Our mission is to improve the health and health care of North Carolina teachers, state employees, retirees, and their dependents, in a financially sustainable manner, thereby serving as a model to the people of North Carolina for improving their health and well-being.
Understanding the Value of Your State Health Plan Coverage

You are now a valued state employee, and the taxpayers of North Carolina invest in you and your health by offering eligible employees full medical and pharmacy benefits through the State Health Plan. The state pays for the majority of your benefit, with you subsidizing the coverage for any dependents you choose to add on to the Plan.

Please note:

- Permanent employees working a minimum of 30 hours per week may enroll in the State Health Plan.
- For you and other permanent employees, your employing agency contributes nearly $500 to your health benefit each month.
- For employee-only coverage each month, you pay $25 on the 70/30 Plan, or $50 on the 80/20 Plan, if you complete a tobacco attestation, plus any dependent premiums, if you choose to cover dependents.
- Non-Permanent employees working a minimum of 30 hours a week can also enroll in State Health Plan benefits, they are just different benefits.

The State Health Plan offers two health plan options: The 80/20 Plan and the 70/30 Plan.

Both plans are administered by Blue Cross and Blue Shield of North Carolina (Blue Cross NC) but benefits are paid by the state, not Blue Cross NC. You can seek care from providers in the NC State Health Plan Network or go out-of-network. However, if you stay in-network, your deductibles, copays and coinsurance will be lower. Both plans cover the same medical and pharmacy services. However, the member cost share varies by each plan.

CVS Caremark is the Plan’s pharmacy manager, but your pharmacy benefits are paid by the state. Members should note that this does NOT mean members will have to go to a CVS pharmacy location for their prescriptions.

The State Health Plan utilizes a custom, closed formulary or drug list. Under a custom, closed formulary, certain drugs are not covered. If you find that your prescription is not covered, speak to your provider about possible alternatives. There is an exception process available to providers who believe that, based on medical necessity, it is in the member’s best interest to remain on a non-covered drug.

80/20 Plan

This plan has higher premiums than the 70/30 Plan in exchange for lower copays and lower coinsurance. In addition, the deductible is lower on this plan than the 70/30 Plan. With this plan, Affordable Care Act preventive services and medications are covered at 100%, which means there is no charge to you. An example of such a service includes an annual physical.

70/30 Plan

This plan has lower premiums in exchange for higher copays and coinsurance. Affordable Care Act preventive services and medications are also covered at 100%, which means there is no charge to you. An example of such a service includes an annual physical.

Affordable Care Act Preventive Services and Medications lists are located on the Plan’s website at www.shpnc.org.
LOWER YOUR MONTHLY PREMIUMS

By completing the tobacco attestation, you can earn a wellness premium credit that will reduce your monthly premium in both plan options. The wellness premium credit only applies to the employee-only premium. In order to receive the premium credit, you must complete the tobacco attestation within 30 days of your hire date. The tobacco attestation can be completed online through eBenefits, the Plan’s enrollment system.

<table>
<thead>
<tr>
<th>2019 PREMIUM CREDIT SAVINGS</th>
<th>80/20 PLAN</th>
<th>70/30 PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee-only Monthly Premium</td>
<td>$110</td>
<td>$85</td>
</tr>
<tr>
<td>Attest that you are tobacco-free or agree to visit a CVS MinuteClinic for at least one tobacco cessation counseling session.*</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>

*Tobacco attestation must be completed each year. For tobacco users that agree to visit a CVS MinuteClinic for a tobacco cessation counseling session, only one visit is required to receive your premium credit. One session must be completed within 60 days of your enrollment.

Save Even More by Visiting Your Primary Care Provider

You can also save money under the 80/20 and 70/30 plans when you visit your selected Primary Care Provider as shown below.

<table>
<thead>
<tr>
<th>ACTION</th>
<th>COPAY REDUCED TO</th>
</tr>
</thead>
<tbody>
<tr>
<td>See your selected Primary Care Provider (or see another provider in your PCP’s office)</td>
<td>$10 on the 80/20 Plan $30 on the 70/30 Plan</td>
</tr>
</tbody>
</table>
HEALTH & WELLNESS RESOURCES

The State Health Plan offers 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
- 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.

