

Your

NORTH CAROLINA STATE HEALTH PLAN



2020 OPEN ENROLLMENT DECISION GUIDE

NOVEMBER 2-19, 2019

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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 review your State Health Plan coverage and take note of any changes for the coming year. Take a look through this enrollment guide to learn more about the High Deductible Health Plan (HDHP). Then you can decide if YOU want to make a change, such as:

- ▶ **Change your dependent coverage**
- ▶ **Disenroll yourself from coverage**

Open Enrollment is the only time you can add or remove dependents or disenroll from the State Health Plan without experiencing a qualifying life event.

If you don't wish to make any changes to your health plan coverage, you do not need to take any action. You will automatically be re-enrolled in the HDHP at your current coverage level (for example, employee only or employee + spouse).

IMPORTANT NEWS FOR 2020

- ▶ **The SAME provider network will be available in 2020 as in 2019.**
- ▶ **There have been no benefits changes to this plan for 2020.**
- ▶ **For the second year in a row, premiums have been frozen for 2020!**

The choices you make during Open Enrollment are for benefits effective January 1, 2020-December 31, 2020, as long as you remain eligible for this plan. Your coverage will stay in effect until the following benefit plan year, unless you experience a qualifying life event such as marriage, birth, death or retirement. You have 30 days from the date of the qualifying event to change your coverage.

You can find a complete list of qualifying life events in your Benefits Booklet, which is available on the State Health Plan website at www.shpnc.org. The deadline for enrolling or making changes is November 19, 2019.

- ▶ **The HDHP medical benefit is administered by Blue Cross and Blue Shield of North Carolina (Blue Cross NC).**
- ▶ **Your pharmacy benefit is administered through CVS Caremark. The formulary (drug list) is a custom, closed formulary, which means that not all drugs are covered.**
- ▶ **During Open Enrollment, your online enrollment process will be through eBenefits. eBenefits is the gateway to all of your benefit information.**

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** provider 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.



UNDERSTANDING YOUR MEDICAL BENEFITS

MEDICAL BENEFITS

With the HDHP, you can seek care from providers in the Blue Cross NC Preferred Provider Organization (PPO) network or go out-of-network. If you stay in-network, the plan pays a greater portion of the cost of your care, and you pay less. (See the HDHP overview chart on page 5.) To locate a provider in the Blue Cross NC Network, visit the State Health Plan website at www.shpnc.org and click "Find a Doctor."

There are no copays with this plan. You will be required to pay 100% of the allowable expense for your covered medical expenses until you meet your deductible. After the deductible is met, you will pay a percentage of the cost for covered services (coinsurance), until you meet your out-of-pocket maximum. The coinsurance you pay for in-network services is 50%. Once you meet your out-of-pocket maximum, the Plan will pay 100% of covered services for the remainder of the benefit year.

Affordable Care Act (ACA) preventive care medical services performed by an in-network provider are covered at 100%, which means there is no charge to you. You can find a full list of covered services on the State Health Plan's website at www.shpnc.org.

HEALTH AND WELLNESS RESOURCES

The State Health Plan continues to offer telephonic coaching for disease and case management for members with the following conditions:

- ▶ asthma
- ▶ chronic obstructive pulmonary disease (COPD)
- ▶ cerebrovascular disease (CVD)
- ▶ coronary artery disease (CAD)
- ▶ peripheral artery disease (PAD)
- ▶ heart failure
- ▶ diabetes

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 be notified.



UNDERSTANDING YOUR PHARMACY BENEFITS

PHARMACY BENEFITS

Pharmacy benefits for the HDHP are administered through CVS Caremark, the Plan's Pharmacy Benefit Manager. The HDHP utilizes a custom, closed formulary (drug list). The formulary indicates which drugs are not covered by the Plan.

For all covered prescription drugs, except ACA Preventive Medications, you will be responsible for the full cost of your prescription until your deductible is met. After your deductible is met, you will pay the 50% coinsurance of your prescription when filled at an in-network pharmacy until your out-of-pocket maximum is met.

Medications on the ACA Preventive Medication List are covered at 100% with no member cost share when filled with a prescription at an in-network pharmacy.

