“W hen I was sworn in as the 28th State Treasurer of North Carolina, I promised to reduce complexity and add value to the State Health Plan. One of the ways that the Plan has been able to achieve this is through recent negotiations with UnitedHealthcare®, the Plan’s Medicare Advantage carrier. I’m pleased to say that those negotiations resulted in $55 million in savings for the overall Plan, which is primarily funded through taxpayer dollars. We were able to do this by using our “largeness” to get better deals and by signing our contracts. THESE SAVINGS MADE IT POSSIBLE TO NOT INCREASE PREMIUMS FOR THE 2019 BENEFIT YEAR.

I look forward to continuing to serve you as state treasurer, and I thank you for your service to the people of North Carolina.”

- Dale R. Folwell, CPA
  State Treasurer
Open Enrollment is the time to take a look at your current coverage and decide which health plan option best meets your needs for 2019. The online enrollment process is quick, easy and has gone from 50 clicks down to 10! This Decision Guide will help you navigate your options for the 2019 benefit year.

**ACTION REQUIRED!** All members will be automatically enrolled in the 70/30 Plan, which will have an $85 employee-only premium. You can reduce this premium by $60, down to a $25 employee-only premium, by completing the tobacco attestation. Members who wish to reduce their monthly premium by completing the tobacco attestation or who wish to enroll in the 80/20 Plan will need to take action during Open Enrollment.
A LOOK AT YOUR 2019 OPTIONS

The choices you make during Open Enrollment are for benefits from January 1, 2019, through December 31, 2019. 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 2019, the State Health Plan will offer two Preferred Provider Organization (PPO) plans through Blue Cross and Blue Shield of North Carolina (Blue Cross NC). As a reminder, Blue Cross NC is the Plan’s third-party administrator. They process medical claims and offer a provider network, but taxpayers like you pay for your coverage. Your plan options include:

• The 70/30 Plan
• The 80/20 Plan

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. See more details about each plan on the next page.
The 80/20 Plan

- The 80/20 Plan is a PPO plan where you pay 20% coinsurance for eligible in-network services after you meet your deductible. For some services (i.e., office visits, urgent care or emergency room visits), you pay a copay.

- Affordable Care Act Preventive Services performed by an in-network provider are covered at 100% in this plan.

- The 80/20 Plan’s out-of-pocket maximum has changed from a separate medical and pharmacy out-of-pocket amount to a combined medical and pharmacy out-of-pocket maximum, which totals $4,890. This means that once you reach this amount, your Plan benefit will pick up 100% of covered expenses for the rest of the benefit year.

- The Blue Options Designated Provider Program will not be available in 2019, therefore, a change in the 80/20 Plan’s specialist and inpatient hospital copay was necessary (see plan comparison chart for details).

- The formulary, or drug list of covered medications, changes quarterly, so changes in drug coverage are possible.

REDUCE YOUR PRIMARY CARE PROVIDER COPAY WITH THE 80/20 PLAN

You can also save money under the 80/20 Plan when you visit your selected Primary Care Provider (or see another provider in your PCP’s office). Your copay will be reduced from $25 down to $10.

The 70/30 Plan

- The 70/30 Plan is a PPO plan where you pay 30% coinsurance for eligible in-network expenses after you meet your deductible. 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. This means your annual physical or a preventative screening, such as a colonoscopy, will NOT be covered by your Plan benefit at 100%. You will be responsible for the applicable copay or deductible/coinsurance out-of-pocket amount.

- The 70/30 Plan has no changes in medical benefits. The formulary, or drug list of covered medications, changes quarterly, so changes in drug coverage are possible.

LOWER YOUR MONTHLY PREMIUMS

By completing the tobacco attestation, you can earn a wellness premium credit that will reduce your monthly premium by $60 a month. (The wellness premium credit only applies to the employee-only premium.)

