

Your

NORTH CAROLINA STATE HEALTH PLAN



2020 OPEN ENROLLMENT DECISION GUIDE

NOVEMBER 2-19, 2019

“

As your State Treasurer, I've pledged to preserve and protect the State Health Plan for the people that educate, protect and serve. This year with the Clear Pricing Project, the goal was to get rid of secret contracts, lower health care costs and ultimately, lower family premiums. This was all done in an effort to tackle the rising cost of health care you and your family face every day. Members will continue to have access to the same broad, statewide provider network for 2020 as you enjoy today. The Plan will continue to fight for transparency and lower costs. I encourage you to review your options in this Decision Guide and select the best benefit choice for you and your family.

”

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 2020. See our special section on the Clear Pricing Project and our new North Carolina State Health Plan Network!

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 to a \$25 employee-only premium by completing the tobacco attestation.

Members who wish to enroll in the 80/20 Plan or who wish to reduce their monthly premium in either the 80/20 Plan or the 70/30 Plan by completing the tobacco attestation will need to **take action** during Open Enrollment. This process has been improved from last year.

IMPORTANT NEWS FOR 2020

- ▶ **The SAME provider network will be available in 2020 as in 2019.**
- ▶ **For the second year in a row, premiums have been frozen for 2020!**
Please see rates on page 6.
- ▶ **The 70/30 Plan has several changes:**
 - Preventive services *will be covered* at 100% (copays have been eliminated)!
 - Primary Care Provider (PCP) copay **REDUCED** from \$45 down to \$30 when you visit the PCP listed on your ID card.
 - Medical and pharmacy deductibles, copays and coinsurance will be combined into one maximum out-of-pocket amount for member simplification.
 - Deductible and some copays will change, see page 4.
- ▶ **The 80/20 Plan remains the same, with no changes to any out-of-pocket amounts.**

The choices you make during Open Enrollment are for benefits from January 1, 2020, through December 31, 2020. 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.

THE 2020 NORTH CAROLINA STATE HEALTH PLAN NETWORK

The State Health Plan's Clear Pricing Project was developed to secure the Plan's financial future and to promote quality, accessible health care. The goal of this effort was to ensure that members have this valuable benefit for years to come, while bringing transparency to health care expenses and addressing the rising health costs that you and your family face every day.

This effort resulted in more than 25,000 providers partnering with the Plan for transparent and affordable health care. In the future the Plan will be highlighting providers who support non-secret contracts and transparency. However, no major hospitals were willing to partner with the Plan. Their demands for secret contracts and higher costs prevented the Plan from actually being able to lower family premiums for 2020.

To ensure members continue to have access to a broad, statewide provider network, the decision was made that members will continue to have access to the **SAME** network available to you today, in addition to those providers that committed to transparent pricing.

What does this mean for members?

- ✔ You and your family will have access to the **SAME** provider network that you have today, which is called the Blue Options network administered by Blue Cross NC.
- ✔ This includes statewide coverage and all hospitals. It also includes Blue Cross NC's national network.
- ✔ The goal for 2020 was to **LOWER** family premiums. However, the Plan was only able to hold premiums steady, because North Carolina's major hospitals didn't agree to transparency or join in our effort to lower rising health care costs.

Finding a provider is easy. Visit www.shpnc.org and click "Find a Doctor."
This search tool allows you to find a provider by name, location or specialty.



A LOOK AT YOUR 2020 OPTIONS

For 2020, 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 for the North Carolina State Health Plan Network. They process medical claims and offer a provider network, but taxpayers like you pay for your coverage.

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.
- **Preventive services performed by an in-network provider are now covered at 100%!** This means that for your next annual physical or preventive screenings, like a colonoscopy, **THERE WILL BE NO COPAY FOR THOSE SERVICES.**
- **The 70/30 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 \$5,900 (in-network/individual).** 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 formulary, or drug list of covered medications, changes quarterly, so changes in drug coverage are possible.** There have been changes to the prescription copays. See information in this guide for more details.

