DECISION GUIDE FOR
OPEN ENROLLMENT

September 30 - October 31, 2017

CHANGES AHEAD!

Open Enrollment is the perfect time to take a look at your current coverage and decide which health plan option best meets your needs for 2018—your best choice may be different from your current plan.

This Decision Guide will help you navigate your options for the 2018 benefit year.

ALL MEMBERS MUST TAKE ACTION DURING OPEN ENROLLMENT!

All members will be automatically enrolled in the 70/30 Plan, but YOU MUST TAKE ACTION to reduce your premium. If you prefer the 80/20 Plan, YOU MUST TAKE ACTION! If you want to reduce your monthly premium on either Plan, YOU MUST TAKE ACTION by completing the tobacco attestation! If you fail to take action during Open Enrollment, your monthly premiums will be considerably higher in 2018!
The State Health Plan’s Board of Trustees under the direction of Treasurer Dale R. Folwell, CPA, approved several changes for the 2018 benefit year. **These changes are meant to reduce plan complexity for members while still maintaining quality health coverage** and providing long-term financial stability for the State Health Plan.

The first thing you will notice is what used to take about 50 “clicks” to complete online enrollment will now only take about 10! Other changes include:

- **Family premiums have been frozen** for the 2018 benefit year.
- **Copays and deductibles will not increase** in 2018.
- **You will only have to complete one wellness premium credit**, the tobacco attestation credit.
- **The Consumer-Directed Health Plan (CDHP) is being eliminated.**

**A LOOK AT YOUR OPTIONS**

The choices you make during Open Enrollment are for benefits from January 1, 2018, through December 31, 2018. Once you choose your benefit plan, you may not elect to switch plans until the next Open Enrollment period. The coverage type you select (for example, employee-only) will remain in effect until the next benefit year, unless you experience a qualifying life event. A list of qualifying life events is included in your Benefit Booklet available on the State Health Plan website at [www.shpnc.org](http://www.shpnc.org).

For 2018, the State Health Plan will offer two Preferred Provider Organization (PPO) plans through Blue Cross and Blue Shield of North Carolina (BCBSNC). These PPO plans allow you the flexibility to visit any provider—in- or out-of-network—and receive benefits. Generally, you pay less when you visit an in-network provider. Both plans offer comprehensive coverage and a large provider network.
**The 80/20 Plan**

The 80/20 Plan is a PPO plan where you pay 20% coinsurance for eligible in-network services. For some services (i.e., office visits, urgent care or emergency room visits), you pay a copay. Affordable Care Act (ACA) Preventive Services performed by an in-network provider are covered at 100% in this plan.

**Save Even More with the 80/20 Plan**

You can also save money under the 80/20 Plan when you choose high-quality provider options as shown below. These actions will earn you reductions to copays if you enroll in the 80/20 Plan.

<table>
<thead>
<tr>
<th>ACTION</th>
<th>80/20 PLAN – COPAY REDUCED TO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visit your selected Primary Care Provider &lt;br&gt;(or see another provider in your PCP’s office)</td>
<td>$10</td>
</tr>
<tr>
<td>See a Blue Options Designated Specialist</td>
<td>$45</td>
</tr>
<tr>
<td>Use a Blue Options Designated Hospital for an inpatient stay</td>
<td>$0 (copay not applied)</td>
</tr>
</tbody>
</table>

**Finding a Blue Options Designated Provider**

Blue Options Designated providers have been designated because they provide high-quality and cost-effective services. The specialties in which you may find a Blue Options Designated provider are: General Surgery, OB/GYN, Orthopedics, Cardiology, Neurology, Endocrinology and Gastroenterology.

To find a Blue Options Designated provider or hospital, visit Blue Connect and look for the label “Designated for Cost and Quality” or call Blue Cross and Blue Shield of North Carolina (BCBSNC) at 888-234-2416. To access Blue Connect, visit the State Health Plan’s website at [www.shpnc.org](http://www.shpnc.org) and click Enroll Now/Access Benefits to log into eEnroll, the Plan’s enrollment system. Once you’re logged into eEnroll you will see a Blue Connect Quick Link.