<table>
<thead>
<tr>
<th>2019 PREMIUM CREDIT SAVINGS</th>
<th>80/20 PLAN</th>
<th>70/30 PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subscriber Only Monthly Premium (At Time Of Enrollment)</td>
<td>$110</td>
<td>$85</td>
</tr>
<tr>
<td>*Attest to being a non-tobacco user or agree to visit the CVS MinuteClinic for at least one tobacco cessation counseling session to earn a monthly premium credit of $60</td>
<td>-$60</td>
<td>-$60</td>
</tr>
<tr>
<td>Total Monthly Employee-Only Premium (With Credit)</td>
<td>$50</td>
<td>$25</td>
</tr>
</tbody>
</table>

*Even if you completed the tobacco attestation during last year’s Open Enrollment or as a recent new hire, you must attest again during this year’s Open Enrollment period, which is September 29-October 31, 2018, to receive the $60 premium credit for the 2019 Plan benefit year.
RISING HEALTH CARE COSTS AND HOW THEY AFFECT YOU

The majority of your health benefit is paid for by you and taxpayers like you. The State Health Plan has a front-row seat in watching health care costs skyrocket, for the Plan and our members. We have to work together to get a handle on rising costs. Otherwise, the state may be forced to cut spending in education, transportation, economic development and other core functions of government to cover those costs.

The Plan is doing its part by asking you to be a Watchdog over your health care spending. That includes shopping around for services and knowing in advance how much a health exam or procedure will cost.

In addition, we’re asking providers to accept a new reimbursement method that uses Medicare as a reference point to serve as a partner in delivering quality care while controlling the cost of health care. Join us in our effort and ask your provider about their plans to join us in this effort.

If providers don’t partner with the State Health Plan, they will no longer be considered an in-network provider. This may result in you paying more out of pocket. If the Plan is able to partner with providers to commit to this strategy, the Plan may be able to lower premium rates, keep copays reasonable and secure a more financially stable future. Together, we can achieve greater cost transparency and cost control over our health care.

BE A STATE HEALTH PLAN WATCHDOG and shop around for the medical services you need. Don’t just assume your provider is referring you to the least expensive specialist or place of service. Do your homework and research the cost so you can help us contain health care spending—and lower your own out-of-pocket costs as well!
<table>
<thead>
<tr>
<th>PLAN DESIGN FEATURES</th>
<th>80/20 PLAN IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
<th>70/30 PLAN IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Deductible</td>
<td>$1,250 Individual</td>
<td>$2,500 Individual</td>
<td>$1,080 Individual</td>
<td>$2,160 Individual</td>
</tr>
<tr>
<td></td>
<td>$3,750 Family</td>
<td>$7,500 Family</td>
<td>$3,240 Family</td>
<td>$6,480 Family</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>20% of eligible</td>
<td>40% of eligible</td>
<td>30% of eligible</td>
<td>50% of eligible</td>
</tr>
<tr>
<td></td>
<td>expenses after</td>
<td>expenses after</td>
<td>expenses after</td>
<td>expenses after</td>
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<td></td>
<td>deductible is met</td>
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<td>amount and the charge</td>
<td>amount and the charge</td>
<td>amount and the charge</td>
</tr>
<tr>
<td>Medical Coinsurance Maximum</td>
<td>N/A</td>
<td>$4,388 Individual</td>
<td>$8,776 Individual</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>$13,164 Family</td>
<td>$26,328 Family</td>
<td></td>
</tr>
<tr>
<td>Pharmacy Out-of-Pocket Maximum</td>
<td>N/A</td>
<td>$3,360 Individual;</td>
<td>$10,080 Family</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>$10,080 Family</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Out-of-Pocket Maximum (Combined</td>
<td>$4,890 Individual</td>
<td>$9,780 Individual</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$14,670 Family</td>
<td>$29,340 Family</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACA Preventive Services</td>
<td>$0 (covered at 100%)</td>
<td>Dependent on</td>
<td>$40 for PCP;</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>service</td>
<td>$94 for specialist,</td>
<td></td>
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<td></td>
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<td></td>
<td>(outpatient services,</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>at deductible/coins)</td>
<td></td>
</tr>
<tr>
<td>Office Visits</td>
<td>$25 for primary doctor;</td>
<td>$40 for PCP;</td>
<td>Only certain services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$10 if you use PCP on</td>
<td>$94 for Specialist</td>
<td>are covered</td>
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<td></td>
<td>ID card;</td>
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</tr>
<tr>
<td></td>
<td>$80 for Specialist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgent Care</td>
<td>$70</td>
<td>$337 copay, then 30% after deductible is met</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Room</td>
<td>$300 copay, then 20% after deductible is met</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$337 copay, then 30% after deductible is met</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Hospital</td>
<td>$300 copay, then 20% after deductible is met</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$300 copay, then 40% after deductible is met</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$337 copay, then 30% after deductible is met</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>$337 copay, then 50% after deductible is met</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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 $250 per 30-day supply |
| Tier 6 (Non-preferred Specialty)    | Deductible / coinsurance   |
|                                     | 25% up to $125 per 30-day supply |
| Preferred Diabetic Testing Supplies*| $5 copay per 30-day supply |
|                                     | $10 copay per 30-day supply |
| ACA Preventive Medications          | $0 (covered by the Plan at 100%) |
|                                     | N/A |

