Active Members

DECISION GUIDE FOR OPEN ENROLLMENT

October 1–31, 2016

Get Ready to En-ROLL With the Changes!

Times change, lives change, people change, plans change. Your State Health Plan coverage is changing too.

Open Enrollment is the perfect time to take a look at your current coverage and the three health plan options available to you and decide which one best meets your needs for 2017—your best choice may be different from your current plan.

2017

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

ROLL CALL: A LOOK AT YOUR OPTIONS

For 2017, the State Health Plan will continue offering three Preferred Provider Organization (PPO) plans through Blue Cross and Blue Shield of North Carolina (BCBSNC):

- **The Consumer-Directed Health Plan (CDHP) (85/15) with a Health Reimbursement Account (HRA)**
- **The Enhanced 80/20 Plan**
- **The Traditional 70/30 Plan**

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. All three plans offer comprehensive coverage and a large provider network.

New for 2017

- **If you do nothing during Open Enrollment, you and any currently covered dependents will be automatically enrolled in the Traditional 70/30 Plan for 2017 coverage.**
- If you remain enrolled in the Traditional 70/30 Plan for 2017, you will need to complete a tobacco attestation (during Open Enrollment) in order to receive employee coverage at no monthly cost to you.

If you want to reduce your premium or enroll in either the Enhanced 80/20 Plan or the CDHP (85/15), you must take action during Open Enrollment.

NEW PHARMACY BENEFIT MANAGER

As of January 1, 2017, CVS Caremark will become the State Health Plan's new Pharmacy Benefit Manager for all three PPO plans.

During Open Enrollment, 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. Visit the Plan's website at **www.shpnc.org** for more information.

In December, you will receive more information from CVS Caremark regarding your prescription drug coverage and the new programs and tools available. You will also receive a new member ID card from BCBSNC. This is the card that you MUST start using as of January 1, 2017. Your old card will not work at the pharmacy or provider's office.

New for 2017: Rolling Out the Changes

This year, the State Health Plan is making the following changes to your health coverage:

1. Under the Enhanced 80/20 and Traditional 70/30 Plans, there are changes to the annual deductible, out-of-pocket maximum and various copays.

2. Under all three health plans, the formulary, or drug list, for prescription drugs is moving from an open formulary to a closed formulary. Under a closed formulary, certain drugs are not covered. Members who are currently taking a drug that will not be covered beginning in 2017 will receive information regarding their prescription.

   Please note that there will be 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).

3. Under all three health plans, there is a new Diabetic Testing Supplies pharmacy tier that includes coinsurance or a copay for test strips, lancets, syringes and needles.

LOWER YOUR MONTHLY PREMIUMS

The State Health Plan offers you several ways to lower your costs for health plan coverage in 2017.

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.)

New for 2017

If you enroll in the **Traditional 70/30 Plan** for 2017, attesting that you are tobacco-free or agreeing to enroll in QuitlineNC will reduce your employee-only premium to $0. **Important:** This is **required** if you want **premium-free** employee coverage under the Traditional 70/30 Plan in 2017.

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* between October 1 and October 31	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, 2016.	$40	$40	**$40**
Select or confirm a Primary Care Provider (PCP) for you and all covered dependents	If you have already selected a PCP for yourself and, if applicable, for each of your dependents, then all you have to do during Open Enrollment is confirm in eEnroll that they are correct.	$20	$25	N/A
Take your Health Assessment	Complete or update your Health Assessment between May 1, 2016 and October 31, 2016 to earn this wellness premium credit for 2017. To take or update your Health Assessment: • **Online:** You can quickly and easily access and complete the Health Assessment through **eEnroll** during the enrollment process. • **By telephone:** Call **800-817-7044** to take or update your Health Assessment by telephone.	$20	$25	N/A
Maximum Total Monthly Savings:		**$80**	**$90**	**$40**
Total Monthly Employee-Only Premium: (Assuming Maximum Credits)		**$0**	**$15.04**	**$0**

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

Take Your Health Assessment Online Early—by October 15—for a Chance to Win a Prize

If you take your Health Assessment **online** between May 1 and October 15, 2016, not only will it count toward your wellness premium credit for 2017, but you also will be entered into a weekly drawing beginning in September for a $250 Amazon gift card—and one lucky grand prize winner will receive an Apple Watch!

Don't delay and let this chance pass you by! You can take your Health Assessment online now by visiting the Plan's website at **www.shpnc.org** and clicking My Personal Health Portal. Winners will be notified by phone or mail.

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

Finding a Blue Options Designated Provider

Blue Options Designated providers have been designated because they provide high-quality and cost-effective services. To find a Blue Options Designated provider, visit the State Health Plan website (**www.shpnc.org**) and click Member Login to access Blue Connect. Then, select "Find a Doctor or Facility" 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**.

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. See page 5.