During Open Enrollment and after, you will have access to an online drug lookup tool which allows you to compare costs for various drugs covered under the plan. This tool can help you save money on medications for which you pay coinsurance. For more information, visit the State Health Plan's website at www.shpnc.org or call CVS Caremark at **888-321-3124**.

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 drugs require any prior approvals.

Comprehensive Formulary List:

a complete list of covered medications and their tier placement.

Affordable Care Act Preventive Medication List:

medications on this list are covered at 100%, which means there is no cost to you.

Specialty Drug List:

a complete list of all medications available through CVS Specialty.

The formulary, or drug list, is regularly updated throughout the year on a quarterly basis.

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

MONTHLY PREMIUM RATES

Monthly premiums for the HDHP are listed in the table below. You will be billed monthly for your premiums by the Plan’s direct billing administrator, iTEDIUM. This is a pre-paid plan; therefore, you will be billed a month in advance. For instance, you will receive a bill in December for January coverage. You will be responsible for paying your bill on time. If you don’t pay on time, your coverage under this plan will end. Eligible members would have the opportunity to re-enroll during the next Open Enrollment period for the next plan year.

COVERAGE TYPE	MONTHLY PREMIUM
Employee Only	\$96.00
Employee + Child(ren)	\$284.00
Employee + Spouse	\$513.00
Employee + Family	\$617.00

HIGH DEDUCTIBLE HEALTH PLAN OVERVIEW – WHAT YOU PAY

PLAN DESIGN FEATURES	IN-NETWORK	OUT-OF-NETWORK
MEDICAL COVERAGE		
Deductible	\$5,000 Individual \$10,000 Family	\$10,000 Individual \$20,000 Family
Coinsurance	50% of eligible expenses after deductible is met	60% of eligible expenses after deductible is met
Out-of-Pocket Maximum (Medical and Pharmacy)	\$6,450 Individual \$12,900 Family	\$12,900 Individual \$25,800 Family
ACA Preventive Care Services	\$0 (covered by the Plan at 100%)	Dependent on service
Office Visits	50% after deductible is met	60% after deductible is met
Specialist Visit	50% after deductible is met	60% after deductible is met
Inpatient Hospital	50% after deductible is met	60% after deductible is met
PRESCRIPTION DRUGS		
Covered Prescription Drugs in 2020 CVS Caremark Fomulary	50% after deductible is met	60% after deductible is met
ACA Preventive Medications	\$0 covered by the Plan at 100% with a prescription	50% after deductible is met

USING THE HDHP WITH A HEALTH SAVINGS ACCOUNT (HSA)

The HDHP can be used with a Health Savings Account (HSA). An HSA is a special savings account that includes money you place into the account, and then withdraw to spend on qualified medical and pharmacy expenses. It is not taxed.

You are not required to have an HSA if you want to be enrolled in the HDHP. However, you can use an HSA to help pay for expenses before you meet your HDHP deductible, and the tax savings can help offset the relatively higher out-of-pocket costs of an HDHP.

If you would like to have an HSA, you are responsible for setting one up through a financial institution. Your HSA belongs to you. If you change employers, you keep the account and the money in it, which you can use to pay for qualified expenses.

OPEN ENROLLMENT CHECKLIST

- ✔ Read this Open Enrollment Guide and decide if the HDHP is right for you.
- ✔ Understand what you need to do. During Open Enrollment (**Nov. 2 – Nov. 19, 2019**), you can enroll or disenroll yourself and any eligible dependents.
 - If you are adding dependents to the HDHP, you need to provide documentation regarding their eligibility. You can find a list of required documents on the Plan's website at **www.shpnc.org**. Such documents will need to be uploaded into eBenefits. Don't forget, if you disenroll yourself from coverage, your enrolled dependents will also be disenrolled, meaning they will no longer be covered by the HDHP.
- ✔ When you're ready, visit **www.shpnc.org** and click eBenefits. You will need to log into eBenefits through one of the portals listed to get started. You may need to register as a first-time user.