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 Blue Cross NC, 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 access Blue Connect, visit the State Health Plan’s website at www.shpnc.org and click eBenefits to log into eBenefits, the Plan’s enrollment system. Once you’re logged into eBenefits, 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.
New Member Enrollment

You can enroll yourself as well as eligible family members in health plan coverage. Eligible family members include:

- Your spouse.
- Your or your spouse’s biological, legally adopted or foster child up to age 26 (including a child for whom you are the court-appointed guardian and a stepchild if you are married to the child’s biological parent).
- A dependent child over the age of 26 if he or she is physically or mentally incapacitated to the extent that he or she is incapable of earning a living. The handicap must have either developed or begun to develop before the dependent's 19th birthday, or the handicap must have developed or begun to develop before the dependent's 26th birthday if the dependent was covered by the State Health Plan.

Dependent verification documentation is required for all dependents. You are able to upload these documents in eBenefits, the Plan’s enrollment system.

Decision Support Tools

WHAT ARE THE PREMIUM RATES?

Premium rate charts are available on the State Health Plan’s website at www.shpnc.org. If you are a less than 12-month employee or the employee of a Local Government Employer, please ask your Health Benefits Representative for your applicable rates.

SELECTING THE PLAN THAT IS BEST FOR YOU

Only you can decide which plan option is best for you and your family. However, the State Health Plan provides a number of resources to help you make an informed decision.

Visit www.shpnc.org for details about the 2020 Health Plan options, including:

- Links to the CVS Caremark drug lookup tool to assist you with determining your out-of-pocket costs for medications
- Benefit Booklets
- Plan Comparison
- Informational Videos

Special Enrollment

If you decline coverage for yourself or your eligible dependents and you later experience a qualifying event, you and/or your dependents may be eligible to enroll. You must enroll within 30 days of the qualifying event outside of the annual Open Enrollment period.

Effective Date

The coverage effective date for new employees is the first day of the month following the date of employment, or the first day of the second month. You and any eligible dependents must enroll in the State Health Plan with the same effective date unless you experience a qualifying life event. Enrollment must occur within 30 days of your date of hire.

How Do I Enroll?

To enroll, visit the State Health Plan’s website at www.shpnc.org and click “eBenefits” to access the Plan’s enrollment system. If you need assistance call 855-859-0966.

Stay Informed

Subscribe to the State Health Plan’s Member Focus e-newsletter to keep up to date on your pharmacy and health benefits. You’ll receive monthly tips on how to stay healthy and save money—plus recipes and more. Sign up today at www.shpnc.org. Just click on the “Newsletter” link on the bottom of the page.

Have Questions?

For additional information regarding benefit coverage, visit the State Health Plan website at www.shpnc.org. You may also call Customer Service at 888-234-2416, or ask your Health Benefits Representative. Questions regarding Enrollment and Eligibility should be directed to the Eligibility and Enrollment Support Center at 855-859-0966. For a complete description of the health plans offered, please refer to the Benefits Booklets available online at www.shpnc.org.

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 or employee-spouse) will remain in effect until the next Open Enrollment period. You will not be able to add or drop a spouse or dependents until the next benefit plan year unless you experience a qualifying event. These events include changes such as marriage, birth and retirement. For a complete list of qualifying events, refer to the IRS Section 125 legal notice included in this kit, or ask your Health Benefits Representative. Open Enrollment is typically held in the fall.
# 2020 State Health Plan Comparison

