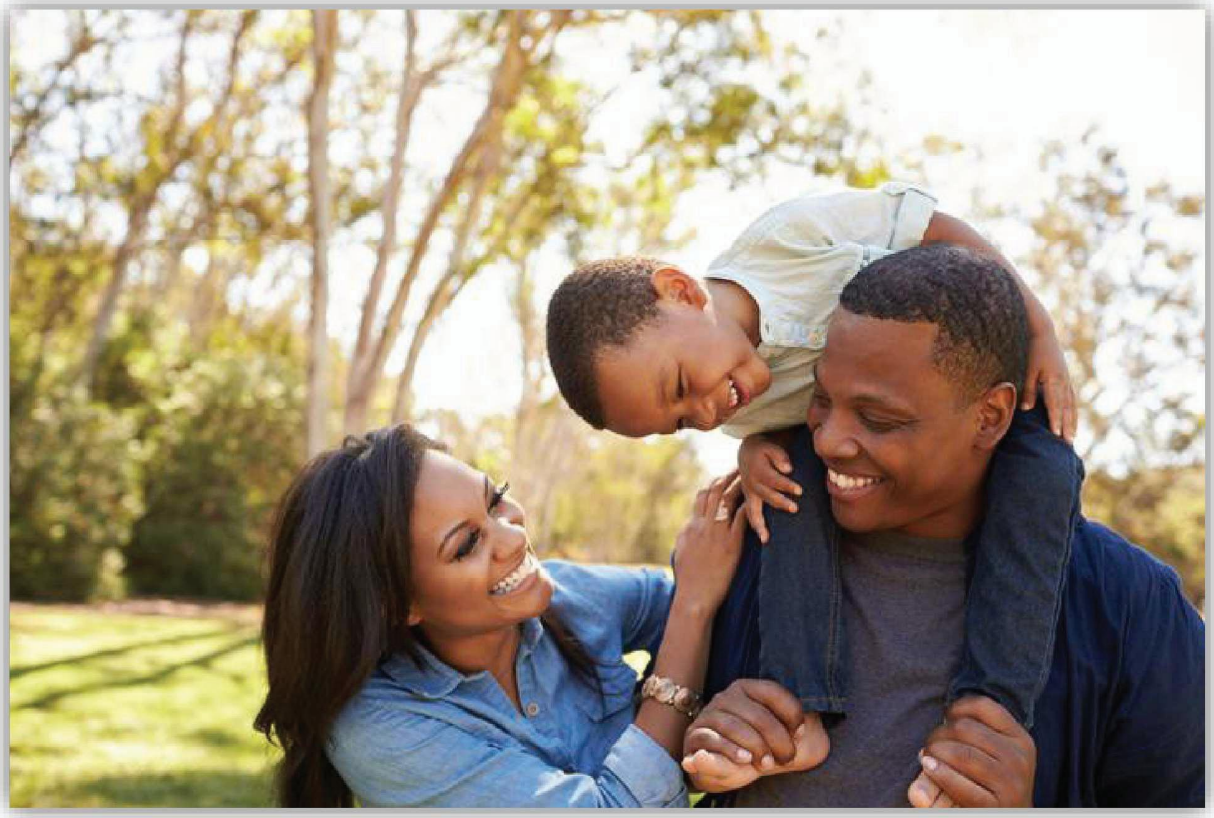
STATE TREASURER OF NORTH CAROLINA
DALE R. FOLWELL, CPA

State Health Plan for Teachers and State Employees

70/30 PPO Plan

Benefits Booklet

January 1, 2018 – December 31, 2018



BlueCross BlueShield of North Carolina

Revised: Sept. 26, 2018

Outside of North Carolina

Although *prior authorization* is not required in an *emergency*, you may contact the *Mental Health Case Manager* for assistance in locating a *provider*.