Eligible dependents include the following:

- ▶ Your legal spouse.
- ▶ Your children up to age 26, including natural, legally adopted, foster children, children for which you have legal guardianship and stepchildren.
- ▶ Your children who are covered by the Plan when they turn age 26 to the extent that they are physically or mentally incapacitated on or before the date that they turn age 26. A child is physically or mentally incapacitated if they are incapable of earning a living due to a mental or physical condition. Proof of the child's incapacity must be provided to the Plan prior to the child's 26th birthday. Coverage continues for such children until they are disenrolled or until the incapacity no longer exists.

REMEMBER: OPEN ENROLLMENT WILL BE HELD NOV. 2-19, 2019!

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

Eligibility and Enrollment Support Center:

855-859-0966

Monday–Friday: 8 a.m.–10 p.m. ET

Saturdays: 8 a.m.–5 p.m. and Sundays: Noon–5 p.m.

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.

TERMS TO UNDERSTAND

► **ACA Preventive Medications**

A list of preventive medications the Affordable Care Act (ACA) requires to be covered at 100% with no member cost share if filled with a prescription at an in-network pharmacy.

► **Allowed Amount**

The amount the HDHP and its PPO network allow an in-network provider to charge, or determines to be reasonable. This is the amount on which the plan bases its cost sharing and payment of benefits. If the amount charged by an in-network provider exceeds the allowed amount, the PPO network reduces the charge to an allowed amount on which payment is based. If the provider or facility is out-of-network, the allowed amount will typically be based on the lower of the billed charge or a reasonable charge established by Blue Cross NC.

► **Coinsurance**

The percentage of the allowable amount you pay for certain services once you meet your deductible. Under the HDHP, once you reach your deductible, you pay 50% coinsurance for medical care and pharmacy benefit received in-network. Coinsurance is applied towards the out-of-pocket maximum. Amounts in excess of the allowed amounts are not considered coinsurance and are not applied towards the deductible or out-of-pocket maximum.

► **Deductible**

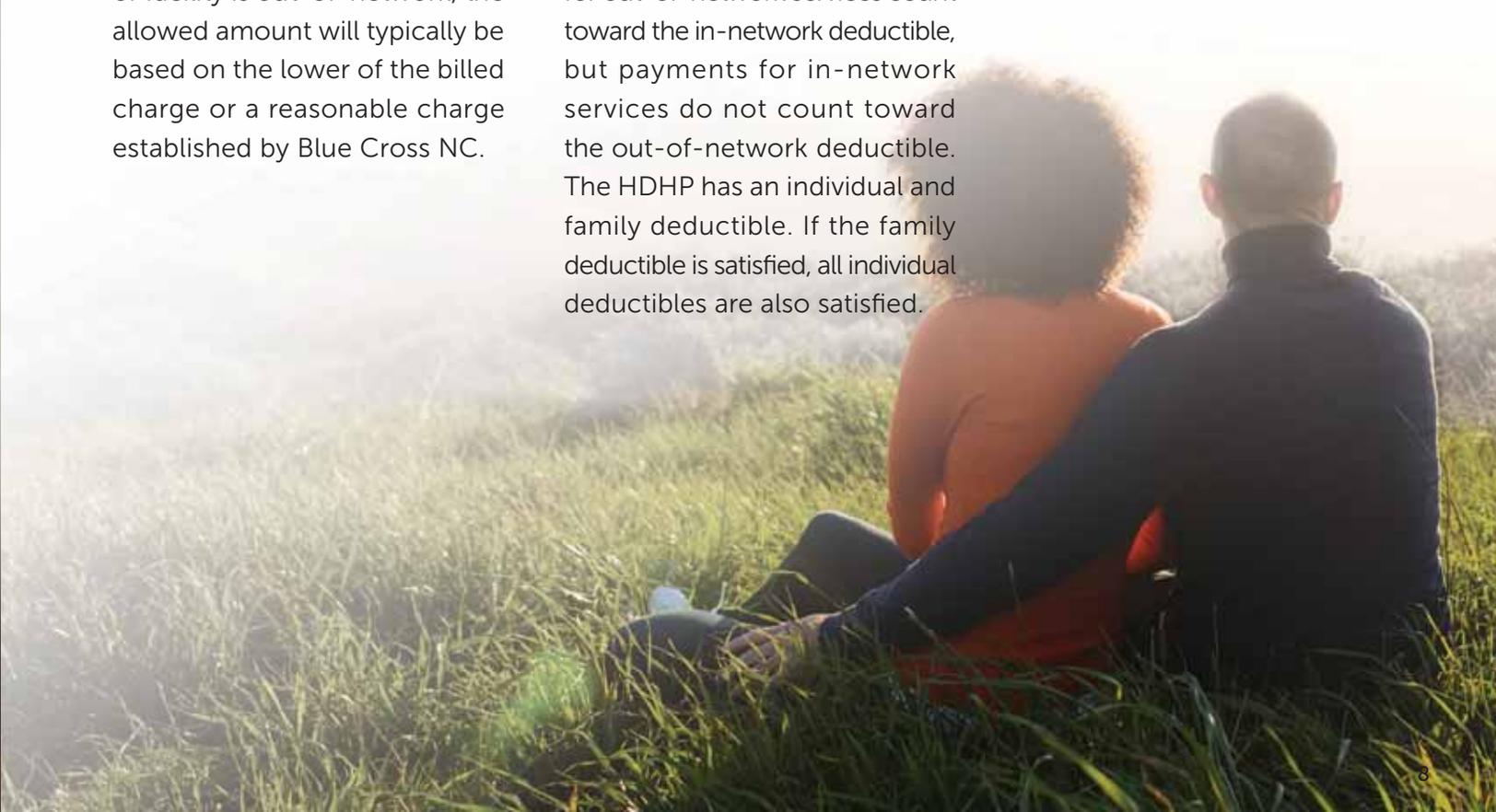
The allowed amounts that you pay each year before the plan pays benefits for services that require coinsurance. Payments for out-of-network services count toward the in-network deductible, but payments for in-network services do not count toward the out-of-network deductible. The HDHP has an individual and family deductible. If the family deductible is satisfied, all individual deductibles are also satisfied.