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.
- **Preventive services performed by an in-network provider are covered at 100%.**
- **The 80/20 Plan has a combined medical and pharmacy out-of-pocket maximum, which totals \$4,890 (in-network/individual).** 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 80/20 Plan has no changes in benefits for the 2020 benefit year.** 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 70/30 and 80/20 Plans

*Now you can save money on the 70/30 and 80/20 plans when you visit your selected Primary Care Provider (or see another provider in your PCP's office). On the 70/30 Plan, your copay will be **REDUCED** from \$45 down to \$30. On the 80/20 Plan, your copay will be **REDUCED** from \$25 down to \$10.*

These PPO plans allow you the flexibility to visit any provider — in- or out-of-network — and receive benefits; however, you pay less when you visit an in-network provider. See more details about each plan on the next page.

2020 STATE HEALTH PLAN COMPARISON

WHAT YOU PAY				
PLAN DESIGN FEATURES	80/20 PLAN		70/30 PLAN	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible	\$1,250 Individual \$3,750 Family	\$2,500 Individual \$7,500 Family	\$1,500 Individual \$4,500 Family	\$3,000 Individual \$9,000 Family
Coinsurance	20% of eligible expenses after deductible is met	40% of eligible expenses after deductible is met and the difference between the allowed amount and the charge	30% of eligible expenses after deductible is met	50% of eligible expenses after deductible is met and the difference between the allowed amount and the charge
Out-of-Pocket Maximum (Combined Medical and Pharmacy)	\$4,890 Individual \$14,670 Family	\$9,780 Individual \$29,340 Family	\$5,900 Individual \$16,300 Family	\$11,800 Individual \$32,600 Family
Preventive Services	\$0 (covered by the Plan at 100%)	Dependent on service	\$0 (covered by the Plan at 100%)	Dependent on service
Office Visits	\$25 for primary doctor; \$10 if you use PCP on ID card; \$80 for Specialist	40% after deductible is met	\$45 for primary doctor; \$30 if you use PCP on ID card; \$94 for Specialist	50% after deductible is met
Urgent Care	\$70		\$100	
Emergency Room (Copay waived w/ admission or observation stay)	\$300 copay, then 20% after deductible is met		\$337 copay, then 30% after deductible is met	
Inpatient Hospital	\$300 copay, then 20% after deductible is met. Out-of-Network \$300 copay, then 40% after deductible is met.		\$337 copay, then 30% after deductible is met. Out-of-Network \$337 copay, then 50% after deductible is met.	
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		Deductible/coinsurance	
Tier 4 (Low-Cost Generic Specialty)	\$100 copay per 30-day supply		\$200 copay per 30-day supply	
Tier 5 (Preferred Specialty)	\$250 copay per 30-day supply		\$350 copay per 30-day supply	
Tier 6 (Non-preferred Specialty)	Deductible/coinsurance		Deductible/coinsurance	
Preferred Diabetic Testing Supplies*	\$5 copay per 30-day supply		\$10 copay per 30-day supply	
Preventive Medications	\$0 (covered by the Plan at 100%)		\$0 (covered by the Plan at 100%)	

*Preferred Brand is the One Touch Test Strips. Non-preferred diabetic testing supplies are considered a Tier 3 member copay.

UNDERSTANDING YOUR PHARMACY COVERAGE

The State Health Plan utilizes a custom, closed formulary (drug list). The formulary indicates which drugs are 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.**

Once you meet your deductible, you will be responsible for the coinsurance amount until you reach your 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 save you money!

IMPORTANT NOTE ON TIER 3 & TIER 6 MEDICATIONS

*On both the 80/20 and 70/30 plans: 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.** This is new for the 70/30 Plan for 2020!*

PHARMACY BENEFIT RESOURCES

These tools include information based on the 2019 formulary and are subject to change prior to January 1, 2020.

- **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.
- **Preventive Medication List (70/30 and 80/20 plans):** 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, so there is always a possibility that the coverage status of your medication(s) could change, which may affect your out-of-pocket costs.
- **The Plan's Pharmacy Benefit Manager, CVS Caremark:** 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.

YOUR MONTHLY PREMIUMS

TOBACCO ATTESTATION

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.)