## Plan Design Features

<table>
<thead>
<tr>
<th></th>
<th>80/20 Plan</th>
<th>70/30 Plan</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Deductible</strong></td>
<td><strong>IN-NETWORK</strong></td>
<td><strong>OUT-OF-NETWORK</strong></td>
<td><strong>IN-NETWORK</strong></td>
<td><strong>OUT-OF-NETWORK</strong></td>
</tr>
<tr>
<td>Family</td>
<td>$3,750</td>
<td>$7,500</td>
<td>$9,000 Family</td>
<td>$18,000 Family</td>
</tr>
<tr>
<td>Individual</td>
<td>$1,250</td>
<td>$2,500</td>
<td>$1,500 Individual</td>
<td>$3,000 Individual</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>20%</td>
<td>40%</td>
<td>30%</td>
<td>50%</td>
</tr>
<tr>
<td></td>
<td>of eligible expenses after deductible is met</td>
<td>after deductible is met and the difference between the allowed amount and the charge</td>
<td>after deductible is met and the difference between the allowed amount and the charge</td>
<td>after deductible is met and the difference between the allowed amount and the charge</td>
</tr>
<tr>
<td><strong>Out-of-Pocket Maximum</strong></td>
<td><strong>IN-NETWORK</strong></td>
<td><strong>OUT-OF-NETWORK</strong></td>
<td><strong>IN-NETWORK</strong></td>
<td><strong>OUT-OF-NETWORK</strong></td>
</tr>
<tr>
<td>(Combined Medical &amp; Pharmacy)</td>
<td>$14,670</td>
<td>$29,340</td>
<td>$32,600 Family</td>
<td>$65,200 Family</td>
</tr>
<tr>
<td>Individual</td>
<td>$4,890</td>
<td>$9,780</td>
<td>$5,900 Individual</td>
<td>$11,800 Individual</td>
</tr>
<tr>
<td>Family</td>
<td>$14,670</td>
<td>$29,340</td>
<td>$5,900 Individual</td>
<td>$11,800 Individual</td>
</tr>
<tr>
<td>Preventive Services</td>
<td>$0 (covered at 100%)</td>
<td>Dependent on service</td>
<td>$0 (covered at 100%)</td>
<td>Dependent on service</td>
</tr>
<tr>
<td>Office Visits</td>
<td>$25 for primary doctor; $10 if you use PCP on ID card; $80 for Specialist</td>
<td>$45 for primary doctor; $30 if you use PCP on ID card; $94 for Specialist</td>
<td>$45 for primary doctor; $30 if you use PCP on ID card; $94 for Specialist</td>
<td>$45 for primary doctor; $30 if you use PCP on ID card; $94 for Specialist</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>$70</td>
<td>$100</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Room</td>
<td>$300 copay, then 20% after deductible is met</td>
<td>$337 copay, then 30% after deductible is met</td>
<td>$337 copay, then 30% after deductible is met</td>
<td>$337 copay, then 30% after deductible is met</td>
</tr>
<tr>
<td><strong>Inpatient Hospital</strong></td>
<td>$300 copay, then 20% after deductible is met</td>
<td>$300 copay, then 40% after deductible is met</td>
<td>$337 copay, then 30% after deductible is met</td>
<td>$337 copay, then 50% after deductible is met</td>
</tr>
<tr>
<td><strong>Prescription Drugs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier 1 (Generic)</td>
<td>$5 copay per 30-day supply</td>
<td>$16 copay per 30-day supply</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier 2 (Preferred Brand &amp; High-Cost Generic)</td>
<td>$30 copay per 30-day supply</td>
<td>$47 copay per 30-day supply</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier 3 (Non-preferred Brand)</td>
<td>Deductible / coinsurance</td>
<td>Deductible/coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier 4 (Low-Cost Generic Specialty)</td>
<td>$100 copay per 30-day supply</td>
<td>$200 copay per 30-day supply</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier 5 (Preferred Specialty)</td>
<td>$250 copay per 30-day supply</td>
<td>$350 copay per 30-day supply</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier 6 (Non-preferred Specialty)</td>
<td>Deductible / coinsurance</td>
<td>Deductible/coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preferred Diabetic Testing Supplies*</td>
<td>$5 copay per 30-day supply</td>
<td>$10 copay per 30-day supply</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive Medications</td>
<td>$0 (covered by the Plan at 100%)</td>
<td>$0 (covered by the Plan at 100%)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Preferred Brand is the OneTouch Test Strips. Non-preferred diabetic testing supplies are considered a Tier 3 member copay.
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 the information we 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 Regarding Protected Health Information (PHI)
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. Asks 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 ask, 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)(3); (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/noticcepp.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, 800-537-7697 (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

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 by paying your premiums 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 contribution 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 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 NC Flex, 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 under IRS Section 125) 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 Plan or the state’s flexible spending plan. If you choose the State Health Plan, you may change your election with the Secretary of the Department of Health and Human Services. 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 which an election change was permitted, you may have a corresponding election change under the 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 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., cover-age 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 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 Women’s Health and Cancer Rights Act of 1998

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.

