DECISION GUIDE FOR OPEN ENROLLMENT

September 30 - October 31, 2017

CHANGES AHEAD!

Open Enrollment is the perfect time to take a look at your current coverage and decide which health plan option best meets your needs for 2018—your best choice may be different from your current plan.

This Decision Guide will help you navigate your options for the 2018 benefit year.

ALL MEMBERS MUST TAKE ACTION DURING OPEN ENROLLMENT!

All members will be automatically enrolled in the 70/30 Plan, but YOU MUST TAKE ACTION to reduce your premium. If you prefer the 80/20 Plan, YOU MUST TAKE ACTION! If you want to reduce your monthly premium on either Plan, YOU MUST TAKE ACTION by completing the tobacco attestation! If you fail to take action during Open Enrollment, your monthly premiums will be considerably higher in 2018!

2018

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

New for 2018

The State Health Plan's Board of Trustees under the direction of Treasurer Dale R. Folwell, CPA, approved several changes for the 2018 benefit year. **These changes are meant to reduce plan complexity for members while still maintaining quality health coverage** and providing long-term financial stability for the State Health Plan.

The first thing you will notice is what used to take about 50 "clicks" to complete online enrollment will now only take about 10! Other changes include:

- Family premiums have been **frozen** for the 2018 benefit year.
- Copays and deductibles will **not** increase in 2018.
- You will only have to complete one wellness premium credit, the tobacco attestation credit.
- The Consumer-Directed Health Plan (CDHP) is being eliminated.

A LOOK AT YOUR OPTIONS

The choices you make during Open Enrollment are for benefits from January 1, 2018, through December 31, 2018. Once you choose your benefit plan, you may not elect to switch plans until the next Open Enrollment period. The coverage type you select (for example, employee-only) will remain in effect until the next benefit year, unless you experience a qualifying life event. A list of qualifying life events is included in your Benefit Booklet available on the State Health Plan website at **www.shpnc.org**.

For 2018, the State Health Plan will offer two Preferred Provider Organization (PPO) plans through Blue Cross and Blue Shield of North Carolina (BCBSNC). These PPO plans allow you the flexibility to visit any provider—in- or out-of-network—and receive benefits. Generally, you pay less when you visit an in-network provider. Both plans offer comprehensive coverage and a large provider network.

The 80/20 Plan

The 80/20 Plan is a PPO plan where you pay 20% coinsurance for eligible in-network services. For some services (i.e., office visits, urgent care or emergency room visits), you pay a copay. Affordable Care Act (ACA) Preventive Services performed by an in-network provider are covered at 100% in this plan.

Save Even More with the 80/20 Plan

You can also save money under the 80/20 Plan when you choose high-quality provider options as shown below. These actions will earn you reductions to copays if you enroll in the 80/20 Plan.

ACTION	80/20 PLAN – COPAY REDUCED TO
Visit your selected Primary Care Provider *(or see another provider in your PCP's office)*	$10
See a Blue Options Designated Specialist	$45
Use a Blue Options Designated Hospital for an inpatient stay	$0 (copay not applied)

Finding a Blue Options Designated Provider

Blue Options Designated providers have been designated because they provide high-quality and cost-effective services. The specialties in which you may find a Blue Options Designated provider are: General Surgery, OB/GYN, Orthopedics, Cardiology, Neurology, Endocrinology and Gastroenterology.

To find a Blue Options Designated provider or hospital, visit Blue Connect and look for the label "Designated for Cost and Quality" or call Blue Cross and Blue Shield of North Carolina (BCBSNC) at 888-234-2416. To access Blue Connect, visit the State Health Plan's website at **www.shpnc.org** and click Enroll Now/Access Benefits to log into eEnroll, the Plan's enrollment system. Once you're logged into eEnroll you will see a Blue Connect Quick Link.

The 70/30 Plan

The 70/30 Plan is a PPO Plan where you pay 30% coinsurance for eligible in-network services. For some services (i.e., office visits, urgent care or emergency room visits), you pay a copay. Affordable Care Act preventive services and medications require the applicable copay under this plan.

Lower Your Monthly Premiums

By completing the tobacco attestation, you can earn a wellness premium credit that will reduce your monthly premium. (The wellness premium credit only applies to the employee-only premium.)