**The 70/30 Plan**

The 70/30 Plan is a PPO Plan where you pay 30% coinsurance for eligible in-network services. For some services (i.e., office visits, urgent care or emergency room visits), you pay a copay. Affordable Care Act preventive services and medications require the applicable copay under this plan.

**Lower Your Monthly Premiums**

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

<table>
<thead>
<tr>
<th>2018 PREMIUM CREDIT SAVINGS</th>
<th>80/20 PLAN</th>
<th>70/30 PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee-only Monthly Premium</td>
<td>$110</td>
<td>$85</td>
</tr>
<tr>
<td>Attest that you are tobacco-free or will enroll in QuitlineNC’s multiple-call program between Sept. 30 and Oct. 31*</td>
<td>-$60</td>
<td>-$60</td>
</tr>
<tr>
<td>Total Monthly Employee-Only Premium: (With Credit)</td>
<td>$50</td>
<td>$25</td>
</tr>
</tbody>
</table>

* Even if you attested during last year’s Open Enrollment, you will need to re-attest during Open Enrollment!

If you are a tobacco user, you must enroll in the QuitlineNC tobacco-cessation program to receive the wellness credit. You can enroll in QuitlineNC’s program any time between now and December 31, 2017.
## PLAN DESIGN FEATURES

<table>
<thead>
<tr>
<th>PLAN DESIGN FEATURES</th>
<th>80/20 PLAN</th>
<th>70/30 PLAN</th>
<th>80/20 PLAN</th>
<th>70/30 PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>IN-NETWORK</td>
<td>OUT-OF-NETWORK</td>
<td>IN-NETWORK</td>
<td>OUT-OF-NETWORK</td>
</tr>
<tr>
<td><strong>Annual Deductible</strong></td>
<td>$1,250 Individual</td>
<td>$2,500 Individual</td>
<td>$1,080 Individual</td>
<td>$2,160 Individual</td>
</tr>
<tr>
<td></td>
<td>$3,750 Family</td>
<td>$7,500 Family</td>
<td>$3,240 Family</td>
<td>$6,480 Family</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>20% of eligible expenses after deductible</td>
<td>40% of eligible expenses after deductible</td>
<td>30% of eligible expenses after deductible</td>
<td>50% of eligible expenses after deductible</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Medical Coinsurance Maximum</strong></td>
<td>N/A</td>
<td>$4,388 Individual</td>
<td>$13,164 Family</td>
<td>$8,776 Individual</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$8,700 Individual</td>
<td>$26,100 Family</td>
<td>$26,328 Family</td>
</tr>
<tr>
<td><strong>Medical Out-of-Pocket Maximum</strong></td>
<td>$4,350 Individual</td>
<td>$10,300 Family</td>
<td>N/A</td>
<td>$3,360</td>
</tr>
<tr>
<td><strong>Pharmacy Out-of-Pocket Maximum</strong></td>
<td>$2,500 Individual</td>
<td>$4,000 Family</td>
<td>$11,200 Individual</td>
<td>$30,100 Family</td>
</tr>
<tr>
<td><strong>Out-of-Pocket Maximum (Combined Medical &amp; Pharmacy)</strong>*</td>
<td>$6,850 Individual</td>
<td>$14,300 Family</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>ACA Preventive Services</strong></td>
<td>$0 (covered at 100%)</td>
<td>$40 for primary doctor; $94 for specialist</td>
<td>50% after deductible, dependent on service</td>
<td>50% after deductible, dependent on service</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Office Visits</strong></td>
<td>$25 for primary doctor; $10 if you use PCP on ID card; $35 for specialist; $45 if you use Blue Options Designated specialist</td>
<td>$40 for primary doctor; $94 for specialist</td>
<td>40% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td><strong>Urgent Care</strong></td>
<td>$70</td>
<td>$70</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Emergency Room (Copay waived w/admission or observation stay)</strong></td>
<td>$300 copay, then 20% after deductible</td>
<td>$337 copay, then 30% after deductible</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Inpatient Hospital</strong></td>
<td>$450 copay, then 20% after deductible; copay not applied if you use a Blue Options Designated Hospital</td>
<td>$450 copay, then 40% after deductible</td>
<td>$337 copay, then 30% after deductible</td>
<td>$337 copay, then 50% after deductible</td>
</tr>
</tbody>
</table>