THE CONSUMER-DIRECTED HEALTH PLAN (CDHP) (85/15)

The CDHP (85/15) is a high deductible health plan that is accompanied by a Health Reimbursement Account (HRA). Under this plan, once you meet your deductible, you will pay 15% coinsurance for most eligible in-network services. Affordable Care Act (ACA) Preventive Services performed by an in-network provider are covered at 100% in this plan.

What's New Under the CDHP (85/15) for 2017?

- You have more opportunities to earn incentives under the Health Engagement Program.
- Other than the prescription drug coverage changes mentioned on page 2, there are no other benefit changes for 2017.

How the CDHP (85/15) Works

When you enroll in the CDHP (85/15), the State Health Plan automatically sets up a Health Reimbursement Account (HRA) in your name. This account starts with a balance provided by the State Health Plan. Your HRA is used to help you meet the deductible and pay other out-of-pocket covered medical expenses.

The State Health Plan's contribution to your HRA in 2017 depends on how many people you enroll in your plan, as shown below. If you are enrolled in the CDHP (85/15) now and have funds remaining in your HRA, those funds will roll over and be added to the amounts below.

- Yourself only: $600; or
- Yourself and one dependent: $1,200; or
- Yourself and two or more dependents: $1,800.

Health Engagement Program

If you're enrolled in the CDHP (85/15), you will have the opportunity to earn additional HRA contributions under the State Health Plan's Health Engagement Program.

The Health Engagement Program is all about helping you live a healthier life. There are two parts to the program:

1. **Healthy Lifestyles:** You earn incentives just by doing things that can help improve your health and prevent disease, such as working with an NC Health*Smart* lifestyle coach and tracking your daily physical activity and/or nutrition through the Personal Health Portal.
2. **Positive Pursuits:** If you're living with diabetes, chronic obstructive pulmonary disease (COPD), asthma, high blood pressure, high cholesterol, congestive heart failure or coronary artery disease, you can earn extra HRA funds by (any of the following):
   - Visiting your Primary Care Provider
   - Getting doctor-recommended lab tests
   - Following prescribed treatments to improve your health
   - Completing educational activities to learn more about your condition

CDHP (85/15) PHARMACY DEBIT CARD

You'll receive a pharmacy debit card when you enroll in the CDHP (85/15) for 2017—or if you're currently a CDHP (85/15) member, you'll use the same card you have today. Use this card like a regular debit card when paying for prescriptions at your local pharmacy. Most retail pharmacies accept the card—be sure to ask your pharmacy if it does.

Your payment will be deducted from your HRA automatically. By using the card, you won't need to pay the full cost of a prescription when it's filled and then wait for reimbursement.

New for 2017

You will have more activities in which to earn incentives with **RivalHealth**! RivalHealth is a fitness-based wellness platform that engages members with daily exercise and nutrition activities as well as social interaction and challenges. Check them out at **www.rivalhealth.com**!

THE ENHANCED 80/20 PLAN

The Enhanced 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. Under this plan, you generally pay less out-of-pocket than with the Traditional 70/30 Plan, in exchange for a higher monthly premium. Affordable Care Act (ACA) Preventive Services performed by an in-network provider are covered at 100% in this plan.

What's New for 2017?

Along with the prescription drug changes mentioned on page 2, below are additional changes to the Enhanced 80/20 Plan:

- A higher deductible. (Both medical and pharmacy expenses count toward meeting the deductible.)
- As a limit on the amount you are required to pay out-of-pocket in a calendar year, the medical coinsurance maximum is being replaced by a general medical out-of-pocket maximum. Expenses you pay that apply toward meeting this out-of-pocket maximum include medical coinsurance amounts, medical copays and any other covered medical expenses you pay out-of-pocket that apply toward the deductible.
- **Lower** copays for most office visits and urgent care
- Larger copays for the following:
  - Emergency room visit
  - Out-of-network or non-Blue Options Designated hospital admissions
- Restructuring of prescription drug coverage tiers, with **lower** copays for Tiers 1 and 2

See the plan comparison chart on pages 8-9 for details regarding the benefits changes.

THE TRADITIONAL 70/30 PLAN

The Traditional 70/30 Plan is a PPO Plan where you pay 30% coinsurance for eligible in-network expenses. 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.

What's New for 2017?

Along with the prescription drug changes mentioned on page 2, below are additional changes to the Traditional 70/30 Plan:

- You **must** complete the tobacco attestation during Open Enrollment to receive employee-only coverage premium-free
- Larger deductible
- Larger medical coinsurance maximum
- Larger pharmacy out-of-pocket maximum
- Larger copays for:
  - Office visits
  - Urgent care
  - Emergency room visit (waived with hospital admission or observation stay)
  - Hospital admissions
- Pharmacy copays and the maximum amount you can be required to pay for a supply of prescription drugs are increasing, in most cases slightly

See the plan comparison chart on pages 8-9 for details regarding the benefits changes.

