

# NEW EMPLOYEE ENROLLMENT GUIDE

January 1, 2017 - December 31, 2017

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



2017

Welcome to the State Health Plan. See inside for an introduction to the Plan and important information about benefits, plan comparisons and how to enroll. Let us help you navigate through your options to determine the best health plan for you and your family.

**The State Health Plan offers three health plan options:** Consumer-Directed Health Plan (CDHP) (85/15), Enhanced 80/20 Plan and the Traditional 70/30 Plan.

All three plans are administered by Blue Cross and Blue Shield of North Carolina (BCBSNC), which means you can seek care from providers in the BCBSNC Blue Options network or go out-of-network. However, if you stay in-network, your deductibles, copays and coinsurance will be lower. All three plans cover the same medical and pharmacy services; however, the member cost share varies by each plan. Benefit booklets are available at [www.shpnc.org](http://www.shpnc.org) that include a complete summary of your medical and pharmacy benefits.

CVS Caremark is the State Health Plan's Pharmacy Benefit Manager. Members should note that this does NOT mean members will have to go to a CVS pharmacy location for their prescriptions. CVS Caremark has a broad pharmacy network, which can be found using the Pharmacy Locator Tool on the Plan's website at [www.shpnc.org](http://www.shpnc.org).

Under all three health plans, the formulary, or drug list, for prescription drugs is a closed formulary. Under a closed formulary, certain drugs are not covered. If you find that your prescription is not covered, speak to your provider about possible alternatives. There is an exception process available to providers who believe that, based on medical necessity, it is in the member's best interest to remain on the non-covered drug(s). CVS Caremark Customer Care can be reached by calling **888-321-3124**.

## Consumer-Directed Health Plan (CDHP) (85/15)

This is a high deductible health plan that is accompanied by a Health Reimbursement Account (HRA), which is set up for you by the State Health Plan. Rather than having copays for some services, members in this Plan must first meet the deductible, then coinsurance is applied. Your HRA starts with a balance provided by the Plan, which is used to help you meet the deductible. The amount provided in your HRA is dependent on your effective date in the plan and will be pro-rated for the months remaining in the benefit year. Any unused funds at the end of the benefit year will roll over to the next benefit year.

With this plan, Affordable Care Act preventive services and medications are covered at 100%, which means there is no charge to you, as long as medical management requirements are met. CDHP preventive medications are subject to coinsurance only, which means you don't have to meet your deductible before the Plan starts paying.

This plan includes the ability to lower your monthly premium by completing wellness activities.

## Enhanced 80/20 Plan

This plan has higher premiums than the Traditional 70/30 Plan in exchange for lower copays, coinsurance and deductibles. With this plan, Affordable Care Act preventive services and medications are covered at 100%, which means there is no charge to you, as long as medical management requirements are met.

This plan includes the ability to lower your monthly premium by completing wellness activities.

## Traditional 70/30 Plan

This plan has lower premiums in exchange for higher copays, coinsurance and deductibles. Affordable Care Act preventive services and medications are not covered at 100% and will require the applicable copay under this plan. This plan includes the ability to lower your monthly premium by completing the tobacco attestation premium credit.



The Affordable Care Act Preventive Services and Medications lists are located on the Plan's website at [www.shpnc.org](http://www.shpnc.org). Click Plans for Active Employees.



# WELLNESS PREMIUM CREDITS

The State Health Plan offers you several ways to lower your costs for health plan coverage. By participating in the wellness activities shown below, you can earn wellness premium credits that will reduce your monthly premium. Wellness premium credits only apply to the employee premium. In order to receive the wellness premium credit(s), you must complete your wellness activities within 30 days of your hire date.

IF YOU COMPLETE THE FOLLOWING WELLNESS ACTIVITIES	YOUR MONTHLY PREMIUM WILL BE REDUCED BY		
	CDHP (85/15)	ENHANCED 80/20 PLAN	TRADITIONAL 70/30 PLAN
Attest that you are tobacco-free or will enroll in QuitlineNC's multiple-call program*	\$40	\$40	\$40
Select a Primary Care Provider (PCP) for you and all covered dependents	\$20	\$25	N/A
Take your Health Assessment*	\$20	\$25	N/A
<b>Maximum Total Monthly Savings:</b>	<b>\$80</b>	<b>\$90</b>	<b>\$40</b>
<b>Total Monthly Employee-Only Premium:</b> (Assuming all credits are completed)	<b>\$0</b>	<b>\$15.04</b>	<b>\$0</b>

\* Tobacco attestation must be completed each year. The tobacco attestation is different from the smoking question asked in the Health Assessment.