2018 PREMIUM CREDIT SAVINGS	80/20 PLAN	70/30 PLAN
Employee-only Monthly Premium	$110	$85
Attest that you are tobacco-free or will enroll in QuitlineNC's multiple-call program between Sept. 30 and Oct. 31*	-$60	-$60
Total Monthly Employee-Only Premium: (With Credit)	$50	$25

* Even if you attested during last year's Open Enrollment, **you will need to re-attest during Open Enrollment**! If you are a tobacco user, you must enroll in the QuitlineNC tobacco-cessation program to receive the wellness credit. You can enroll in QuitlineNC's program any time between now and December 31, 2017.

2018 STATE HEALTH PLAN COMPARISON

PLAN DESIGN FEATURES	80/20 PLAN		70/30 PLAN	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible	$1,250 Individual $3,750 Family	$2,500 Individual $7,500 Family	$1,080 Individual $3,240 Family	$2,160 Individual $6,480 Family
Coinsurance	20% of eligible expenses after deductible	40% of eligible expenses after deductible and the difference between the allowed amount and the charge	30% of eligible expenses after deductible	50% of eligible expenses after deductible and the difference between the allowed amount and the charge
Medical CoinsuranceMaximum	N/A		$4,388 Individual $13,164 Family	$8,776 Individual $26,328 Family
Medical Out-of-Pocket Maximum	$4,350 Individual $10,300 Family	$8,700 Individual $26,100 Family	N/A	
Pharmacy Out-of- Pocket Maximum	$2,500 Individual $4,000 Family		$3,360	
Out-of-Pocket Maximum *(Combined Medical & Pharmacy)*	$6,850 Individual $14,300 Family	$11,200 Individual $30,100 Family	N/A	
ACA Preventive Services	$0 (covered at 100%)	40% after deductible, dependent on service	$40 for primary doctor; $94 for specialist	50% after deductible, dependent on service
Office Visits	$25 for primary doctor; $10 if you use PCP on ID card; $85 for specialist; $45 if you use Blue Options Designated specialist	40% after deductible	$40 for primary doctor; $94 for specialist	50% after deductible
Urgent Care	$70		$100	
Emergency Room *(Copay waived w/admission or observation stay)*	$300 copay, then 20% after deductible		$337 copay, then 30% after deductible	
Inpatient Hospital	$450 copay, then 20% after deductible; copay not applied if you use a Blue Options Designated Hospital	$450 copay, then 40% after deductible	$337 copay, then 30% after deductible	$337 copay, then 50% after deductible
PRESCRIPTION DRUGS				
Tier 1 *(Generic)*	$5 copay per 30-day supply		$16 copay per 30-day supply	
Tier 2 *(Preferred Brand & High- Cost Generic)*	$30 copay per 30-day supply		$47 copay per 30-day supply	
Tier 3 *(Non-preferred Brand)*	Deductible/ coinsurance		$74 copay per 30-day supply	
Tier 4 *(Low-Cost Generic Specialty)*	$100 copay per 30-day supply		10% up to $100 per 30-day supply	
Tier 5 *(Preferred Specialty)*	$250 copay per 30-day supply		25% up to $103 per 30-day supply	
Tier 6 *(Non-preferred Specialty)*	Deductible/ coinsurance		25% up to $133 per 30-day supply	
Preferred Diabetic Testing Supplies*	$5 copay per 30-day supply		$10 copay per 30-day supply	
ACA Preventive Medications	$0		N/A	

**** Non-preferred diabetic testing supplies are paid at Tier 3.***

HOW YOUR PRESCRIPTIONS MAY FACTOR INTO YOUR 2018 BENEFIT PLAN DECISION

As a reminder, the State Health Plan continues to utilize a custom, closed formulary (drug list). The formulary indicates which drugs are excluded from the formulary and not covered by the Plan. All other drugs that are on the formulary are grouped into tiers. Your medication's tier determines your portion of the drug cost. For 2018, the Plan's pharmacy benefit will include six tiers, which include generics, brands and specialty medications. These are shown on page 4.

A formulary exclusion exception process is available for Plan members who, per their provider, have a medical necessity to remain on an excluded, or non-covered, medication. If a member is approved for the excluded drug, that drug will be placed into Tier 3 or Tier 6 and the member will be subject to the applicable cost share.