* Non-preferred diabetic testing supplies are paid at Tier 3.
2019 MONTHLY PREMIUMS

The monthly premiums below apply only to Active subscribers. Monthly premiums for all members can be found on the Plan’s website at [www.shpnc.org](http://www.shpnc.org).

<table>
<thead>
<tr>
<th>MONTHLY PREMIUM RATES</th>
<th>2019 RATES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>80/20 PLAN</strong></td>
<td></td>
</tr>
<tr>
<td>Subscriber Only</td>
<td>$50.00*</td>
</tr>
<tr>
<td>Subscriber + Child(ren)</td>
<td>$305.00*</td>
</tr>
<tr>
<td>Subscriber + Spouse</td>
<td>$700.00*</td>
</tr>
<tr>
<td>Subscriber + Family</td>
<td>$720.00*</td>
</tr>
</tbody>
</table>

| **70/30 PLAN**        |            |
| Subscriber Only       | $25.00*    |
| Subscriber + Child(ren) | $218.00*  |
| Subscriber + Spouse   | $590.00*   |
| Subscriber + Family   | $598.00*   |

*Assumes completion of tobacco attestation.

UNDERSTANDING YOUR PHARMACY COVERAGE

The State Health Plan utilizes 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.

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.**

**IMPORTANT FACT:** In the 80/20 Plan, Tier 3 and Tier 6 non-preferred medications do not have a defined copay, but are subject to a deductible/coinsurance. **This means that you will have to pay the full cost of the medication until you meet your deductible.** Once you meet your deductible, you will be responsible for the 20% coinsurance amount until you reach our out-of-pocket maximum. Medications that are subject to coinsurance in most cases will result in higher out-of-pocket costs to members. You are encouraged to speak with your provider about generic medication options, which saves you money and helps the Plan control Pharmacy spending.
YOUR PLAN. YOUR BENEFITS. YOUR RESOURCES

Get Connected with Blue Connect

State Health Plan subscribers have access to Blue Connect, a protected online resource to help you manage your health plan and maximize your benefits. With Blue Connect, registered users can complete a variety of self-service tasks online, 24 hours a day, without ever picking up the phone.

- Find a provider and read provider reviews
- Search for a procedure to view cost estimates customized to your plan and benefits
- View your claim status and where you are in meeting your deductible
- View your Health Care Summary Report
- Order new ID cards

• View your Explanation of Benefits (EOB), which has recently been redesigned to provide more transparency, greater detail and enhanced understanding of your health care costs
• Research health and wellness topics to help you make more informed health care decisions
• Register for Blue365® Discount Program, which provides:
  - Gym memberships and fitness gear
  - Vision and hearing care
  - Weight loss and nutrition programs
  - Travel and family activities
  - Mind/body wellness tools and resources
  - Financial tools and programs

Pharmacy Benefit Resources

These tools include information based on the 2018 formulary and are subject to change prior to January 1, 2019.

**Drug Lookup Tool:**
an online tool that 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 formulary or drug list is regularly updated throughout the year, on a quarterly basis.

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.

**IMPORTANT FACT:** “Utilizing these tools is a great way to help you be smarter, more educated health care consumers, which is key if we’re going to keep this benefit on a sustainable path.”