The tobacco attestation and selection of a Primary Care Provider can be completed through eEnroll. You can complete your Health Assessment through your enrollment system or by logging into your Personal Health Portal, which is available via the State Health Plan website at [www.shpnc.org](http://www.shpnc.org), or by calling 800-817-7044.

## Save Even More with the CDHP (85/15) and Enhanced 80/20 Plan

You can also earn or save money under the CDHP (85/15) or Enhanced 80/20 Plan when you choose high-quality provider options as shown below. These actions will earn you additional contributions to your HRA if you enroll in the CDHP (85/15), or reductions to copays if you enroll in the Enhanced 80/20 Plan.

ACTION	REWARD	
	CDHP (85/15): ADDITIONAL HRA CONTRIBUTION	ENHANCED 80/20 PLAN: COPAY REDUCED TO
See your selected Primary Care Provider (or see another provider in your PCP's office)	\$25	\$10
See a Blue Options Designated Specialist	\$20	\$45
Use a Blue Options Designated Hospital for an inpatient stay	\$200	\$0; copay not applied

**Note:** The CDHP (85/15) offers the opportunity to receive even more HRA contributions if you participate in the State Health Plan's Health Engagement Program. For more information, visit the Plan's website at [www.shpnc.org](http://www.shpnc.org).



## NCHEALTH*Smart*

An initiative of the State Health Plan

If you enroll in the State Health Plan regardless of the Plan you choose, you are also eligible to participate in NC HealthSmart, the Plan's healthy living initiative. NC HealthSmart provides you with tools and services to help you meet your health and wellness goals and/or manage your chronic disease. Many of the NC HealthSmart tools and services are available at no added cost to you, and include healthy lifestyle, tobacco cessation, maternity, nurse case management, and health coaches. The Health Assessment, Digital Health Coaching Modules, your secure Personal Health Record, and other materials are available on your Personal Health Portal, which can be accessed on the Plan's website at [www.shpnc.org](http://www.shpnc.org).

Members eligible for NC HealthSmart services are members whose primary health coverage is through the State Health Plan. Federal and state law prohibits the State Health Plan from using your personal information to discriminate against you in any way, or from giving this information to your employer or other unauthorized third party unless required by law.



To access your NC HealthSmart resources, call  
**800-817-7044** or visit [www.shpnc.org](http://www.shpnc.org).



## **New Member Enrollment**

If you enroll yourself, you can also enroll your eligible family members in health plan coverage. Eligible family members include:

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

*Dependent verification documentation is required for all.*

## **Decision Support Tools**

### **WHAT ARE THE RATES?**

Rate charts are available on the State Health Plan's website at [www.shpnc.org](http://www.shpnc.org). There is also a rate calculator online to assist you with determining your rate based on the plan you elect and the number of dependents you add to your plan coverage. If you are less than a 12-month employee or the employee of a Local Government Employer, please ask your Health Benefits Representative for your applicable rates for coverage.

### **SELECTING THE PLAN THAT IS BEST FOR YOU**

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

Visit [www.shpnc.org](http://www.shpnc.org) for details about the 2017 Health Plan options. Here you will find tools and resources including:

- Videos about your State Health Plan options
- A Health Benefits Cost Estimator to help you choose which plan is right for you
- Links to the CVS Caremark drug lookup tool to assist you with determining your out-of-pocket costs for medications

## **Special Enrollment**

If you decline coverage for yourself or your eligible dependents and you experience a qualifying event, you and/or your dependents are eligible to enroll. You must apply within 30 days of the qualifying event.

## **Effective Date**

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

## **How Do I Enroll?**

To enroll, visit the State Health Plan's website at [www.shpnc.org](http://www.shpnc.org) and click "Enroll Now." You will be able to access the eEnroll system from that page.