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

➢ Timeframe Requirements for *Prior Authorization* and Treatment *Certification* of *Covered Services*

Covered Service	Within Two (2) Business Days of Admission	Prior to Admission to the Program	Continuing Treatment *Certifications**
Crisis Evaluation & Stabilization	X		X
Psychiatric *Inpatient Hospital*	X		X
Substance Abuse Inpatient Hospital	X		X
***Inpatient* Medical Detoxification**	X		X
Psychiatric Residential Treatment Center		X	X
***Substance Abuse* Residential Treatment Center**		X	X
Psychiatric Partial Hospitalization Program		X	X
***Substance Abuse* Partial Hospitalization Program**		X	X
Psychiatric Intensive *Outpatient* Program		X	X
***Substance Abuse* Intensive *Outpatient* Program**		X	X

**Continuing treatment certifications must be requested by the last date of any previously certified period. Otherwise, certification decisions by the* Mental Health Case Manager *are effective as of the date the request for certification is received by the* Mental Health Case Manager.

*The following notice applies only when you are responsible for obtaining *certification*. NOTICE: Your actual expenses for *covered services* may exceed the stated *coinsurance* percentage or *copayment* amount because actual *provider* charges may not be used to determine the *Plan's* and *member's* payment obligations. For *out-of-network* benefits, you may be required to pay for charges over the *allowed amount* in addition to any *copayment* or *coinsurance* amount. In addition, certain services require *prior authorization* and *certification*. You are responsible for obtaining or having your *provider* obtain *certification* on your behalf if you go to an *out-of-network*, or out-of-state *provider*. Failure to obtain *certification* will result in a full denial of benefits.

Mental Health and Substance Abuse Services Exclusions and Limitations

- Care for conditions not classified as psychiatric, emotional, or *substance abuse* illnesses
- Psychoanalysis
- Counseling with relatives about a patient with *mental illness*, alcoholism, drug addiction or *substance abuse*
- *Inpatient* confinements that are primarily intended as a change of environment
- Mental health services received in psychiatric residential treatment facilities when age 18 or older
- *Substance abuse* residential treatment facilities are covered for all ages.
- Marriage Counseling

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

- **Travel**, whether or not recommended or prescribed by a *doctor* or other licensed health care professional, except as specifically covered by the *Plan*.
- Treatment or studies leading to or in connection with sex changes or modifications and related care

V

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

W

- **Wigs**, hair pieces and services for hair implants and electrolysis for any reason.

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

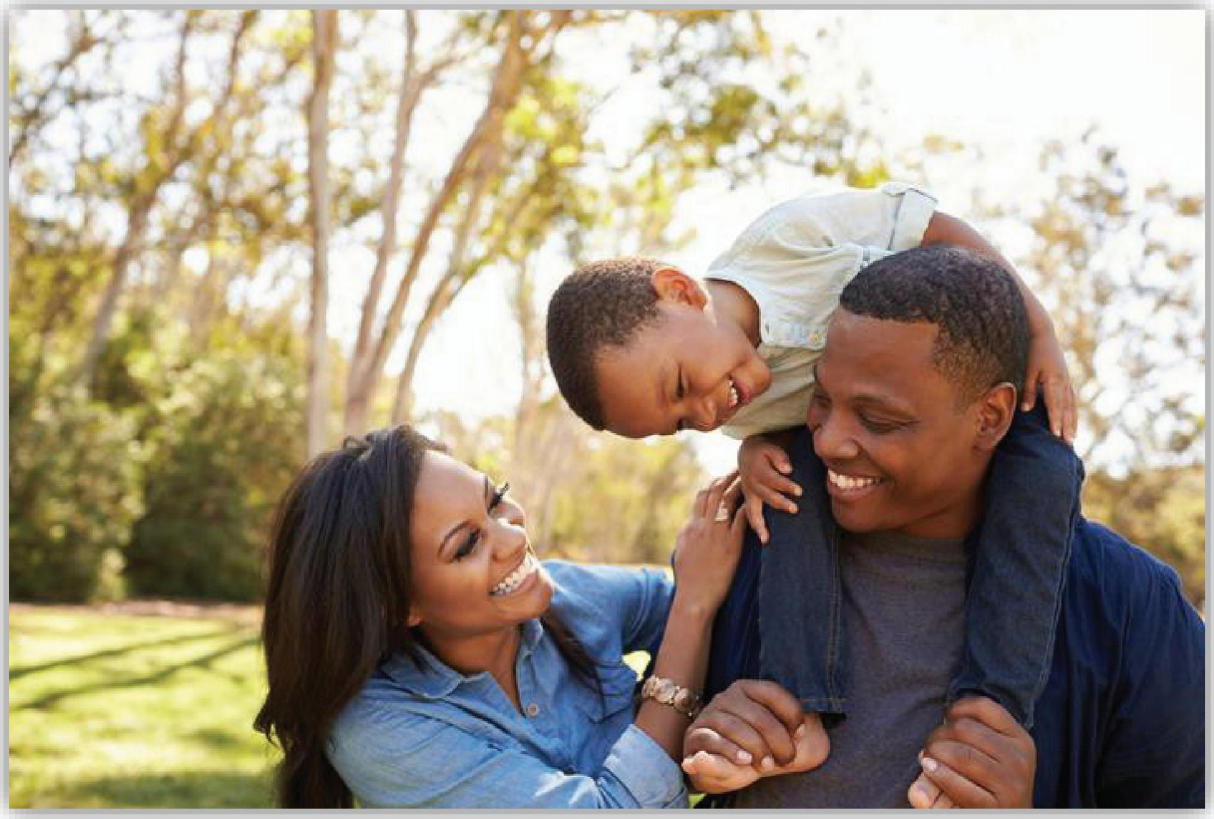
Dale R. Folwell, CPA
STATE TREASURER OF NORTH CAROLINA
DALE R. FOLWELL, CPA