It is important to note that in the 80/20 Plan, Tier 3 and Tier 6 medications do not have a defined copay, but are subject to a deductible/coinsurance. **Medications that are subject to coinsurance in most cases will result in higher out-of-pocket costs to members.**

Pharmacy Benefit Resources:

Drug Lookup Tool: this tool allows you to search for a medication to determine if it is a covered drug and get an estimated out-of-pocket cost.	**Preferred Drug List**: a list of preferred medications noting which drug requires any prior approvals.	**Comprehensive Formulary List**: a complete list of covered medications and their tier placement.	**Affordable Care Act Preventive Medication List (80/20 Plan only)**: medications on this list are covered at 100%, which means there is no cost to you.	**Specialty Drug List**: a complete list of all medications available through CVS Specialty.

The tools listed above include information based on the 2017 formulary and are subject to change prior to January 1, 2018. The formulary is regularly updated throughout the year, on a quarterly basis, so there is always a possibility that the coverage status of your medication(s) could change, which may affect your out-of-pocket costs.

The Plan's Pharmacy Benefit Manager, CVS Caremark, is another valuable resource as you navigate through your decisions. CVS Customer Service can be reached at **888-321-3124**, or you can log in to your own account at www.caremark.com. Remember to always discuss your prescription options with your health care provider to find the most cost-effective therapy.

STRENGTHEN OPIOID MISUSE PREVENTION (STOP) ACT:

Under North Carolina's new STOP Act, effective January 1, 2018, prescribers of controlled substances are limited to issuing only a 5-day supply of an opioid or narcotic medication for the initial treatment of acute pain (or a 7-day supply after surgery). This requirement does not apply to cancer care, palliative care, hospice care, chronic pain management or medication-assisted treatment for substance use disorders. If you are suffering with acute pain, please check with your health care provider prior to the end of this year to make sure your current medication therapy isn't interrupted.

2018 MONTHLY PREMIUM RATES

Note that the monthly premiums below apply only to Active members. Monthly premiums for all members and plans can be found on the State Health Plan website at **www.shpnc.org**.

80/20 PLAN	MONTHLY PREMIUM
Employee Only	$50*
Employee + Child(ren)	$305.00*
Employee + Spouse	$700.00*
Employee + Family	$720.00*

Assumes completion of tobacco attestation. The employee-only premium will be $60 higher per month if the tobacco attestation is not completed.

70/30 PLAN	MONTHLY PREMIUM
Employee Only	$25.00*
Employee + Child(ren)	$218.00*
Employee + Spouse	$590.00*
Employee + Family	$598.00*

Assumes completion of tobacco attestation. The employee-only premium will be $60 higher per month if the tobacco attestation is not completed.

INFORMATION TO HELP YOU CHOOSE A PLAN

Follow the steps below to choose the coverage that's best for you in 2018.



1. Visit **www.shpnc.org** for more information about your 2018 benefits. Utilize the resources to assist you with your decision making. Resource tools include:

- Plan Comparisons
- Health Care Summary Report (located in Blue Connect)
  This is a customized report where you can find recent benefit use and health expense details.
- Informational videos

2. Attend a Member Outreach Event. See below for the schedule. Details are available at **www.shpnc.org**. Seating is limited so you're encouraged to register!

COUNTY	DATE	TIME	LOCATION
Burke	9/18/17	10-11 a.m.	Western Piedmont CC
Forsyth	9/18/17	3-4 p.m.	Forsyth Tech CC
Wake	9/25/17	10-11 a.m., 1-2 p.m.	Wake Tech Main
New Hanover	9/27/17	2-3 p.m.	UNC-Wilmington
Wake	9/28/17	12:30-1:30 p.m.	NC Museum of History
Cumberland	10/5/17	2-3 p.m.	Fayetteville Tech CC
Wayne	10/10/17	2-3 p.m.	Wayne CC

3. Participate in a webinar regarding Open Enrollment. Reserve your spot by visiting **www.shpnc.org**.

DATE	TIME
9/8/17	12:30 p.m., 4 p.m.
9/12/17	12:30 p.m.
9/14/17	12:30 p.m.
10/3/17	12:30 p.m., 4 p.m.
10/11/17	12:30 p.m.

OPEN ENROLLMENT CHECKLIST

Decide who you want to cover under the plan: you only, you + spouse, you + children, you + family. Remember, if you are adding a new dependent you will need to provide a Social Security number and will be prompted to upload required documentation in order to verify eligibility.