## **Have Questions?**

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

Subscribe to the State Health Plan's Member Focus e-newsletter to keep up to date on your pharmacy and health benefits. You'll receive monthly tips on how to stay healthy and save money—plus recipes and more. Sign up today at [www.shpnc.org](http://www.shpnc.org). Just click on the "Stay Connected" link at the top of the page.

**Once you choose your benefit plan, you may not elect to switch plans until the next Open Enrollment period.**

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

# 2017 STATE HEALTH PLAN COMPARISON

PLAN DESIGN FEATURES	CONSUMER-DIRECTED HEALTH PLAN (CDHP) (85/15)		ENHANCED 80/20 PLAN		TRADITIONAL 70/30 PLAN	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
HRA Starting Balance	\$600 Employee* \$1,200 Employee +1* \$1,800 Employee + 2 or more*		N/A		N/A	
Annual Deductible	\$1,500 Individual \$4,500 Family	\$3,000 Individual \$9,000 Family	\$1,250 Individual \$3,750 Family	\$2,500 Individual \$7,500 Family	\$1,080 Individual \$3,240 Family	\$2,160 Individual \$6,480 Family
Coinsurance	15% of eligible expenses after deductible	35% of eligible expenses after deductible and the difference between the allowed amount and the charge	20% of eligible expenses after deductible	40% of eligible expenses after deductible and the difference between the allowed amount and the charge	30% of eligible expenses after deductible	50% of eligible expenses after deductible and the difference between the allowed amount and the charge
Medical Coinsurance Maximum	N/A	N/A	N/A	N/A	\$4,388 Individual \$13,164 Family	\$8,776 Individual \$26,328 Family
Medical Out-of-Pocket Maximum	See Out-of-Pocket Maximum		\$4,350 Individual \$10,300 Family	\$8,700 Individual \$26,100 Family	N/A	N/A
Pharmacy Out-of-Pocket Maximum	See Out-of-Pocket Maximum		\$2,500 Individual \$4,000 Family	\$2,500 Individual \$4,000 Family	\$3,360	
Out-of-Pocket Maximum (Combined Medical and Pharmacy)	\$3,500 Individual \$10,500 Family	\$7,000 Individual \$21,000 Family	\$6,850 Individual \$14,300 Family	\$11,200 Individual \$30,100 Family	N/A	N/A
Affordable Care Act (ACA) Preventive Services	\$0 (covered at 100%)	35% after deductible dependent on service	\$0 (covered at 100%)	40% after deductible dependent on service	\$40 for primary doctor; \$94 for specialist	50% after deductible dependent on service
Office Visits	15% after deductible; \$25 added to HRA if you use PCP on ID card; \$20 added to HRA if you use Blue Options Designated specialist	35% after deductible	\$25 for primary doctor; \$10 if you use PCP on ID card; \$85 for specialist; \$45 if you use Blue Options Designated specialist	40% after deductible	\$40 for primary doctor; \$94 for specialist	50% after deductible
Urgent Care	15% after deductible	15% after deductible	\$70	\$70	\$100	\$100

\* This amount is pro-rated based on your hire date.

PLAN DESIGN FEATURES	CONSUMER-DIRECTED HEALTH PLAN (CDHP) (85/15)		ENHANCED 80/20 PLAN		TRADITIONAL 70/30 PLAN	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Emergency Room (Copay waived w/admission or observation stay)	15% after deductible	15% after deductible	\$300 copay, then 20% after deductible	\$300 copay, then 20% after deductible	\$337 copay, then 30% after deductible	\$337 copay, then 30% after deductible
Inpatient Hospital	15% after deductible; \$200 added to HRA if you use Blue Options Designated Hospital	35% after deductible	\$450 copay, then 20% after deductible; copay not applied if you use a Blue Options Designated Hospital	\$450 copay, then 40% after deductible	\$337 copay, then 30% after deductible	\$337 copay, then 50% after deductible
<b>PRESCRIPTION DRUGS</b>						
Tier 1 (Generic)	15% after deductible	35% after deductible	\$5 copay per 30-day supply		\$16 copay per 30-day supply	
Tier 2 (Preferred Brand & High-Cost Generic)			\$30 copay per 30-day supply		\$47 copay per 30-day supply	
Tier 3 (Non-preferred Brand)			Deductible/coinsurance		\$74 copay per 30-day supply	
Tier 4 (Low-Cost Generic Specialty)			\$100 copay per 30-day supply		10% up to \$100 per 30-day supply	
Tier 5 (Preferred Specialty)			\$250 copay per 30-day supply		25% up to \$103 per 30-day supply	
Tier 6 (Non-preferred Specialty)			Deductible/coinsurance		25% up to \$133 per 30-day supply	
Preferred Diabetic Testing Supplies*			\$5 copay per 30-day supply		\$10 copay per 30-day supply	
ACA Preventive Medications	\$0	\$0	\$0	\$0	N/A	N/A
CDHP Preventive Medications	15%, no deductible	15%, no deductible	N/A	N/A	N/A	N/A