At Time of Enrollment	80/20 PLAN	70/30 PLAN
Subscriber-Only Monthly Premium	\$110	\$85
*Attest to being a non-tobacco user or agree to visit a CVS MinuteClinic (by Dec. 31, 2019) for at least one cessation counseling session to earn a monthly premium credit of \$60. No voucher needed!	-\$60	-\$60
Total Monthly Employee-Only Premium (With Credit)	\$50	\$25

NEW FOR 2020:

Tobacco users who want to earn the premium credit must visit a CVS MinuteClinic for at least one tobacco cessation counseling session by **December 31, 2019**, to receive the monthly premium credit. Vouchers will no longer be needed for the visit.

* Even if you completed the tobacco attestation during last year's Open Enrollment, you must attest again during this year's Open Enrollment period to receive the \$60 premium credit for the 2020 Plan benefit year.

2020 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.

2020 MONTHLY PREMIUM RATES		
	80/20 PLAN	70/30 PLAN
Subscriber Only	\$50.00*	\$25.00*
Subscriber + Child(ren)	\$305.00	\$218.00
Subscriber + Spouse	\$700.00	\$590.00
Subscriber + Family	\$720.00	\$598.00

*Assumes completion of tobacco attestation.

NORTH CAROLINA HEALTH INFORMATION EXCHANGE AND YOU

North Carolina's new Health Information Exchange (HIE) system, NC HealthConnex, is a secure computer system for doctors, hospitals and other health care providers to share information that can improve your care. The system links your key medical information from all your health care providers to create a single, electronic patient health record.

The deadline for most providers to connect to NC HealthConnex is June 1, 2020. If providers are not connected by this date, Blue Cross NC, the Plan's third-party administrator, will reject claims from non-compliant providers for services provided to State Health Plan members.

This means that if you visit a non-compliant provider after June 1, 2020, your service will not be covered, you will not be able to submit a claim and you will be responsible for all costs. It's important to ask your provider if they are part of the NC HealthConnex system.

NC HealthConnex is not mandatory for members, who can opt out of the system. More details on NC HealthConnex, including FAQs and how to opt out, are available at www.hiea.nc.gov.

OPEN ENROLLMENT CHECKLIST

✔ **Decide who you want to cover under the plan.** 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 2020 benefits.** Utilize the resources to assist you with your decision making. You'll find a plan comparison, videos and Benefit Booklets.

✔ **Confirm or elect a new Primary Care Provider to make sure you receive a lower copay for office visits!**

✔ **Participate in a webinar regarding Open Enrollment.** These webinars will review your 2020 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 your confirmation statement for your records.

IMPORTANT:

After you have made your choices, and they are displayed for you to review and print, you **MUST** scroll down to the bottom and click **SAVE** or your choices will not be recorded!

Register for an upcoming webinar at www.shpnc.org today!

WEBINAR DATES	WEBINAR TIMES
October 30	12:30 p.m. & 4 p.m.
November 5	12:30 p.m. & 4 p.m.
November 7	12:30 p.m. & 4 p.m.
November 13	12:30 p.m. & 4 p.m.
November 15	12:30 p.m. & 4 p.m.

Health and Wellness Resources

The State Health Plan continues to 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 is also provided for members with complex health care needs and with conditions such as chronic and end stage renal disease.

If you are eligible for these services, you will receive notification.

GET CONNECTED WITH BLUE CONNECT

State Health Plan subscribers have access to Blue Connect, a secure 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
- 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)**, to understand the details of your claims
- 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

How to Access Blue Connect: 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 on the left menu.

REMEMBER: 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 enroll in the 80/20 Plan or who wish to reduce their monthly premium in either the 80/20 Plan or the 70/30 Plan by completing the tobacco attestation will need to **take action** during Open Enrollment.

DON'T WAIT UNTIL THE LAST MINUTE! TAKE ACTION TODAY AND PICK THE BEST CHOICE FOR YOU AND YOUR FAMILY FOR 2020!