-Dale R. Folwell, CPA, State Treasurer
Decide who you want to cover under the plan. Remember, if you are adding a new dependent you will need to provide Social Security numbers and will be prompted to upload required documentation. You may find it helpful to gather these documents, if needed, before starting the enrollment process.

Visit www.shpnc.org for more information about your 2019 benefits. Utilize the resources to assist you with your decision making. You’ll find a plan comparison, videos and Benefit Booklets.

Participate in a webinar regarding Open Enrollment. These webinars will review your 2019 options, benefit changes and offer the opportunity to ask questions. Reserve your spot by visiting www.shpnc.org.

When you’re ready to enroll or change your plan, visit www.shpnc.org and click eBenefits.

Log into the eBenefits system. You may be required to create an account if you are a first-time 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. Don’t forget this critical step!
- Print 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!
**Health and Wellness Resources**

Beginning January 1, 2019, the State Health Plan will offer telephonic coaching for disease and case management for members with the following conditions: chronic obstructive pulmonary disease (COPD), congestive heart failure, coronary artery disease, diabetes, asthma, cerebrovascular disease and peripheral artery disease. Case management will also be provided for members with complex health care needs and with conditions such as chronic and end stage renal disease.

Eligible members will receive more information about these services after January 1, 2019.
LEGAL AND PRIVACY NOTICES

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 and how you can get access to this information. Please review it carefully.

Original Effective Date: April 14, 2003
Revised Effective Date: January 20, 2018

Introduction
A federal law, the Health Insurance Portability and Accountability Act (HIPAA), requires that we protect the privacy of identifiable health information that is created or received by or on behalf of the Plan. This notice describes the obligations of the Plan under HIPAA, how medical information about you may be used and disclosed, your rights under the privacy provisions of HIPAA, and how you can get access to this information. Please review it carefully. For a print-friendly version of this notice, go to www.shpnc.org.

Your Rights
You have the right to:
• Get a copy of your health and claims records
• Correct your health and claims records
• Request confidential communication
• Ask us to limit what we use or share
• Get a list of those with whom we’ve shared your information
• Get a copy of this privacy notice
• Choose someone to act for you
• File a complaint if you believe your privacy rights have been violated

Your Choices
You have some choices in the way that we use and share information if we:
• Answer coverage questions from your family and friends
• Provide disaster relief
• Market our services or sell your information

Our Uses and Disclosures
We may use and share your information as we:
• Help manage the health care treatment you receive
• Run our organization
• Pay for your health services
• Administer your health plan
• Help with public health and safety issues
• Do research
• Comply with the law
• Respond to organ and tissue donation requests and work with a medical examiner or funeral director
• Address workers’ compensation, law enforcement, and other government requests
• Respond to lawsuits and legal actions

Your Rights
When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records.
• You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
• We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
• Ask us to correct health and claims records
• You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
• We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications
• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
• We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.
• Ask us to limit what we use or share
• You can ask us not to use or share certain health information for treatment, payment, or our operations.
• We are not required to agree to your request, and we may say “no” if it would affect your care.

Get a list of those with whom we’ve shared information
• You can ask for a list (accounting) of the times we’ve shared your health information (including medical records, billing records, and any other records used to make decisions regarding your health care benefits) for six years prior to the date you asked, who we shared it with, and why.
• We will include all the disclosures except: (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.

Get a copy of this privacy notice
You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you
• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
• We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated
• You can complain if you feel we have violated your rights by contacting us using the information provided in this document.
• You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
• We will not retaliate against you for filing a complaint.

Your Choices
For certain health information, you can tell us your choices about what we share.

If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:
• Share information with your family, close friends, or others involved in payment for your care
• Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:
• Marketing purposes
• Sale of your information

Our Uses and Disclosures
How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Help manage the health care treatment you receive
We can use your health information and share it with professionals who are treating you.
Example: The Plan may disclose your health information so that your doctors, pharmacies, hospitals, and other health care providers may provide you with medical treatment.

Run our organization
We can use and disclose your information to run our organization (healthcare operations), improve the quality of care we provide, reduce healthcare costs, and contact you when necessary.
Example: The Plan may use and disclose your information to determine the budget for the following year, or to set premiums.
We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long-term care plans.
Example: We use health information about you to develop better services for you.