- Review your plan options and choose a plan that fits best for you and your family.
- When you're ready to enroll or change your plan, visit **www.shpnc.org** and click **Enroll Now/Access Benefits** in the green bar.
- Log into the eEnroll system. You may be required to create an account if you are a first-time eEnroll user.
- Review your dependent information and make changes, if needed.
- Elect your plan: 80/20 Plan or 70/30 Plan.
- Complete the tobacco attestation to reduce your monthly premium.
- Make sure your Primary Care Provider information is up to date.
- Review the benefits you've selected. If you are OK with your elections, you will be prompted to SAVE your enrollment.
- Print your confirmation statement for your records.

IMPORTANT:

After you have made your choices, and they are displayed for you to review and print, you MUST scroll down to the bottom and click SAVE or your choices will not be recorded! Don't overlook this critical step! A green congratulations message will appear when you have successfully completed your enrollment.

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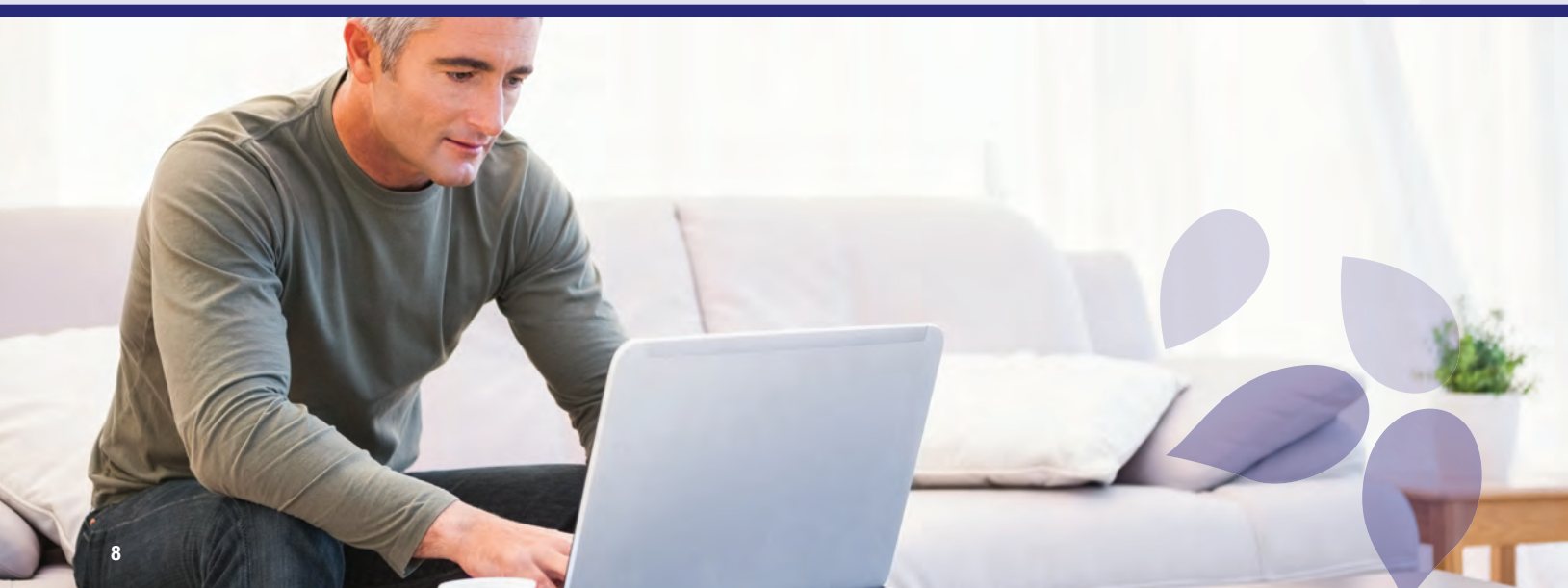

HEALTH AND WELLNESS RESOURCES

NC Health*Smart*

The State Health Plan is making changes to help improve services to all members, as well as reduce complexity, add value and secure the Plan's long-term financial stability. As a result, the Plan is adopting a more focused approach to Population Health Management services.

Beginning January 1, 2018, telephonic coaching for disease and case management will be provided for the following conditions only: asthma, chronic obstructive pulmonary disease (COPD), cerebrovascular disease (CVD), coronary artery disease (CAD), peripheral vascular disease (PAD), heart failure, and diabetes. Case management will continue to be provided for members with complex health care needs and with conditions such as chronic and end stage renal disease.