New for 2017

Tobacco Attestation

In order to receive coverage in 2017 without paying the employee premium, you must attest during Open Enrollment that you are tobacco-free or enroll in the QuitlineNC multiple-call tobacco-cessation program by responding to the attestation question in eEnroll as part of the online enrollment process. Even if you were enrolled in another plan option and attested during last year's Open Enrollment, you will need to re-attest. If you are a tobacco user, you must enroll in QuitlineNC to receive the wellness credit. You can enroll in QuitlineNC's program any time between now and December 31, 2016.

If you do not complete the tobacco attestation, you will have to pay for employee-only coverage under this plan.

2017 STATE HEALTH PLAN COMPARISON

PLAN DESIGN FEATURES	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
ACA Preventive Services	$0 (covered at 100%)	65% after deductible	$0 (covered at 100%)	Dependent on service	$40 for primary doctor; $94 for specialist	Only certain services are covered
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

PLAN DESIGN FEATURES	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
PRESCRIPTION DRUGS						
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.*

2017 MONTHLY PREMIUMS

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

CDHP (85/15)

COVERAGE TYPE	EMPLOYEE MONTHLY PREMIUM	MONTHLY WELLNESS PREMIUM CREDIT	NET MONTHLY PREMIUM
Employee	$80	($80)	$0*
Employee + Child(ren)	$276.32	($80)	$196.32*
Employee + Spouse	$585.90	($80)	$505.90*
Employee + Family	$618.82	($80)	$538.82*

**Assumes completion of all wellness activities.*

Enhanced 80/20 Plan

COVERAGE TYPE	EMPLOYEE MONTHLY PREMIUM	MONTHLY WELLNESS PREMIUM CREDIT	NET MONTHLY PREMIUM
Employee	$105.04	($90)	$15.04*
Employee + Child(ren)	$395.18	($90)	$305.18*
Employee + Spouse	$773.52	($90)	$683.52*
Employee + Family	$813.76	($90)	$723.76*

**Assumes completion of all wellness activities.*

Traditional 70/30 Plan

COVERAGE TYPE	EMPLOYEE MONTHLY PREMIUM	MONTHLY WELLNESS PREMIUM CREDIT	NET MONTHLY PREMIUM
Employee	$40	($40)	$0*
Employee + Child(ren)	$258.14	($40)	$218.14*
Employee + Spouse	$602.10	($40)	$562.10*
Employee + Family	$638.70	($40)	$598.70*

**Assumes completion of tobacco attestation.*

LET'S ROLL: TAKE ACTION AND ENROLL!

Follow the steps below to choose the coverage that's best for you in 2017.

Visit **www.shpnc.org** for information about your 2017 benefits.

Consider your options: CDHP (85/15), Enhanced 80/20 Plan or Traditional 70/30 Plan.

Decide who you want to cover under the plan: you only, you + spouse, you + children, you + family. Gather Social Security numbers for all dependents you want to enroll.

When you're ready to enroll or change your plan, visit **www.shpnc.org** and click Enroll Now 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: CDHP (85/15), Enhanced 80/20 Plan or Traditional 70/30 Plan.
- Attest to and complete the applicable wellness activities to reduce your monthly premium.
- Review the benefits you've selected. If you are OK with your elections, you will be prompted to **save** your enrollment.

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!**

Print your confirmation statement for your records.

You must enroll by the deadline of October 31, 2016, or you and your currently covered dependents will be enrolled in the Traditional 70/30 Plan effective January 1, 2017.

INFORMATION TO HELP YOU CHOOSE A PLAN

There are a number of resources available to help you make an informed decision.

1. Visit **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 and how to complete the online enrollment process through eEnroll
   - 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
   - Benefits summaries
   - Comparison charts showing details of how the State Health Plan options stack up against each other
   - Rate sheets showing your premiums for each option
2. Participate in a Telephone Town Hall meeting. Reserve your spot now by visiting **www.shpnc.org**.

DATE	TIME
September 20, 2016	7 p.m.
September 29, 2016	7 p.m.