Pay for your health services
We can use and disclose your health information as we pay for your health services.
Example: We share information about you with CVS Caremark to coordinate payment for your prescriptions.

Administer your plan
We may disclose your health information to your health plan sponsor for plan administration.
Example: Your employer’s Health Benefit Representative is provided information to help you understand your health benefits, and help make sure you are enrolled.

How else can we use or share your health information?
We are allowed or required to share your information in other ways - usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

continued on the next page
Help with public health and safety issues
We can share health information about you for certain situations such as:
• Preventing disease
• Helping with product recalls
• Reporting adverse reactions to medications
• Reporting suspected abuse, neglect, or domestic violence
• Preventing or reducing a serious threat to anyone's health or safety

Do research
We can use or share your information for health research. Research done using Plan information must go through a special review process. We will not use or disclose your information unless we have your authorization, or we have determined that your privacy is protected.

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we’re complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director
• We can share health information about you with organ procurement organizations.
• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers’ compensation, law enforcement, and other government requests
We can use or share health information about you:
• For workers’ compensation claims
• For law enforcement purposes or with a law enforcement official
• With health oversight agencies for activities authorized by law
• For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Other uses and Disclosures
Some uses and disclosures of your information will be made only with your written authorization. For example, your written 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)(1); (iii) any disclosure which constitutes a sale of protected health information (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 receive your revocation. It will not have any effect on the prior uses and disclosures of your PHI.

Our Responsibilities
• We are required by law to maintain the privacy and security of your protected health information.
• We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
• We must follow the duties and privacy practices described in this notice and give you a copy of it.
• We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticessp.html

Changes to the Terms of 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. The Plan will post a copy of the current notice at www.shpnc.org. You may request a copy by calling 919-814-4400.

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. You will not be penalized or retaliated against for filing a complaint.

To file a complaint with the Plan, contact the Privacy Contact identified in this Notice.

To file a complaint with the Secretary of the Department of Health and Human Services for Civil rights use this contact information:

U.S. Department of Health and Human Services
200 Independence Avenue SW.
Room 509F, HHH Building
Washington, DC 20201
1-800-368-1019, 800-537-7977 (TDD)
Filing complaints online: https://ocportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

Privacy Contact
The Privacy Contact at the Plan 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 eBenefits 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 participate in 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 following a qualifying life event. These events include, but are not limited to the following:
• 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 defined by the plan) 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 (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.
• 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 of HIPAA Special Enrollment Rights
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 Eligibility and Enrollment Support Center at 855-859-0966.

Notice Regarding Mastectomy-Related Services

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women’s Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

• All stages of reconstruction of the breast on which the mastectomy was performed;
• Surgery and reconstruction of the other breast to produce a symmetrical appearance;
• Prostheses; and
• Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under your elected plan. For more information, contact Customer Service at 888-234-2416.

Disclosure of Grandfathered Plan Status

The 70/30 Plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the 70/30 Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. On the 70/30 Plan, as a plan “grandfathered” under the Affordable Care Act, cost sharing for preventive benefits will continue as it does currently and will be based on the location where the service is provided.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Customer Service at 888-234-2416. You may also contact the US Department of Health and Human Services at www.healthcare.gov.

Notice of Patient Protections for Non-Grandfathered Plans

The following notice applies to plans offered by the North Carolina State Health Plan for Teachers and State Employees (“the Plan”) that are not considered to be a “grandfathered health plan” under the Patient Protection and Affordable Care Act. The Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Customer Service at 888-234-2416.

You do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Customer Service at 888-234-2416.

Mental Health Parity and Addiction Equity Act

For more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

Employer CHIP (Children’s Health Insurance Program) Notice

If you or your children are eligible for Medicaid or CHIP and you’re eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren’t eligible for Medicaid or CHIP, you won’t be eligible for these premiums but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed in the chart on the next two pages, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren’t already enrolled. This is called a “special enrollment” opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askeb={() or call 1-866-444-4634 (3272).

continued on the next page
If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2018. Contact your state for more information on eligibility.