All members will continue to have access to online resources such as a Personal Health Portal to assist you in your health goals. For details, visit **www.shpnc.org** and click on the NC Health*Smart* tab at the top of the page.

Blue365: **A Wellness Resource and Discount Program for Healthy Living.**

As State Health Plan members, you can save money, live healthier and find great member discounts on fitness and health tools through Blue365®.

Staying healthy and active is easy and affordable. It's the best investment you can make in your future.

Blue365, offered through BCBSNC, is a simple way to access trusted wellness resources, and valuable offers like these:

- Fitness: Gym memberships and fitness gear
- Personal Care: Vision and hearing care
- Healthy Eating: Weight loss and nutrition programs
- Lifestyle: Travel and family activities
- Wellness: Mind/body wellness tools and resources
- Financial Health: Financial tools and programs

To get started, register for Blue365 following these steps:

To access Blue Connect, visit the State Health Plan's website at **www.shpnc.org** and click Enroll Now/Access Benefits to log into eEnroll, the Plan's enrollment system. Once you're logged into eEnroll you will see a Blue Connect Quick Link.

Once you are in Blue Connect, look for the Blue365 tab. Members must register to use Blue365 services. You can also find more information in your benefit booklet and by calling **855-511-2583, 8 a.m. - 6 p.m., Monday-Friday**.

Don't wait until the last minute! Take action today and pick the best choice for you and your family for 2018!

Eligibility and Enrollment Support Center: **855-859-0966**

During Open Enrollment, the Eligibility and Enrollment Support Center will offer extended hours to assist you with your questions.

Monday–Friday: 8 a.m.–10 p.m. ET and Saturday: 8 a.m.–noon ET.

Notice of Privacy Practices for the State Health Plan for Teachers and State Employees

This notice describes how medical information about you may be used and disclosed by the Plan and how you can get access to this information. Please review it carefully. The privacy of your medical information is important to us.

- Original Effective Date: April 14, 2003
- Revised Effective Date: September 23, 2013

Introduction

A federal law, the Health Insurance Portability and Accountability Act (HIPAA), requires that health plan and health care providers protect the privacy of certain medical information. This notice covers the medical information practices of the State Health Plan for Teachers and State Employees. This notice is intended to inform you of your rights under the privacy provisions of HIPAA and the HIPAA obligations imposed on the Plan. The Plan is required to maintain the privacy of PHI in accordance with HIPAA (as summarized herein), provide this Notice to covered individuals, and notify affected individuals following a "breach" of unsecured Protected Health Information (PHI) (as defined by HIPAA). The privacy laws of a particular state or other federal laws might impose a stricter privacy standard than HIPAA. If these stricter laws apply, the Plan will comply with the stricter law to the extent such laws are not otherwise preempted. It is necessary that certain employees of the plan sponsor be permitted to access, use, and/or disclose the minimum amount of your PHI to perform certain plan administration functions. In accordance with HIPAA, we restrict access to your health plan information only to certain employees who need to know that information to perform plan administration and we maintain physical, electronic, and procedural safeguards that comply with federal regulations to guard your health plan information. If you have general questions about your medical claims information maintained by the Plan, call or write to the privacy contact identified at the end of this notice.

What Information Is Protected?

Only identifiable health information that is created or received by or on behalf of the Plan is protected by HIPAA. This health information is called "protected health information" (PHI).

How the Plan May Use and Disclose Your PHI

This section describes how the Plan can use and disclose PHI. Please note that this notice does not list every use or disclosure; instead, it gives examples of the most common uses and disclosures.

It is necessary for certain third parties to assist the Plan in administering your health benefits under the Plan. These entities keep and use most of the PHI maintained by or on behalf of the Plan such as information about your health condition, the health care services you receive, and the payments for such services. They use and disclose your PHI to process your benefit claims and to provide other services necessary to plan administration. They are legally obligated to use the same privacy protections as the Plan.

Primary Uses and Disclosures of PHI

The Plan may disclose your PHI so that your doctors, dentists, pharmacies, hospitals and other health care providers may provide you with medical treatment.