## PRESCRIPTION DRUGS

<table>
<thead>
<tr>
<th>PRESCRIPTION DRUGS</th>
<th>80/20 PLAN</th>
<th>70/30 PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1 (Generic)</td>
<td>$5 copay per 30-day supply</td>
<td>$16 copay per 30-day supply</td>
</tr>
<tr>
<td>Tier 2 (Preferred Brand &amp; High-Cost Generic)</td>
<td>$30 copay per 30-day supply</td>
<td>$47 copay per 30-day supply</td>
</tr>
<tr>
<td>Tier 3 (Non-preferred Brand)</td>
<td>Deductible/coinsurance</td>
<td>$74 copay per 30-day supply</td>
</tr>
<tr>
<td>Tier 4 (Low-Cost Generic Specialty)</td>
<td>$100 copay per 30-day supply</td>
<td>10% up to $100 per 30-day supply</td>
</tr>
<tr>
<td>Tier 5 (Preferred Specialty)</td>
<td>$250 copay per 30-day supply</td>
<td>25% up to $103 per 30-day supply</td>
</tr>
<tr>
<td>Tier 6 (Non-preferred Specialty)</td>
<td>Deductible/coinsurance</td>
<td>25% up to $133 per 30-day supply</td>
</tr>
<tr>
<td>Preferred Diabetic Testing Supplies*</td>
<td>$5 copay per 30-day supply</td>
<td>$10 copay per 30-day supply</td>
</tr>
<tr>
<td>ACA Preventive Medications</td>
<td>$0</td>
<td>N/A</td>
</tr>
</tbody>
</table>

* Non-preferred diabetic testing supplies are paid at Tier 3.
HOW YOUR PRESCRIPTIONS MAY FACTOR INTO YOUR 2018 BENEFIT PLAN DECISION

As a reminder, the State Health Plan continues to utilize a custom, closed formulary (drug list). The formulary indicates which drugs are excluded from the formulary and not covered by the Plan. All other drugs that are on the formulary are grouped into tiers. Your medication’s tier determines your portion of the drug cost. For 2018, the Plan’s pharmacy benefit will include six tiers, which include generics, brands and specialty medications. These are shown on page 4.

A formulary exclusion exception process is available for Plan members who, per their provider, have a medical necessity to remain on an excluded, or non-covered, medication. If a member is approved for the excluded drug, that drug will be placed into Tier 3 or Tier 6 and the member will be subject to the applicable cost share.

It is important to note that in the 80/20 Plan, Tier 3 and Tier 6 medications do not have a defined copay, but are subject to a deductible/coinsurance. Medications that are subject to coinsurance in most cases will result in higher out-of-pocket costs to members.

Pharmacy Benefit Resources:

| Drug Lookup Tool: this tool allows you to search for a medication to determine if it is a covered drug and get an estimated out-of-pocket cost. | Preferred Drug List: a list of preferred medications noting which drug requires any prior approvals. | Comprehensive Formulary List: a complete list of covered medications and their tier placement. | Affordable Care Act Preventive Medication List (80/20 Plan only): medications on this list are covered at 100%, which means there is no cost to you. | Specialty Drug List: a complete list of all medications available through CVS Specialty. |

The tools listed above include information based on the 2017 formulary and are subject to change prior to January 1, 2018. The formulary is regularly updated throughout the year, on a quarterly basis, so there is always a possibility that the coverage status of your medication(s) could change, which may affect your out-of-pocket costs.

The Plan’s Pharmacy Benefit Manager, CVS Caremark, 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.