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. However, you 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 Opt-Out Notice

Election to be Exempt from Certain Federal law requirements in Title XXVII of the Public Health Service Act

Group health plans sponsored by State and local governmental employers must generally comply with Federal law requirements in Title XXVII of the Public Health Service Act. However, these employers are permitted to exempt their employees from the requirements of the Act if the employer can show that the requirements listed below for any part of the plan that is “self-funded” by the employer, rather than provided through the employee’s employer contributions. You may also request your State Health Plan for Teachers and State Employees to exempt your plan from the requirements listed below for any part of the plan that meets certain standards. The savings on your premium that you are eligible for depends on your household income. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer’s health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the “minimum value” standard set by the Affordable Care Act, you may be eligible for a tax credit. An employer-sponsored health plan meets the “minimum value standard” if the plan’s share of the total allowed benefit costs covered by the plan is no less than 60% of such costs.

It is important to note, if you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution to the employer-offered coverage. Also, this employer contribution, as well as your employee contribution to employer-offered coverage, is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. For more information about your coverage offered by your employer, please review the summary plan description or contact Customer Service at 888-234-2416. The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov 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, you are 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 premium assistance programs 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 1-866-444-EBSA (3272).
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 July 31, 2019. Contact your State for more information on eligibility.

<table>
<thead>
<tr>
<th>State</th>
<th>Medicaid Website</th>
<th>Medicaid Phone</th>
</tr>
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</table>
| ALABAMA - Medicaid | Website: http://myalhipp.com/  
Phone: 1-855-692-5447 |                                                                |
| FLORIDA - Medicaid | Website: http://fimedicaidtplrecovery.com/hipp/  
Phone: 1-877-357-3268 |                                                                |
| ALASKA - Medicaid | The AK Health Insurance Premium Payment Program  
Website: http://myakhipp.com/  
Phone: 1-866-251-4861  
Email: CustomerService@MyAKHIPP.com  
Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx | Healthy Indian Plan for low-income adults 19-64  
Website: http://www.in.gov/fssa/hip/  
Phone: 1-877-435-4479  
All other Medicaid  
Website: http://www.indianamedicaid.com  
Phone: 1-800-403-0864 |
| GEORGIA - Medicaid | Website: https://medicaid.georgia.gov/healthinsurance-premium-payment-program-hipp  
Phone: 678-564-1162 ext 2131 |                                                                |
| ARKANSAS - Medicaid | Website: http://myarhipp.com/  
Phone: 1-855-MyARHIPP (855-692-7447) | Healthy Indiana Plan for low-income adults 19-64  
Website: http://www.in.gov/fssa/hip/  
Phone: 1-877-435-4479  
All other Medicaid  
Website: http://www.indianamedicaid.com  
Phone: 1-800-403-0864 |
| COLORADO - Medicaid | Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+)  
Website: https://www.healthfirstcolorado.com/HealthFirstColoradoMemberContactCenter/  
Phone: 1-800-221-3043  
State Relay 711  
CHP+: https://www.colorado.gov/pacific/hcpf/child-healthplan-plus-CHP+  
State Relay 711 | IOHWA - Medicaid  
Website: http://dhs.iowa.gov/Hawki  
Phone: 1-800-257-8563 |
| KANSAS - Medicaid | Website: https://www.kdheks.gov/hcf/  
Phone: 1-785-296-3512 | NEW HAMPSHIRE - Medicaid  
Website: https://www.dhhs.nh.gov/oii/hipp.htm  
Phone: 603-271-5218  
Toll free number for the HIPP program: 1-800-852-3345, ext 5218 |
| KENTUCKY - Medicaid | Website: https://chfs.ky.gov  