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

# 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 BY THE PLAN AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.**

### Introduction

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

### What information is protected?

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

### How the Plan May Use and Disclose your PHI

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

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

### Primary Uses and Disclosures of PHI

- The Plan may disclose your PHI so that your doctors, dentists, pharmacies, hospitals and other health care providers may provide you with medical treatment.
- The Plan also may send your PHI to doctors for patient safety or other treatment-related reasons.
- The Plan may use and disclose your PHI to facilitate payment of benefits under the Plan, including determining eligibility for benefits,

calculating your benefits under the Plan, paying your health care providers for treating you, calculating your copays and coinsurance amounts, deciding claims appeals and inquiries, and/or coordinating coverage. For example, the Plan may disclose information about your medical history to a physician to determine whether a particular treatment is experimental, investigational, or medically necessary or to decide if the Plan will cover the treatment.

- The Plan may use and disclose your PHI for additional related health care operations necessary to operate the Plan, including but not limited to: underwriting and soliciting bids from potential insurance carriers; merger and acquisition activities; setting premiums; deciding employee premium contributions; submitting claims to the Plan’s stop-loss (or excess loss) carrier; conducting or arranging for medical review; legal services; audit services; and fraud and abuse detection programs.  
**NOTE: The Plan will not use or disclose “genetic information” (as defined in 45 C.F.R. 160.103) for purposes of underwriting.**
- The Plan may use your PHI to contact you or give you information about treatment alternatives or other health-related benefits and services that may be of interest to you.



## Other Uses and Disclosures of PHI

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

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

## Your Rights Regarding PHI

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

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

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

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

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

or for disclosures to other individuals involved in your care. We are generally not obligated to comply with any request for restrictions or limitations. To request alternative communications or restrictions and/or limitations, you must submit your request in writing to the appropriate privacy contact listed below or you can call **888-234-2416**. Your request must specify how or where you wish to be contacted.

## Changes to This Notice

The Plan has the right to change this notice at any time. The Plan also has the right to make the revised or changed notice effective for medical information the Plan already has about you as well as any information received in the future. The Plan will post a copy of the current notice at [www.shpnc.org](http://www.shpnc.org). You may request a copy by calling **888-234-2416**.

## Complaints

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

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

### Privacy Contact

The Privacy Contact is:

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

## Notice Regarding Wellness Incentives

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. A reasonable alternative to tobacco use status (participation in a tobacco cessation program) has been provided to you. If your physician recommends a different alternative because he or she believes the program we make available is not medically appropriate, that recommendation may be accommodated to enable you to achieve the reward. Contact us at **855-859-0966** to make an accommodation request.

## Notice of Grandfather Status

The State Health Plan believes the Traditional 70/30 is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Customer Service at **888-234-2416**. You may also contact the U.S. Department of Health and Human Services at **www.healthcare.gov**. As a plan “grandfathered” under the Affordable Care Act, cost sharing for preventive benefits may continue as it does currently and be based on the location where the service is provided.

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

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

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

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

- Your marital status changes due to marriage, death of spouse, divorce, legal separation, or annulment.
- You increase or decrease the number of your eligible dependents due to birth, adoption, placement for adoption, or death of the dependent.
- You, your spouse, or your eligible dependent experiences an employment

status change that results in the loss or gain of group health coverage.