<table>
<thead>
<tr>
<th>State</th>
<th>Program</th>
<th>Website</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>MEDICAID</td>
<td>Website: <a href="http://myalhipp.com/">http://myalhipp.com/</a></td>
<td>Phone: 1-855-692-5447</td>
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<tr>
<td>Florida</td>
<td>MEDICAID</td>
<td>Website: <a href="http://flmedicaidtplrecovery.com/hipp/">http://flmedicaidtplrecovery.com/hipp/</a></td>
<td>Phone: 1-877-357-3268</td>
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<tr>
<td>Alaska</td>
<td>MEDICAID</td>
<td>Website: <a href="http://myakhipp.com/">http://myakhipp.com/</a></td>
<td>Phone: 1-866-251-4861</td>
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<tr>
<td>Georgia</td>
<td>MEDICAID</td>
<td>Website: <a href="http://dch.georgia.gov/medicaid">http://dch.georgia.gov/medicaid</a></td>
<td>Phone: 404-656-4507</td>
</tr>
<tr>
<td>Alaska</td>
<td>AK Health Insurance Premium Payment Program</td>
<td>Website: <a href="http://myakhipp.com/">http://myakhipp.com/</a></td>
<td>Phone: 1-866-251-4861</td>
</tr>
<tr>
<td>Georgia</td>
<td>Medicaid Eligibility:</td>
<td><a href="http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx">http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx</a></td>
<td></td>
</tr>
<tr>
<td>Arkansas</td>
<td>MEDICAID</td>
<td>Website: <a href="http://myarhipp.com/">http://myarhipp.com/</a></td>
<td>Phone: 1-855-MyARHIPP (855-692-7447)</td>
</tr>
<tr>
<td>Indiana</td>
<td>MEDICAID</td>
<td>Website: <a href="http://www.indianamedicaid.com">http://www.indianamedicaid.com</a></td>
<td>Phone: 1-800-403-0864</td>
</tr>
<tr>
<td>Colorado</td>
<td>HEALTH FIRST COLORADO</td>
<td>Website: <a href="https://www.healthfirstcolorado.com/">https://www.healthfirstcolorado.com/</a></td>
<td></td>
</tr>
<tr>
<td>Iowa</td>
<td>MEDICAID</td>
<td>Website: <a href="http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp">http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp</a></td>
<td>Phone: 1-888-346-9562</td>
</tr>
<tr>
<td>Kansas</td>
<td>MEDICAID</td>
<td>Website: <a href="http://www.kdheks.gov/hcf/">http://www.kdheks.gov/hcf/</a></td>
<td>Phone: 1-785-296-3512</td>
</tr>
<tr>
<td>Kentucky</td>
<td>MEDICAID</td>
<td>Website: <a href="http://chfs.ky.gov/dms/default.htm">http://chfs.ky.gov/dms/default.htm</a></td>
<td>Phone: 1-800-635-2570</td>
</tr>
<tr>
<td>Louisiana</td>
<td>MEDICAID</td>
<td>Website: <a href="http://dhh.louisiana.gov/index.cfm/subhome/1/n/331">http://dhh.louisiana.gov/index.cfm/subhome/1/n/331</a></td>
<td>Phone: 1-888-695-2447</td>
</tr>
<tr>
<td>Maine</td>
<td>MEDICAID</td>
<td>Website: <a href="http://www.maine.gov/dhhs/people-we-serve/seniors/health-care/medical-assistance.jsp">http://www.maine.gov/dhhs/people-we-serve/seniors/health-care/medical-assistance.jsp</a></td>
<td>Phone: 1-800-657-3739</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>MEDICAID + CHIP</td>
<td>Website: <a href="https://www.mass.gov/eohhs/gov/departments/masshealth/">https://www.mass.gov/eohhs/gov/departments/masshealth/</a></td>
<td>Phone: 1-800-862-4840</td>
</tr>
<tr>
<td>Minnesota</td>
<td>MEDICAID</td>
<td>Website: <a href="http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp">http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp</a></td>
<td>Phone: 1-800-657-3739</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>MEDICAID</td>
<td>Website: <a href="https://www.dhhs.nh.gov/ombp/nhhpp/">https://www.dhhs.nh.gov/ombp/nhhpp/</a></td>
<td>Phone: 603-271-5218</td>
</tr>
<tr>
<td>New Jersey</td>
<td>MEDICAID + CHIP</td>
<td>Medicaid Website: <a href="http://www.state.nj.us/humanservices/dmahnhs/clients/medicaid/">http://www.state.nj.us/humanservices/dmahnhs/clients/medicaid/</a></td>
<td>Medicaid Phone: 609-651-2392</td>
</tr>
<tr>
<td>New York</td>
<td>MEDICAID</td>
<td>Website: <a href="https://www.health.ny.gov/health_care/medicaid/">https://www.health.ny.gov/health_care/medicaid/</a></td>
<td>Medicaid Phone: 609-651-2392</td>
</tr>
<tr>
<td>North Carolina</td>
<td>MEDICAID</td>
<td>Website: <a href="https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp">https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp</a></td>
<td>Phone: 1-888-346-9562</td>
</tr>
<tr>
<td>North Dakota</td>
<td>MEDICAID</td>
<td>Website: <a href="https://www.insureoklahoma.org">https://www.insureoklahoma.org</a></td>
<td>Phone: 1-888-365-3742</td>
</tr>
</tbody>
</table>
### Missouri - Medicaid