STRENGTHEN OPIOID MISUSE PREVENTION (STOP) ACT:
Under North Carolina’s new STOP Act, effective January 1, 2018, prescribers of controlled substances are limited to issuing only a 5-day supply of an opioid or narcotic medication for the initial treatment of acute pain (or a 7-day supply after surgery). This requirement does not apply to cancer care, palliative care, hospice care, chronic pain management or medication-assisted treatment for substance use disorders. If you are suffering with acute pain, please check with your health care provider prior to the end of this year to make sure your current medication therapy isn’t interrupted.
2018 MONTHLY PREMIUM RATES

Note that the monthly premiums below apply only to Active members. Monthly premiums for all members and plans can be found on the State Health Plan website at www.shpnc.org.

<table>
<thead>
<tr>
<th>80/20 PLAN</th>
<th>MONTHLY PREMIUM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only</td>
<td>$50*</td>
</tr>
<tr>
<td>Employee + Child(ren)</td>
<td>$305.00*</td>
</tr>
<tr>
<td>Employee + Spouse</td>
<td>$700.00*</td>
</tr>
<tr>
<td>Employee + Family</td>
<td>$720.00*</td>
</tr>
</tbody>
</table>

*Assumes completion of tobacco attestation. The employee-only premium will be $60 higher per month if the tobacco attestation is not completed.

<table>
<thead>
<tr>
<th>70/30 PLAN</th>
<th>MONTHLY PREMIUM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only</td>
<td>$25.00*</td>
</tr>
<tr>
<td>Employee + Child(ren)</td>
<td>$218.00*</td>
</tr>
<tr>
<td>Employee + Spouse</td>
<td>$590.00*</td>
</tr>
<tr>
<td>Employee + Family</td>
<td>$598.00*</td>
</tr>
</tbody>
</table>

*Assumes completion of tobacco attestation. The employee-only premium will be $60 higher per month if the tobacco attestation is not completed.
INFORMATION TO HELP YOU CHOOSE A PLAN

Follow the steps below to choose the coverage that’s best for you in 2018.

1. Visit www.shpnc.org for more information about your 2018 benefits. Utilize the resources to assist you with your decision making. Resource tools include:
   • Plan Comparisons
   • Health Care Summary Report (located in Blue Connect)
     *This is a customized report where you can find recent benefit use and health expense details.*
   • Informational videos

2. Attend a Member Outreach Event. See below for the schedule. Details are available at www.shpnc.org. Seating is limited so you’re encouraged to register!

<table>
<thead>
<tr>
<th>COUNTY</th>
<th>DATE</th>
<th>TIME</th>
<th>LOCATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burke</td>
<td>9/18/17</td>
<td>10-11 a.m.</td>
<td>Western Piedmont CC</td>
</tr>
<tr>
<td>Forsyth</td>
<td>9/18/17</td>
<td>3-4 p.m.</td>
<td>Forsyth Tech CC</td>
</tr>
<tr>
<td>Wake</td>
<td>9/25/17</td>
<td>10-11 a.m., 1-2 p.m.</td>
<td>Wake Tech Main</td>
</tr>
<tr>
<td>New Hanover</td>
<td>9/27/17</td>
<td>2-3 p.m.</td>
<td>UNC-Wilmington</td>
</tr>
<tr>
<td>Wake</td>
<td>9/28/17</td>
<td>12:30-1:30 p.m.</td>
<td>NC Museum of History</td>
</tr>
<tr>
<td>Cumberland</td>
<td>10/5/17</td>
<td>2-3 p.m.</td>
<td>Fayetteville Tech CC</td>
</tr>
<tr>
<td>Wayne</td>
<td>10/10/17</td>
<td>2-3 p.m.</td>
<td>Wayne CC</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>DATE</th>
<th>TIME</th>
</tr>
</thead>
<tbody>
<tr>
<td>9/8/17</td>
<td>12:30 p.m., 4 p.m.</td>
</tr>
<tr>
<td>9/12/17</td>
<td>12:30 p.m.</td>
</tr>
<tr>
<td>9/14/17</td>
<td>12:30 p.m.</td>
</tr>
<tr>
<td>10/3/17</td>
<td>12:30 p.m., 4 p.m.</td>
</tr>
<tr>
<td>10/11/17</td>
<td>12:30 p.m.</td>
</tr>
</tbody>
</table>
OPEN ENROLLMENT CHECKLIST

Decide who you want to cover under the plan: you only, you + spouse, you + children, you + family. Remember, if you are adding a new dependent you will need to provide a Social Security number and will be prompted to upload required documentation in order to verify eligibility.