- You, your spouse, or your dependents become entitled to coverage under Part A or Part B of Medicare, or Medicaid.
- Your dependent ceases to be an eligible dependent (e.g., the dependent child reaches age 26).
- You, your spouse, or your dependents commence or return from an unpaid leave of absence such as Family and Medical Leave or military leave.
- You receive a qualified medical child support order (as determined by the plan administrator) that requires the plan to provide coverage for your children.
- If you, your spouse or dependents experience a cost or coverage change under another group health plan for which an election change was permitted, you may make a corresponding election change under the Flex Plan (e.g., your spouse’s employer significantly increases the cost of coverage and as a result, allows the spouse to change his/her election).
- If you change employment status such that you are no longer expected to average 30 hours of service per week but you do not lose eligibility for coverage under the State Health Plan (e.g., you are in a stability period during which you qualify as full time), you may still revoke your election provided that you certify that you have or will enroll yourself (and any other covered family members) in other coverage providing minimum essential coverage (e.g., the marketplace) that is effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.
- You may prospectively revoke your State Health Plan election if you certify your intent to enroll yourself and any covered dependents in the marketplace for coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.

- You or your children lose eligibility under Medicaid or a state Children’s Health Insurance Program. In this case you must request enrollment within 60 days of losing eligibility.
- If you, your spouse or your dependent loses eligibility for coverage (as defined by HIPAA) under any group health plan or health insurance coverage (e.g., coverage in the individual market, including the marketplace), you may change your participation election.

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

**Notice to Members of the State Health Plan for Teachers and State Employees Regarding Your Mental Health Benefits**

Under a Federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Public Law 104-191, as amended, group health plans must generally comply with the requirements listed below.

However, the law also permits State and local government employers that sponsor health plans to elect to exempt a plan from certain of these requirements for the part of the plan that is “self-funded” by the employer, rather than provided through an insurance policy. The State of North Carolina has elected to exempt the State Health Plan for Teachers and State Employees (State Health Plan) from the following requirements:

*The requirement calling for parity in the application of certain limits to mental health benefits*

That requirement states that group health plans (of employers that employ more than 50 employees) that provide both medical and surgical benefits and mental health or substance abuse disorder benefits must ensure that financial requirements and treatment limitations applicable to mental health or substance abuse benefits are no more restrictive than the predominant financial requirements and treatment limitations applicable to substantially all medical and surgical benefits covered by the plan.

State law, under N.C.G.S. § 135-48.50 (4), requires that the Plan provide benefits for the treatment of mental illness and chemical dependency and that the benefits provided have the same deductibles, durational limits and co-insurance factors as the benefits for physical illness generally. The current mental health benefits are in compliance with state law.

The exemption from these Federal requirements will be in effect for the 2017 plan year, beginning January 1, 2017, and ending December 31, 2017. The election may be renewed for subsequent plan years.

*What does this mean for you?*

Please note that you will not lose your health coverage as a result of these elections, and your mental health benefits are not changing. The State Health Plan’s mental health benefits are established under North Carolina statutes and Plan policy. Members pay a copayment for in-network office services; after 26 mental health office visits per benefit year, members must seek authorization for additional visits to verify medical necessity. It is also the member’s responsibility to ensure that all out-of-network inpatient and outpatient hospital services are authorized prior to services being rendered and that out-of-network emergency admissions are authorized as soon as reasonably

possible following admission. Services performed in an outpatient hospital setting are subject to the deductible and coinsurance, and inpatient services are subject to an inpatient copayment, the deductible and coinsurance. For additional information, read your Benefits Booklet, or go to [www.shpnc.org](http://www.shpnc.org), select “My Medical Benefits,” and review the “Plan Comparison Chart.”

**Notice Regarding Mastectomy-Related Services**

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

**Nondiscrimination and Accessibility Notice**

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

The State Health Plan:

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

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

State Health Plan Compliance Officer  
**919-814-4400**

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

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

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

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

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

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

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

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

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

تامدخ نإف، نغلا رنكدا شحتت تنك اذا: تقو حلم لصتا. ن اجملا اب لكل رفاوتت تقو غللا تدع اسملا مقرب **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, សេវាជំនួយផ្នែកភាសាដោយមិនគិតល្បួលគឺអាចមានសំរាប់បំរើអ្នក។ 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**.

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີຢ່ອມໃຫ້ທ່ານ. ໂທ **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

Benefit Questions: **888-234-2416**

Prescription Questions: **888-321-3124**

NC HealthSmart: **800-817-7044**

Eligibility and Enrollment Support Center/eEnroll Questions: **855-859-0966**