**Website:** [https://www.dss.mo.gov/mhd/participants/pages/hipp.htm](https://www.dss.mo.gov/mhd/participants/pages/hipp.htm)

**Phone:** 573-751-2005

### Oregon - Medicaid

**Website:** [https://healthcare.oregon.gov/Pages/index.aspx](https://healthcare.oregon.gov/Pages/index.aspx)

**Phone:** 1-800-699-9075

### Montana - Medicaid

**Website:** [http://dphealth.mt.gov/MontanaHealthcarePrograms/HIPP](http://dphealth.mt.gov/MontanaHealthcarePrograms/HIPP)

**Phone:** 1-800-694-3084

### Pennsylvania - Medicaid

**Website:** [http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm](http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm)

**Phone:** 1-800-697-7462

### Nebraska - Medicaid

**Website:** [http://www.ACCESSNebraska.ne.gov](http://www.ACCESSNebraska.ne.gov)

**Phone:** 1-800-694-3084

### Rhode Island - Medicaid

**Website:** [http://www.eohhs.ri.gov/](http://www.eohhs.ri.gov/)

**Phone:** 855-697-4347

### Nevada - Medicaid

**Medicaid Website:** [https://dhcfp.nv.gov](https://dhcfp.nv.gov)

**Medicaid Phone:** 1-800-992-0900

### South Carolina - Medicaid

**Website:** [https://www.scdhhs.gov](https://www.scdhhs.gov)

**Phone:** 1-888-549-0820

### South Dakota - Medicaid

**Website:** [http://dss.sd.gov](http://dss.sd.gov)

**Phone:** 1-888-828-0059

### Wisconsin - Medicaid

**Website:** [https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf](https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf)

**Phone:** 1-800-362-3002 Ext. 15473

### Vermont - Medicaid

**Website:** [http://www.greenmountaincare.org/](http://www.greenmountaincare.org/)

**Phone:** 1-800-250-8427

### Virginia - Medicaid + CHIP

**Medicaid Website:** [http://www.coverva.org/programs_premium_assistance.cfm](http://www.coverva.org/programs_premium_assistance.cfm)

**Medicaid Phone:** 1-800-432-5924

**CHIP Website:** [http://www.coverva.org/programs_premium_assistance.cfm](http://www.coverva.org/programs_premium_assistance.cfm)

**CHIP Phone:** 1-855-242-8282

### 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)
  - The State Health Plan website is Americans with Disabilities Act (ADA) compliant for the visually impaired.
  - 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:


File complaint electronically at: [https://ocrportal.hhs.gov/ocr/portal/lobby.jsf](https://ocrportal.hhs.gov/ocr/portal/lobby.jsf).

CONTACT US

Eligibility and Enrollment Support Center (eBenefits 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 benefit questions): 888-321-3124

OPEN IMMEDIATELY!

2019 OPEN ENROLLMENT DECISION GUIDE

State Health Plan

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Durham, NC

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For Teachers and School Staff...