- Review your plan options and choose a plan that fits best for you and your family.
- When you’re ready to enroll or change your plan, visit www.shpnc.org and click Enroll Now/Access Benefits in the green bar.
- Log into the eEnroll system. You may be required to create an account if you are a first-time eEnroll user.
- Review your dependent information and make changes, if needed.
- Elect your plan: 80/20 Plan or 70/30 Plan.
- Complete the tobacco attestation to reduce your monthly premium.
- Make sure your Primary Care Provider information is up to date.
- Review the benefits you’ve selected. If you are OK with your elections, you will be prompted to SAVE your enrollment.
- Print your confirmation statement for your records.

IMPORTANT:
After you have made your choices, and they are displayed for you to review and print, you MUST scroll down to the bottom and click SAVE or your choices will not be recorded! Don’t overlook this critical step! A green congratulations message will appear when you have successfully completed your enrollment.

ALL MEMBERS MUST TAKE ACTION DURING OPEN ENROLLMENT!

All members will be automatically enrolled in the 70/30 Plan, but YOU MUST TAKE ACTION to reduce your premium. If you prefer the 80/20 Plan, YOU MUST TAKE ACTION! If you want to reduce your monthly premium on either Plan, YOU MUST TAKE ACTION by completing the tobacco attestation! If you fail to take action during Open Enrollment, your monthly premiums will be considerably higher in 2018!
NC HealthSmart

The State Health Plan is making changes to help improve services to all members, as well as reduce complexity, add value and secure the Plan’s long-term financial stability. As a result, the Plan is adopting a more focused approach to Population Health Management services.

Beginning January 1, 2018, telephonic coaching for disease and case management will be provided for the following conditions only: asthma, chronic obstructive pulmonary disease (COPD), cerebrovascular disease (CVD), coronary artery disease (CAD), peripheral vascular disease (PAD), heart failure, and diabetes. Case management will continue to be provided for members with complex health care needs and with conditions such as chronic and end stage renal disease.

All members will continue to have access to online resources such as a Personal Health Portal to assist you in your health goals. For details, visit www.shpnc.org and click on the NC HealthSmart tab at the top of the page.

Blue365: A Wellness Resource and Discount Program for Healthy Living.

As State Health Plan members, you can save money, live healthier and find great member discounts on fitness and health tools through Blue365®.

Staying healthy and active is easy and affordable. It’s the best investment you can make in your future.

Blue365, offered through BCBSNC, is a simple way to access trusted wellness resources, and valuable offers like these:

- Fitness: Gym memberships and fitness gear
- Personal Care: Vision and hearing care
- Healthy Eating: Weight loss and nutrition programs
- Lifestyle: Travel and family activities
- Wellness: Mind/body wellness tools and resources
- Financial Health: Financial tools and programs

To get started, register for Blue365 following these steps:

To access Blue Connect, visit the State Health Plan’s website at www.shpnc.org and click Enroll Now/Access Benefits to log into eEnroll, the Plan’s enrollment system. Once you’re logged into eEnroll you will see a Blue Connect Quick Link.

Once you are in Blue Connect, look for the Blue365 tab. Members must register to use Blue365 services. You can also find more information in your benefit booklet and by calling 855-511-2583, 8 a.m. - 6 p.m., Monday-Friday.

Don’t wait until the last minute! Take action today and pick the best choice for you and your family for 2018!

Eligibility and Enrollment Support Center: 855-859-0966

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

Monday–Friday: 8 a.m.–10 p.m. ET and Saturday: 8 a.m.–noon ET.
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.