State Health Plan for Teachers and State Employees

70/30 *PPO Plan*

Benefits Booklet

January 1, 2019 – December 31, 2019



BlueCross BlueShield of North Carolina

Revised: October 2, 2018

Psychiatric *Inpatient Hospital*	**X**		**X**
Substance Abuse Inpatient Hospital	**X**		**X**
Inpatient Medical Detoxification	**X**		**X**
Psychiatric Residential Treatment Center		**X**	**X**
Substance Abuse Residential Treatment Center		**X**	**X**
Psychiatric Partial *Hospitali*zation Program		**X**	**X**
Substance Abuse Partial *Hospitali*zation Program		**X**	**X**
Psychiatric Intensive *Outpatient* Program		**X**	**X**
Substance Abuse Intensive *Outpatient* Program		**X**	**X**

**Continuing treatment certifications must be requested by the last date of any previously certified period. Otherwise, certification decisions by the Mental Health Case Manager are effective as of the date the request for certification is received by the Mental Health Case Manager.*

*The following notice applies only when you are responsible for obtaining *certification*. NOTICE: Your actual expenses for *covered services* may exceed the stated *coinsurance* percentage or *copayment* amount because actual *provider* charges may not be used to determine the *Plan's* and *member's* payment obligations. For *out-of-network* benefits, you may be required to pay for charges over the *allowed amount* in addition to any *copayment* or *coinsurance* amount. In addition, certain services require *prior authorization* and *certification*. You are responsible for obtaining or having your *provider* obtain *certification* on your behalf if you go to an *out-of-network*, or out-of-state *provider*. Failure to obtain *certification* will result in a full denial of benefits.

Mental Health and *Substance Abuse* Services Exclusions and Limitations:

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

- *Inpatient hospital* care for medical detoxification rendered in a facility which is not licensed as a *hospital* and currently accredited by a national health care organization approved by the *Mental Health Case Manager.*
- Outdoor components of a residential *substance abuse* treatment program, when such program is licensed as a *substance abuse* treatment program in the state in which services are provided, are covered only if facility based services are available as a part of the same program.
- Primary treatment of a psychiatric disorder in a residential treatment center (RTC) unless the RTC is licensed as a psychiatric RTC.
- Primary treatment of a *substance abuse* or *substance abuse* disorder in a residential treatment center (RTC) unless the RTC is licensed as a *substance abuse* or *substance abuse* RTC.
- Services by *providers* not currently licensed in the state in which services are provided.
- Psychotherapy as part of artificial means of conception.
- Psychological assessment and psychotherapy treatment in conjunction with proposed gender transformation.
- Psychological testing for those persons with a *substance abuse* diagnosis until 30 consecutive days of abstinence are obtained.
- Therapeutic boarding schools as a psychiatric residential treatment center (RTC) unless the program is licensed for psychiatric RTC in the state in which services are provided, has *registered nurses* who are present on-site 24-hours per day, and holds current national accreditation by a national health care accrediting body approved by the *Mental Health Case Manager.*
- Therapeutic boarding schools as a *substance abuse* or *substance abuse* residential treatment center (RTC) unless the program is licensed as a *substance abuse* RTC in the state in which services are provided and has licensed supervision of all residents 24 hours per day, seven days per week.
- Wilderness camps, wilderness “step-down” components of a residential program, and stand-alone outdoor treatment programs or outdoor “step-down” components of a residential program are not covered as a psychiatric RTC unless the program is licensed for psychiatric residential treatment in the state in which services are provided, has *registered nurses* who are present on-site 24-hours per day, and holds current national accreditation by a national health care accrediting body approved by the *Mental Health Case Manager.*
- Wilderness camps and stand-along outdoor treatment programs are not covered as *substance abuse or substance abuse RTC programs.*
- Academic education during residential treatment when charged separately.
- Administrative psychiatric services (e.g., expert testimony, report writing, medical records review and maintenance, case management or case coordination, chart review, etc.)
- Consultation with a mental health professional for adjudication of marital, child support, and custody cases.
- Evaluations, consultations, testing or therapy for educational, professional training, or for investigation purposes relating to employment, insurance, judicial or administrative proceedings.
- Training analysis.
- Treatment for personal or professional growth, development, training or professional *certification.*
- Aversive Treatment.
- Treatment programs based solely on the 12-step Model.
- Erhard Seminar Training (EST) or similar motivational services.

Medicare Part D

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

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

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

What Is Not Covered?

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- Anything specifically listed in this benefits booklet as not covered or excluded, regardless of *medical necessity.*
- Any condition, disease, ailment, injury or diagnostic service to the extent that benefits are provided or persons are eligible for coverage under Title XVIII of the Social Security Act of 1965, including amendments, except as otherwise required by federal law.
- Conditions that federal, state or local law requires to be treated in a public facility.
- Any condition, disease, illness or injury that occurs in the course of employment, if the *member*, employer or carrier is liable or responsible for the specific medical charge (1) according to a final adjudication of the claim under a state's workers' compensation laws, or (2) by an order of a state Industrial Commission or other applicable regulatory agency approving a settlement agreement.
- Basic life or work-related or medical disability examinations.
- Benefits that are provided by any governmental unit except as required by law.
- Services that are ordered by a court that are otherwise excluded from benefits under this *Plan.*
- Any condition suffered as a result of any act of war or while on active or reserve military duty.
- Services in excess of any *benefit period maximum* or *lifetime maximum.*
- Received prior to the *member's effective date.*
- Received after the coverage termination date, regardless of when the treated condition occurred, and regardless of whether the care is a continuation of care received prior to the termination.

	equipment used similarly, except as specifically covered by the *Plan.* ○ Maintenance therapy. ○ Massage therapy. ○ Alternative therapy. ○ Hypothermia therapy. • **Thermography** or **thermograph** examination. • **Travel,** whether or not recommended or prescribed by a *doctor* or other licensed health care professional, except as specifically covered by the *Plan*. • **Treatment** or studies leading to or in connection with sex changes or modifications and related care.
V	• The following **vision** services: ○ Radial keratotomy and other refractive eye *surgery*, and related services to correct vision except for surgical correction of an eye injury. Also excluded are premium intraocular lenses or the services related to the insertion of premium lenses beyond what is required for insertion of conventional intraocular lenses, which are small, lightweight, clear disks that replace the distance-focusing power of the eye's natural crystalline lens. ○ Routine eye examination services except as specifically covered by the *Plan.* ○ Eyeglasses or contact lenses, except as specifically covered in "*Prosthetic appliances*. • Orthoptics, vision training, and low vision aids. For over-the-counter and non-federal legend **Vitamins**, food supplements or replacements, nutritional or dietary supplements, formulas or special foods of any kind, except for *prescription* prenatal vitamins or *prescription* vitamin B-12 injections for anemias, neuropathies or dementias secondary to a vitamin B-12 deficiency, or certain over-the-counter medications that may be available under your *preventive care* benefits for certain individuals.
W	• **Wigs**, hair pieces and services for hair im*plan*ts and electrolysis for any reason.