- The Plan also may send your PHI to doctors for patient safety or other treatment-related reasons.
- The Plan may use and disclose your PHI to facilitate payment of benefits under the Plan; including determining eligibility for benefits, calculating your benefits under the Plan, paying your health care providers for treating you, calculating your copays and coinsurance amounts, deciding claims appeals and inquiries, and/or coordinating coverage. For example, the Plan may disclose information about your medical history to a physician to determine whether a particular treatment is experimental, investigational, or medically necessary or to decide if the Plan will cover the treatment.
- The Plan may use and disclose your PHI for additional related health care operations necessary to operate the Plan, including but not limited to: underwriting and soliciting bids from potential insurance carriers; merger and acquisition activities; setting premiums; deciding employee premium contributions; submitting claims to the Plan's stop-loss (or excess-loss) carrier; conducting or arranging for medical review; legal services; audit services; and fraud and abuse detection programs. **NOTE:** The Plan will not use or disclose "genetic information" (as defined in 45 C.F.R. 160.103) for purposes of underwriting.
- The Plan may use your PHI to contact you or give you information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Other Uses and Disclosures of PHI

The Plan is required to disclose your PHI to the Secretary of the U.S. Department of Health and Human Services if the Secretary is investigating or determining compliance with HIPAA.

- The Plan will disclose PHI about you when required to do so by federal, state or local law.
- The Plan may release your PHI for Workers' Compensation or similar programs.
- The Plan may use and disclose PHI about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
- If you are an organ donor, the Plan may release your PHI to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.
- If you are a member of the armed forces, the Plan may release your PHI as required by military command authorities.
- The Plan may disclose your PHI for certain public health activities including but not limited to:
  - Disclosure to a public health authority that is authorized by law to collect or receive information for the purpose of preventing or controlling disease and conducting public health surveillance and public health investigations;
  - Disclosure to a person who has responsibility to the FDA regarding the quality, safety, or effectiveness of an FDA-regulated product or activity; and
  - Disclosure to a person who may have been exposed to a communicable disease or who may be otherwise at risk of contracting or spreading a disease or condition, if the covered entity is authorized by law to notify such person.
- If the Plan reasonably believes that you or a child has been the victim of domestic or child abuse or neglect, the Plan may disclose PHI to certain entities authorized by law to receive such information provided certain conditions are satisfied (in most cases your agreement is necessary unless you are incapacitated or the Plan reasonably believes that disclosure is necessary to prevent harm or threat to life).
- The Plan may disclose your PHI to a health oversight agency for activities authorized by law (for example, audits, investigations, inspections, and licensure).
- If you are involved in a lawsuit or a dispute, the Plan may disclose your PHI in response to a court or administrative order.
- The Plan may also disclose your PHI in response to a subpoena, discovery request, or other lawful process provided that, if the Plan is not a party to the litigation, good faith attempts have been made to tell you about the request or to obtain an order protecting the information requested.
- The Plan may release your PHI if asked to do so by a law enforcement official in certain instances.
- The Plan may disclose PHI to a coroner or medical examiner for purposes of identifying a deceased person, determining the cause of death, or other duties as authorized by law.
- The Plan may disclose your PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
- If you are an inmate of a correctional institution or under the custody of a law enforcement official, the Plan may release your PHI to the correctional institution or law enforcement official.
- Using its best judgment, the Plan may disclose your PHI to a family member, other relative, or close friend. Such a use will be based on how involved the person is in your care or payment that relates to that care.
- The Plan may release claims payment information to spouses, parents, or guardians, unless you specifically object in writing to the Privacy Manager identified in the Notice.

Other uses and disclosures of your PHI that are not described above will be made only with your written authorization. For example, an authorization is required in the following instances: (i) any use or disclosure of psychotherapy notes except as otherwise permitted in 45 C.F.R. 164.508(a)(2); (ii) any use or disclosure for "marketing" except as otherwise permitted in 45 C.F.R. 164.508(a)(3); (iii) any disclosure which constitutes a sale of PHI. If you authorize the Plan to use or disclose your PHI, you may revoke the authorization at any time in writing. However, your revocation will only stop future uses and disclosures that are made after the Plan receives your revocation. It will not have any effect on the prior uses and disclosures of your PHI.