► **Formulary (Drug List)**

A list of drugs that are covered under the HDHP's pharmacy benefit. Some drugs may be excluded. For information about the coverage of a particular drug, call CVS Caremark at **888-321-3124**.

► **Out-of-Pocket Maximum**

Under the HDHP, this is the most you pay out-of-pocket for covered expenses (medical and pharmacy) in a benefit year. It includes deductibles and coinsurance but excludes premiums. Once the maximum is met, the plan pays for covered expenses at 100% of the allowable amount for the rest of the calendar year.



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

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.

Notice of HIPAA Special Enrollment Rights

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

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

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

To request special enrollment or obtain more information, contact the Eligibility and Enrollment Support Center at **855-859-0966**.

Notice Regarding Mastectomy-Related Services

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

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

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

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/ofi/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>.

continued on the next page

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

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

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

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

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

تدع اسماء تادمخ ناف، تامل رلندا تدمحتت تنك اذا! تظوولم ققرب لصتا. ناملاب كل رفاوتت قيوغوللا **919-814-4400**.

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

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

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

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

ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សូមពិនិត្យជូនកែភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់ប្រើអ្នក។ ចូរ ទូរស័ព្ទ **919-814-4400**.

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

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

ໄປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໄດຍບໍ່ເສັຽຄ່າ, ດ້ານນີ້ພ້ອມໃຫ້ທ່ານ. ໂທສ **919-814-4400**.

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

CONTACT US

Eligibility and Enrollment Support Center
(eBenefits questions):
855-859-0966

Extended hours during Open Enrollment:
Monday-Friday: 8 a.m.-10 p.m.
Saturdays: 8 a.m.-5 p.m. • Sundays: Noon-5 p.m.

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

CVS Caremark
(pharmacy benefit questions):
888-321-3124

SHF308-HDHS

NOVEMBER 2-19, 2019

OPEN IMMEDIATELY!

2020 OPEN ENROLLMENT
DECISION GUIDE

State Health Plan
3200 Atlantic Avenue
Raleigh, NC 27604

DALE R. FOLWELL, CPA
STATE TREASURER OF NORTH CAROLINA



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