Utilization Management

To make sure you have access to high quality, cost effective health care, the *State Health Plan* has a *Utilization Management* (*UM*) program. The *UM* program requires that certain health care services be reviewed and approved by the *State Health Plan* or its representative in order to receive benefits. As part of this process, the

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STATE TREASURER OF NORTH CAROLINA
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State Health Plan for Teachers and State Employees

70/30 PPO Plan

Benefits Booklet

January 1, 2020 - December 31, 2020

BlueCross BlueShield of North Carolina

Revised: November 5, 2019

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- Any condition, disease, illness, or injury that occurs in the course of employment, if the *member*, employer or carrier is liable or responsible for the specific medical charge (1) according to a final adjudication of the claim under a state's workers' compensation laws, or (2) by an order of a state Industrial Commission or other applicable regulatory agency approving a settlement agreement.
- Basic life or work-related or medical disability examinations.
- Benefits that are provided by any governmental unit except as required by law.
- Services that are ordered by a court that are otherwise excluded from benefits under this Plan.
- Any condition suffered as a result of any act of war or while on active or reserve military duty.
- Services in excess of any *benefit period maximum* or *lifetime maximum*.
- Received prior to the *member's effective date*.
- Received after the coverage termination date, regardless of when the treated condition occurred, and regardless of whether the care is a continuation of care received prior to the termination.
- Received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust or similar person or group.
- Services provided at request of patient in a location other than physician's office which are normally provided in the physician's office.
- Day care services, chore services, attendant care services, homemaker services, companion care services, foster care services.
- Hair analysis, excluding arsenic.
- Transportation of portable X-ray equipment and personnel to home or nursing home, transportation of portable EKG to facility or other location.
- *Emergency* response systems.
- *Alternative medicine* services, which are unproven preventive or treatment modalities, also described as alternative, integrative, or complementary medicine, whether performed by a physician or any *other provider*.

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

A

- **Acupuncture** and **acupressure.**
- **Administrative** charges billed by a *provider*, including, but not limited to charges for failure to keep a scheduled visit, completion of a claim form, obtaining medical records, late payments, shipping and handling, taxes and telephone charges.
- Costs in excess of the ***allowed amount*** for services usually provided by one *doctor*, when those services are provided by multiple *doctors* or *medical care* provided by more than one *doctor* for treatment of the same condition.

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

- Occlusal (bite) adjustments.
- Extractions.

- The following types of **therapy:**
  - Applied Behavior Analysis (ABA) therapy except as specifically identified by the *Plan*.
  - Music therapy, recreational or activity therapy, and all types of animal therapy. Remedial reading and all forms of special education and supplies or equipment used similarly, except as specifically covered by the *Plan*.
  - Massage therapy.
  - Alternative therapy.
  - Hypothermia therapy.
  - Cognitive therapy.
  - Speech therapy for stammering, stuttering, or developmental delay.
  - Treatment of speech, language, voice, communication and/or auditory processing disorder.
  - Pulmonary rehabilitation group sessions.
  - Peripheral arterial disease rehabilitation.
  - Community or work integration training, work hardening or conditioning.
- **Thermography** or **thermograph** examination.
- **Transplant** exclusions include:
  - The purchase price of the organ or tissue if any organ or tissue is sold rather than donated to the recipient *member*.
  - The procurement of organs, tissue, bone marrow or peripheral blood stem cells or any other donor services if the recipient is not a *member*.
  - *Transplants*, including high dose chemotherapy, considered *experimental* or *investigational*.
  - Services for or related to the transplantation of animal or artificial organs or tissues.
- **Travel**, whether or not recommended or prescribed by a *doctor* or other licensed health care professional, except as specifically covered by the *Plan*.
- **Treatment** or studies leading to or in connection with sex changes or modifications and related care.