Original Effective Date: April 14, 2003
• Revised Effective Date: September 23, 2013

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 confidentiality of PHI in accordance with HIPAA (as summarized herein), provide this Notice to covered individuals, and notify affected individuals following a “breach” of unsecured Protected Health Information (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 preempted. It is necessary that certain employees of the plan sponsor be permitted to access, use, and/or disclose the minimum amount of your PHI necessary 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 in administering your health benefits under the Plan. It is necessary that these entities keep and use the PHI maintained 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.

Primary Uses and Disclosures of PHI
The Plan may use or disclose your PHI as required by law.

• The Plan may use and disclose your PHI to a health care provider for treatment, 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, mergers, acquisition activities, setting premiums; deciding employee premium contributions; submitting claims to the Plan’s stop-loss (or excess-loss) carrier; conducting or performing certain medical review, legal 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 or disclose 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 it 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 obtain information for use in, a civil, criminal or administrative action or 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.
  - Disclosure to a person who has responsibility to the FDA regarding the quality, safety, or effectiveness of an FDA-regulated product or activity; and
  - Disclosure to a person to whom you have authorized to receive information for purposes of preventing or controlling disease and conducting public health surveillance and public health investigations.

• The Plan may disclose 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.

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, you must specifically object in writing to the Privacy Manager listed in the Notice.

• 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 PHI to authorized federal officials for intelligence, counterintelligence, national security and related 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 described above; (ii) any use or disclosure for “marketing” except as otherwise permitted in 45 C.F.R. 164.508(a)(3); (iii) any use or disclosure for payment purposes, as otherwise permitted in 45 C.F.R. 164.508(a)(3); (iv) 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 not stop future uses and disclosures that are made after the Plan receives your revocation.

The Plan will not use or disclose your PHI in any manner not authorized by you.

• If you are involved in a lawsuit or a dispute, the Plan may 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 PHI to authorized federal officials for intelligence, counterintelligence, national security and related 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.

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, you must specifically object in writing to the Privacy Manager listed in the Notice.

• 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 PHI to authorized federal officials for intelligence, counterintelligence, national security and related 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.

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The Plan will not use or disclose your PHI in any manner not authorized by you.
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 plan premiums only on a pre-tax basis only and is separate and distinct from NC Flex, which is administered by the Office of State Human Resources.

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

- Your marital status changes due to marriage, death of spouse, divorce, legal separation, or annulment.
- 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.
- You, your spouse or your 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 which 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 for coverage under 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, or death of the dependent.
- If you are declining enrollment for yourself or your dependents (including your spouse) while Medicare 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 (or if the employer stops contributing towards your or your dependents’ other coverage). However, you must request enrollment within 60 days after your or your dependents’ coverage ends under Medicaid or a state children’s health insurance program.
- If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children’s health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents’ determination of eligibility for assistance.

To request special enrollment or obtain more information, contact the Enrollment and Billing Support Center at 855-422-6272.
ALL MEMBERS MUST TAKE ACTION DURING OPEN ENROLLMENT!

All members will be automatically enrolled in the 70/30 Plan, but YOU MUST TAKE ACTION to reduce your premium. If you prefer the 80/20 Plan, YOU MUST TAKE ACTION! If you want to reduce your monthly premium on either Plan, YOU MUST TAKE ACTION by completing the tobacco attestation! If you fail to take action during Open Enrollment, your monthly premiums will be considerably higher in 2018!

SHP306

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, at:

U.S. Department of Health and Human Services, Office for Civil Rights
200 Independence Avenue SW, Room 5020F
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

ATENCION: 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.

Contact Us
Eligibility and Enrollment Support Center (eEnroll questions): 855-859-0966
(Extended hours during Open Enrollment: Monday–Friday, 8 a.m.–10 p.m. ET and Saturday, 8 a.m.–noon ET)

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

LUS CIEV: Yog tias koj has lus Hmooh, cov kev pab tong lus, maej kev pab dawb rau koj. Ha raq 919-814-4400.
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 919-814-4400.
PAINAWA: Kung nagtatala ka ng Tagalog, maari kang gumamit ng isang servisyu ng tulungan sa wika nang walang bayad. Tumawag sa 919-814-4400.

NOTE: For more information, please visit: http://www.ncshp.org/open_enrollment