Your Rights Regarding PHI

You have the following rights regarding PHI the Plan has about you:

- You have the right to inspect and copy your PHI that may be used to make decisions about your benefits. To inspect and copy your PHI that may be used to make decisions about you, you must submit your request in writing to the appropriate privacy contact listed in this Notice. If you request a copy of this information, the Plan may charge a fee for the costs of copying, mailing or other supplies associated with your request. The Plan may deny your request to inspect and copy your PHI in certain very limited circumstances. HIPAA provides several important exceptions to your right to access your PHI. For example, you will not be permitted to access psychotherapy notes or information compiled in anticipation of, or for use in, a civil, criminal or administrative action or proceeding. The Plan will not allow you to access your PHI if these or any of the exceptions permitted under HIPAA apply. If you are denied access to your PHI, you may request a review of the denial.
- If you feel that PHI the Plan has about you is incorrect or incomplete, you may ask the Plan to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, you must submit your request in writing to the appropriate Privacy Contact listed below. Your request must list the specific PHI you want amended and explain why it is incorrect or

incomplete. The Plan may deny your request for an amendment if it is not in writing or does not list why it is incorrect or incomplete. In addition, the Plan may deny your request if you ask the Plan to amend information that is:

- Not part of the PHI kept by or for the Plan;
- Not created by the Plan or its third party administrators;
- Not part of the information which you would be permitted to inspect and copy; or
- Accurate and complete.

If the Plan denies your request, it must provide you a written explanation for the denial and an explanation of your right to submit a written statement disagreeing with the denial no later than 60 days after receipt of your request.

- When you make a request, we are required to disclose to you the portion of your PHI that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. You also have the right to request an "accounting" of certain disclosures of your PHI. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures. To request an accounting, you must submit a written request to the Privacy Contact identified in this Notice. Your request must state a time period of no longer than six (6) years.
- You have the right to request that the Plan communicate with you about health plan matters in a certain way or at a certain location. We are only obligated to comply with such a request if the disclosure will endanger you. For example, you can ask that the Plan only contact you at work or by mail. You also have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations or for disclosures to other individuals involved in your care. We are generally not obligated to comply with any request for restrictions or limitations. To request alternative communications or restrictions and/or limitations, you must submit your request in writing to the appropriate privacy contact listed below or you can call **888-234-2416**. Your request must specify how or where you wish to be contacted.

Changes to This Notice

The Plan has the right to change this notice at any time. The Plan also has the right to make the revised or changed notice effective for medical information the Plan already has about you as well as any information received in the future. You may request a copy by calling **888-234-2416**.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the Plan or with the Secretary of the Department of Health and Human Services.

To file a complaint with the Plan, contact the Privacy Contact identified in this Notice. You will not be penalized or retaliated against for filing a complaint.

Privacy Contact
The Privacy Contact is:
State Health Plan
Attention: HIPAA Privacy Officer
3200 Atlantic Avenue
Raleigh, NC 27604
919-814-4400

Enrollment in the Flexible Benefit Plan (under IRS Section 125) for the State Health Plan

If you are an active employee, you are eligible for participation in the Flexible Benefit Plan to have your health benefit plan premium payments deducted on a pre-tax basis. Retirees and members with COBRA continuation coverage are not eligible for participation since they must have current earnings from which the premium payments can be deducted. The Flexible Benefit Plan allows any premiums you pay for health benefit coverage to be deducted from your paycheck before Federal, State, and FICA taxes are withheld. By participating, you will be able to lower your taxable income and lower your taxable liability, thereby in effect, lowering the net cost of your health plan coverage.

The Flexible Benefit Plan is designed so that your participation will be automatic unless you decline. If you wish to decline participation and have your contributions paid on an "after-tax" basis, you must do so in the eEnroll system or by completing the Flexible Benefit Plan (IRS Section 125) Rejection form available on the Plan's website at **www.shpnc.org**. You will have the opportunity to change your participation election during each Open Enrollment period. The Flexible Benefit Plan administered by the State Health Plan is for the payment of health benefit plan premiums on a before-tax basis only and is separate and distinct from NCFlex, which is administered by the Office of State Human Resources.

