services from an *out-of-network provider* you may be required to pay the entire bill at the time of service, and file a claim with the *State Health Plan*. In these situations, you will be reimbursed the billed amount minus the applicable *copayment and/*or *coinsurance*. If you are admitted to the *hospital* from the *emergency room*, *inpatient hospital* benefits apply to all *covered services* provided. Non-emergency services provided in an *emergency* room will be covered as an *outpatient* service instead of an *emergency* room service.

If you are admitted as a *hospital inpatient* immediately following *emergency services*, your benefits will be paid like any other *inpatient hospital* or physician charges. See *"Inpatient Hospital* Services." *Prior review* and *certification* by the *State Health Plan* are required for *inpatient* hospitalization and other selected services following *emergency services* (including screening and stabilization) in order to avoid a denial of services. You may need to transfer to an *in-network hospital* once your condition has been *stabilized* in order to continue receiving *in-network* benefits.

Care Following *Emergency Services*

In order to receive *in-network* benefits for follow-up care related to the *emergency* (such as *office visits* or therapy once you leave the *emergency* room or were discharged from the *hospital*), you must use *in-network providers*. Follow-up care related to the *emergency* condition is not considered an *emergency* and will be treated the same as a normal health care benefit.

Urgent Care

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

What To Do When You Need *Urgent Care*

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

Family Planning

Maternity Care

Maternity care benefits are available to all female *subscribers* and enrolled female *spouses* of *subscribers*. Maternity benefits are not available to female *dependent children*. Maternity care includes prenatal care, labor and delivery, and post-delivery care. Prenatal care is all care related to the pregnancy before the baby's birth. Labor and delivery services for mother and newborn received during an *inpatient hospital* stay are covered. Post-delivery care is all care for the mother after the baby's birth that is related to the pregnancy. A *copayment* may apply for the *office visit* to diagnose pregnancy, otherwise *deductible* and *coinsurance* apply for the remainder of your maternity care benefits. If a *member* changes *providers* during pregnancy, terminates coverage during pregnancy, or the pregnancy does not result in delivery, one or more *copayments* may be charged for prenatal services depending upon how the services are billed by the *provider*.

Delivery

Your health benefit plan covers an *inpatient hospital* stay for you and your newborn for 48 hours for a vaginal delivery or 96 hours for a cesarean section, without *prior review* by the *State Health Plan*.

However, the *State Health Plan* may pay for a shorter stay if the attending *provider* (e.g., your *doctor* or nurse midwife), after consultation with the mother, discharges the mother or newborn earlier. If the mother chooses a shorter stay, coverage is available for a *home health* visit for post-delivery follow-up care if received within 72 hours of discharge. In order to avoid a denial of services, *prior review* and *certification* are required for *inpatient* stays extending beyond 48 hours following vaginal delivery or 96 hours following cesarean section.

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

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

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

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

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

Complications Of Pregnancy

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

Complications Of Abortion

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

Newborn Care

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

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

Infertility And Sexual Dysfunction Services

Benefits are provided for certain services related to the diagnosis, treatment and correction of any underlying causes of *infertility* and *sexual dysfunction* for all *subscribers* and enrolled *spouses* of *subscribers*. Refer to "Summary Of Benefits" for limitations that may apply.

Sterilization

This benefit is covered for all *members*. Sterilization includes female tubal ligation and male vasectomy. *Prescription drugs* related to *sexual dysfunction* are not covered. See *Prescription Drug* Exclusions.

Contraceptive Drugs And Devices

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

Family Planning Exclusions

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

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

Facility Services

Outpatient Services

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

The following are *covered services*:

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

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

Inpatient Hospital Services

Your health benefit plan provides coverage when you are admitted to a *hospital* as an *inpatient*. If you are admitted before the *effective date*, benefits will not be available for services received prior to the *effective date*. If you are in the *hospital* as an *inpatient* at the time you begin a new *benefit period*, you may have to meet a new *deductible* for *covered services* from *doctors* or *other professional providers*. You should work with your *doctor* to make sure *prior review* has been requested. *Certification* must be obtained in advance from the *State Health Plan* or its representative to avoid a denial of services.

The following are *covered services*:

- *Medical care* provided by a *doctor* or *other professional provider*
- A semi-private room; or a private room if *medically necessary* or the *hospital* has only private rooms
- Use of the operating room, delivery room, recovery room, nursery and related services
- General nursing care
- Intensive care
- Critical care
- Drugs administered by the *hospital*
- Diagnostic services and *medical supplies*
- Use of appliances and equipment ordinarily provided by the *hospital*
- *Short-term rehabilitative therapies* and *other therapies.*

Ambulatory Surgical Centers

Benefits are provided for surgical services received in an *ambulatory surgical center*.

The following are *covered services*:

- *Medical care* provided by a *doctor* or *other professional provider*
- General nursing care
- Drugs administered by the facility