Eligibility and Enrollment Support Center: 855-859-0966

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

Monday–Friday: 8 a.m.–10 p.m., Saturdays: 8 a.m.–5 p.m. and Sundays: Noon–5 p.m. (ET)

LEGAL 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.

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

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 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.

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/noticepp.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 Office 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

continued on the next page

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 change your participation election during each Open Enrollment period. The Flexible Benefit Plan administered by the State Health Plan is for the payment of health benefit plan premiums on a before-tax basis only and is separate and distinct from NCFlex, which is administered by the Office of State Human Resources.

Your health benefit coverage can only be changed (dependents added or dropped) during the Open Enrollment period or 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 determined by the plan administrator) that requires the plan to provide coverage for your children.

- If you, your spouse or dependents experience a cost or coverage change under another group health plan for which an election change was permitted, you may make a corresponding election change under the Flex Plan (e.g., your spouse's employer significantly increases the cost of coverage and as a result, allows the spouse to change his/her election).
- If you change employment status such that you are no longer expected to average 30 hours of service per week but you do not lose eligibility for coverage under the State Health Plan (e.g., you are in a stability period during which you qualify as full time), you may still revoke your election provided that you certify that you have or will enroll yourself (and any other covered family members) in other coverage providing minimum essential coverage (e.g., the marketplace) that is effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.
- You may prospectively revoke your State Health Plan election if you certify your intent to enroll yourself and any covered dependents in the marketplace for coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.
- You or your children lose eligibility under Medicaid or a state Children's Health Insurance Program. In this case you must request enrollment within 60 days of losing eligibility.
- If you, your spouse or your dependent loses eligibility for coverage (as defined by HIPAA) under any group health plan or health insurance coverage (e.g., coverage in the individual market, including the marketplace), you may change your participation election.

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

Whenever you report a change due to a qualifying event, your premium deduction will be on a pre-tax basis.

Notice 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 Enrollment and Billing Support Center at **855-422-6272**.

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**.

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 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 elect to exempt a plan from the requirements listed below for any part of the plan that is "self-funded" by the employer, rather than provided through a health insurance policy. The North Carolina State Health Plan for Teachers and State Employees has elected to exempt your Plan from the Mental Health Parity and Addiction Equity Act, that includes protections against having benefits for mental health and substance use disorders be subject to more restrictions than apply to medical and surgical benefits covered by the Plan.

The exemption from this Federal requirement will be in effect for the Plan benefit year beginning January 1, 2020 and ending December 31, 2020. The election may be renewed for subsequent plan years.

Notice Regarding Availability of Health Insurance Marketplace Coverage Options (Employer Exchange Notice)

To assist you as you evaluate options for you and your family, this notice provides basic information about the Health Insurance Marketplace ("Marketplace"). The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium.

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet 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.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

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 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 below, 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.askebsa.dol.gov** or call **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.

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtprecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	GEORGIA – 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	Website: https://medicaid.georgia.gov/healthinsurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
ARKANSAS – Medicaid	INDIANA – 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: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone: 1-800-403-0864
COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+)	IOWA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-healthplan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/Hawki Phone: 1-800-257-8563
KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	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	NEW JERSEY – Medicaid and CHIP
Website: https://chfs.ky.gov Phone: 1-800-635-2570	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	NEW YORK – Medicaid
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	NORTH CAROLINA – Medicaid
Website: http://www.maine.gov/dhhs/ofp/publicassistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	NORTH DAKOTA – Medicaid
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	OKLAHOMA – Medicaid and CHIP
Website: https://mn.gov/dhs/people-we-serve/seniors/healthcare/health-care-programs/programs-and-services/otherinsurance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742

MISSOURI – Medicaid	OREGON – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	PENNSYLVANIA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	RHODE ISLAND – Medicaid and CHIP
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347, or 401-462-0311 (Direct Rlte Share Line)
NEVADA – Medicaid	SOUTH CAROLINA – Medicaid
Medicaid Website: https://dhcnp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	WEST VIRGINIA – Medicaid
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	WISCONSIN – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	WYOMING – Medicaid
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924	CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282

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
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services
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, 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>.

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

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