Your health benefit coverage can only be changed (dependents added or dropped) during the Open Enrollment period or when one of the following events occurs:

- Your marital status changes due to marriage, death of spouse, divorce, legal separation, or annulment.
- You increase or decrease the number of your eligible dependents due to birth, adoption, placement for adoption, or death of the dependent.
- You, your spouse, or your eligible dependent experiences an employment status change that results in the loss or gain of group health coverage.
- You, your spouse, or your dependents become entitled to coverage under Part A or Part B of Medicare, or Medicaid.
- Your dependent ceases to be an eligible dependent (e.g., the dependent child reaches age 26).
- You, your spouse, or your dependents commence or return from an unpaid leave of absence such as Family and Medical Leave or military leave.
- You receive a qualified medical child support order (as determined by the plan administrator) that requires the plan to provide coverage for your children.
- If you, your spouse or dependents experience a cost or coverage change under another group health plan for which an election change was permitted, you may make a corresponding election change under the Flex Plan (e.g., your spouse's employer significantly increases the cost of coverage and as a result, allows the spouse to change his/her election).
- If you change employment status such that you are no longer expected to average 30 hours of service per week but you do not lose eligibility for coverage under the State Health Plan (e.g., you are in a stability period during which you qualify as full time), you may still revoke your election provided that you certify that you have or will enroll yourself (and any other covered family members) in other coverage providing minimum essential coverage (e.g., the marketplace) that is effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.
- You may prospectively revoke your State Health Plan election if you certify your intent to enroll yourself and any covered dependents in the marketplace for coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.
- You or your children lose eligibility under Medicaid or a state Children's Health Insurance Program. In this case you must request enrollment within 60 days of losing eligibility.
- If you, your spouse or your dependent loses eligibility for coverage (as defined by HIPAA) under any group health plan or health insurance coverage (e.g., coverage in the individual market, including the marketplace), you may change your participation election.

In addition, even if you have one of these events, your election change must be "consistent" with the event, as defined by the IRS. Consequently, the election change that you desire may not be permitted if not consistent with the event as determined by IRS rules and regulations. When one of these events occurs, you must complete your request through your online enrollment system within 30 days of the event (except as described above). If you do not process the request within 30 days, you must wait until the next Open Enrollment to make the coverage change. Whenever you report a change due to a qualifying event, your premium deduction will be on a pre-tax basis.

Notice Regarding Mastectomy-Related Services

As required by the Women's Health and Cancer Rights Act of 1998, benefits are provided for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. For more information, contact Customer Service at **888-234-2416**.

Notice of HIPAA Special Enrollment

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for assistance.

To request special enrollment or obtain more information, contact the Enrollment and Billing Support Center at **855-422-6272**.

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

State Health Plan
3200 Atlantic Avenue
Raleigh, NC 27604

2018 DECISION GUIDE FOR OPEN ENROLLMENT

ALL MEMBERS MUST TAKE ACTION DURING OPEN ENROLLMENT!

All members will be automatically enrolled in the 70/30 Plan, but YOU MUST TAKE ACTION to reduce your premium. If you prefer the 80/20 Plan, YOU MUST TAKE ACTION! If you want to reduce your monthly premium on either Plan, YOU MUST TAKE ACTION by completing the tobacco attestation! If you fail to take action during Open Enrollment, your monthly premiums will be considerably higher in 2018!

SHP306

Nondiscrimination and Accessibility Notice

The State Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The State Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The State Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator identified below (the "Coordinator"):

State Health Plan Compliance Officer
919-814-4400

If you believe that the State Health Plan has failed to provide these services or discriminated against you, you can file a grievance with the Coordinator. You can file a grievance in person or by mail, fax, or email. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights available at:

U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, **800-368-1019, 800-537-7697 (TDD)**.

File complaint electronically at: **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**.

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **919-814-4400**.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **919-814-4400**.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **919-814-4400**.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **919-814-4400**.

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **919-814-4400**.

ملحوظة: إذا كنت تتحدث اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **919-814-4400**.

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau **919-814-4400**.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **919-814-4400**.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **919-814-4400**.

સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિઃશુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો **919-814-4400**.

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ **919-814 4400**.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **919-814-4400**.

ध्यान दें: यदि आप हिंदी बोलते है तो आपके लिए मुफ़्त में भाषा सहायता सेवाएं उपलब्ध है। **919-814-4400**.

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ **919-814-4400**.

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**919-814-4400**.

Contact Us

Eligibility and Enrollment Support Center (eEnroll questions): **855-859-0966**
(Extended hours during Open Enrollment: Monday–Friday, 8 a.m.–10 p.m. ET and Saturday, 8 a.m.–noon ET)

Blue Cross and Blue Shield of NC (benefits and claims): **888-234-2416**

CVS Caremark (pharmacy benefits questions): **888-321-3124**