V

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

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- **Administrative** charges billed by a *provider*, including, but not limited to charges for failure to keep a scheduled visit, completion of a claim form, obtaining medical records, late payments, shipping and handling, taxes and telephone charges.
- Costs in excess of the ***allowed amount*** for services usually provided by one *doctor*, when those services are provided by multiple *doctors* or *medical care* provided by more than one *doctor* for treatment of the same condition.
- **Ambulance services:**
  - No benefits are provided primarily for the convenience of travel or where not *medically necessary*.
  - Transportation for the purpose of receiving services that are not considered *covered services*, even if the destination is an appropriate facility.

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

M

- Certain **Medical Supplies**
  - *Medical supplies* not ordered by a *doctor* for treatment of a specific diagnosis or procedure.
  - Thermometers.
  - Over-the-counter gauze, tape, adhesive first-aid bandages.
  - Spirometers and all related accessories.
  - Lubricants except when used in conjunction with specialized self-care procedures such as intermittent catheterization and insulin pumps.
  - Chemical or antiseptic solutions except when used in conjunction with specialized self-care procedures such as intermittent catheterization and insulin pumps.
  - Mucus traps.
  - Pocket nebulizers.
  - Replacement bulbs or lamps for therapeutic light
- **Medical testimony.**
- Services or supplies deemed not ***medically necessary*** or ordered by a provider.
- **Mental Nervous and Substance Abuse** exclusions and limitations:
  - Care for conditions not classified as psychiatric, emotional, or *substance abuse* illnesses.
  - Psychoanalysis.
  - Counseling with relatives about a patient with *mental illness*, alcoholism, drug addiction or *substance abuse.*
  - *Inpatient* confinements that are primarily intended as a change of environment.
  - Mental health services received in psychiatric residential treatment facilities when age 18 or older.
  - *Substance Abuse* residential treatment facilities are covered for all ages.
  - Marriage counseling.
  - *Inpatient* psychiatric care rendered in a *hospital* not accredited by JCAHO.
  - *Inpatient Substance Abuse* care rendered in a facility which is not currently accredited by a national health care organization approved by the *Mental Health Case Manager.*
  - *Inpatient hospital* care for medical detoxification rendered in a facility which is not licensed as a *hospital* and currently accredited by a nationally recognized organization approved by the *Mental Health Case Manager.*
  - Outdoor components of a residential *substance abuse* treatment program, when such program is licensed as a *substance abuse* treatment program in the state in which services are provided, are covered only if facility-based services are available as a part of the same program.
  - Primary treatment of a psychiatric disorder in a *residential treatment center* (RTC) unless the RTC is licensed as a psychiatric RTC.
  - Primary treatment of a *substance abuse* or *substance abuse* disorder in a *residential treatment center* (RTC) unless the RTC is licensed as a *substance abuse* or substance abuse RTC.
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- Consultation with a mental health professional for adjudication of marital, child support, and custody cases.
- Evaluations, consultations, testing or therapy for educational, professional training, or for investigation purposes relating to employment, insurance, judicial or administrative proceedings.
- Training analysis.
- Treatment for personal or professional growth, development, training or professional *certification*.
- Aversive Treatment.
- Treatment programs based solely on the 12-step Model.
- Erhard Seminar Training (EST) or similar motivational services.
- Bioenergetic, carbon dioxide, confrontational, hyperbaric or normobaric oxygen, marathon, megavitamin, orthomolecular, primal, rebirthing, or sleep therapies.
- Expressive therapies (art, poetry, movement, psychodrama), guided imagery, or stress and relaxation therapy when billed separately.
- Telephonic crisis management as a separate charge.
- Sedative action, electro stimulation therapy.
- Z therapy, also known as "holding therapy."
- Narcotherapy with LSD.
- Environmental ecology treatments.
- Hemodialysis for schizophrenia.
- Rolfing.
- Sensitivity training.
- Room and Board costs for patients admitted to a partial *hospital* or intensive *outpatient* program are not covered.

- **Thermography** or **thermograph** examination.
- **Transplant** exclusions include:
  - The purchase price of the organ or tissue if any organ or tissue is sold rather than donated to the recipient *member*.
  - The procurement of organs, tissue, bone marrow or peripheral blood stem cells or any other donor services if the recipient is not a *member*.
  - *Transplants*, including high dose chemotherapy, considered *experimental* or *investigational*.
  - Services for or related to the transplantation of animal or artificial organs or tissues.

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