Phone: 1-800-635-2570 | NEW JERSEY - Medicaid  
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/  
Medicaid Phone: 609-631-2392  
CHIP Website: http://www.njfamilycare.org/index.html  
CHIP Phone: 1-800-701-0710 |
| LOUISIANA - Medicaid | Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331  
Phone: 1-888-695-2447 | NEW YORK - Medicaid  
Website: https://www.health.ny.gov/healthcare/medicaid/  
Phone: 1-800-541-2831 |
Phone: 1-800-442-6003  
TTY: Maine relay 711 | NORTH CAROLINA - Medicaid  
Website: https://medicaid.ncdhhs.gov/  
Phone: 919-855-4100 |
| MASSACHUSETTS - Medicaid and CHIP | Website: http://www.mass.gov/eohhs/departments/masshealth/  
Phone: 1-800-862-4340 | NORTH DAKOTA - Medicaid  
Website: http://www.nd.gov/dhs/services/medicalsev/medicaid/  
Phone: 1-844-854-4825 |
| MINNESOTA - Medicaid | Website: https://mn.gov/dhs/people-we-serve/seniors/healthcare/health-care-programs/programs-and-services/otherinsurance.jsp  
Phone: 1-800-657-3739 | OKLAHOMA - Medicaid and CHIP  
Website: http://www.insureoklahoma.org  
Phone: 1-888-365-3742 |
<table>
<thead>
<tr>
<th>State</th>
<th>Medicaid Website</th>
<th>Medicaid Phone</th>
<th>CHIP Website</th>
<th>CHIP Phone</th>
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</thead>
<tbody>
<tr>
<td>MISSOURI</td>
<td><a href="http://www.dss.mo.gov/mhd/participants/pages/hipp.htm">Website</a></td>
<td>573-751-2005</td>
<td><a href="http://www.oregonhealthcare.gov/index-es.html">Website</a></td>
<td>1-800-699-9075</td>
</tr>
<tr>
<td>MONTANA</td>
<td><a href="http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP">Website</a></td>
<td>1-800-694-3084</td>
<td><a href="http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm">Website</a></td>
<td>1-800-692-7462</td>
</tr>
<tr>
<td>NEBRASKA</td>
<td><a href="http://www.ACCESSNebraska.ne.gov">Website</a></td>
<td>(855) 632-7633</td>
<td><a href="http://www.eohhs.ri.gov/">Website</a></td>
<td>855-697-4347, or 401-462-0311 (Direct Rite Share Line)</td>
</tr>
<tr>
<td>NEVADA</td>
<td>Medicaid Website: <a href="https://dhcfp.nv.gov">https://dhcfp.nv.gov</a></td>
<td>1-800-992-0900</td>
<td><a href="http://mywvhipp.com/">Website</a></td>
<td>1-855-MyWVHIP (1-855-699-8447)</td>
</tr>
<tr>
<td>SOUTH DAKOTA</td>
<td>Website: <a href="https://www.hca.wa.gov/">https://www.hca.wa.gov/</a></td>
<td>1-888-549-0820</td>
<td><a href="http://www.wyqualitycare.acs-inc.com/">Website</a></td>
<td>855-242-8282</td>
</tr>
<tr>
<td>TEXAS</td>
<td>Website: <a href="https://gethipptexas.com/">https://gethipptexas.com/</a></td>
<td>1-888-828-0059</td>
<td><a href="http://www.coverva.org/programs_premium_assistance.cfm">Website</a></td>
<td>1-855-432-5924</td>
</tr>
<tr>
<td>VERMONT</td>
<td>Website: <a href="https://www.greenmountaincare.org/">https://www.greenmountaincare.org/</a></td>
<td>1-800-259-8427</td>
<td><a href="http://www.coverva.org/programs_premium_assistance.cfm">Website</a></td>
<td>1-855-432-5924</td>
</tr>
<tr>
<td>VIRGINIA</td>
<td>Medicaid Website: <a href="http://www.coverva.org/programs_premium_assistance.cfm">http://www.coverva.org/programs_premium_assistance.cfm</a></td>
<td>1-800-432-5924</td>
<td>CHIP Website: <a href="http://www.coverva.org/programs_premium_assistance.cfm">http://www.coverva.org/programs_premium_assistance.cfm</a></td>
<td>1-855-432-5924</td>
</tr>
</tbody>
</table>

To see if any other states have added a premium assistance program since July 31, 2019, or for more information on special enrollment rights, contact either:

**U.S. Department of Labor**
Employee Benefits Security Administration
[www.dol.gov/agencies/ebsa](http://www.dol.gov/agencies/ebsa) 1-866-444-EBSA (1-866-444-3272)

**U.S. Department of Health and Human Services**
Centers for Medicare & Medicaid Services
[www.cms.hhs.gov](http://www.cms.hhs.gov) 1-877-267-2323, Menu Option 4, Ext. 61565

**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, or 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:

**U.S. Department of Health and Human Services**
200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

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
Blue Cross and Blue Shield of NC (benefits and claims): 888-234-2416
CVS Caremark (pharmacy benefit questions): 888-321-3124