3. Attend a Member Outreach Event. See below for schedule. Details are available on **www.shpnc.org**.

DATE	TIME	COUNTY	LOCATION
September 13, 2016	2 p.m.	Burke	Western Piedmont Community College
September 15, 2016	2 p.m.	Forsyth	Forsyth Tech Community College
September 19, 2016	10 a.m. and 2 p.m.	Wake	Wake Tech Main
September 21, 2016	2 p.m.	Durham	Durham Tech Community College
September 22, 2016	2 p.m.	Pitt	East Carolina University
September 26, 2016	2 p.m.	New Hanover	UNC-Wilmington
September 27, 2016	10 a.m.	Cabarrus	Rowan-Cabarrus Community College
September 28, 2016	2 p.m.	Wake	NC State University
September 29, 2016	10 a.m.	Cumberland	Fayetteville Tech Community College
September 29, 2016	2 p.m.	Robeson	Robeson Community College
September 29, 2016	2 p.m.	Guilford	Guilford Tech Community College
October 6, 2016	2 p.m.	Wayne	Wayne Community College
October 7, 2016	10 a.m.	Johnston	Johnston Community College
October 11, 2016	2 p.m.	Alamance	Alamance Community College
October 13, 2016	2 p.m.	Pasquotank	College of the Albemarle

4. Participate in a "State Health Plan 101" webinar on Open Enrollment. Reserve your spot now by visiting **www.shpnc.org**.

DATE	TIME
September 13, 2016	12:30 p.m.
September 13, 2016	4 p.m.
September 20, 2016	12:30 p.m.
September 20, 2016	4 p.m.
October 4, 2016	12:30 p.m.
October 4, 2016	4 p.m.
October 18, 2016	12:30 p.m.
October 18, 2016	4 p.m.

Eligibility and Enrollment Support Center: 855-859-0966

During the Open Enrollment period of October 1–31, the Eligibility and Enrollment Support Center will be open extended hours to help you with any enrollment questions you may have.

Monday–Friday: 8 a.m.–10 p.m. ET and Saturday: 8 a.m.–3 p.m. ET.

WHICH PLAN IS RIGHT FOR ME?

Only you can decide which plan option is best for you and your family. But to help you make the decision that's right for you, we're providing some scenarios that show how members may evaluate their medical choices.

Please note in each scenario, you will see the terms "engaged" or "non-engaged." An "engaged" member has completed all premium wellness credit activities to reduce his or her premium and plans to use his or her selected PCP and Blue Options Designated providers. A "non-engaged" member has earned no premium credits and does not plan to use a selected PCP or Blue Options Designated providers.

Meet Holly

Holly is a State Health Plan member with two children covered on her plan trying to decide which plan is right for her and her family in 2017.

A typical year of medical and pharmacy services for Holly and her children might include the following:

- 3 preventive care visits with PCP
- 2 additional Primary Care visits
- 1 specialist visit
- 2 urgent care visits
- 1 monthly maintenance prescription (Tier 1 Preventive Medication)
- 1 Tier 1 prescription

"To help me decide on a plan, I need to know how much I will have to pay under each plan option."

Holly's Health Plan Costs

		CDHP (85/15)				ENHANCED 80/20 PLAN				TRADITIONAL 70/30 PLAN			
		NON-ENGAGED		ENGAGED		NON-ENGAGED		ENGAGED		NON-ENGAGED		ENGAGED	
		UNIT COPAY/ COST	TOTAL COST	UNIT COPAY/ COST	TOTAL COST	UNIT COPAY/ COST	TOTAL COST	UNIT COPAY/ COST	TOTAL COST	UNIT COPAY/ COST	TOTAL COST	UNIT COPAY/ COST	TOTAL COST
MEDICAL SERVICES	**#**												
Preventive Visits with PCP	3	$0	$0	$0	$0	$0	$0	$0	$0	$40	$120	$40	$120
Primary Care Visits	2	$150	$300	$150	$300	$25	$50	$10	$20	$40	$80	$40	$80
Specialist Visits	1	$210	$210	$210	$210	$85	$85	$45	$45	$94	$94	$94	$94
Urgent Care Visits	2	$160	$320	$160	$320	$70	$140	$70	$140	$100	$200	$100	$200
DRUGS													
ACA Preventive Drugs (Tier 1)	12	$0	$0	$0	$0	$0	$0	$0	$0	$16	$192	$16	$192
Tier 1 Prescriptions	1	$40	$40	$40	$40	$5	$5	$5	$5	$16	$16	$16	$16
Total (before considering HRA)			**$870**		**$870**		**$280**		**$210**		**$702**		**$702**
HRA FUNDS PROVIDED BY STATE HEALTH PLAN													
Starting Balance			$1,800		$1,800								
HRA Incentive Dollar													
Identified PCP			$0		$125								
Blue Options Designated Specialist			$0		$20								
Blue Options Designated Hospital			$0		$0								
Healthy Lifestyle Program			$0		$125								
Total HRA Dollars to Use			**$1,800**		**$2,070**								

Holly's Projected Health Care Costs for 2017

ANNUAL MEMBER COSTS	CDHP (85/15)	ENHANCED 80/20 PLAN	TRADITIONAL 70/30 PLAN
IF HOLLY IS "ENGAGED"*			
Premium Payments	$2,356	$3,662	$2,618
Out-of-Pocket Costs	$0*	$210	$702
Engaged Member Total	**$2,356**	**$3,872**	**$3,320**
IF HOLLY IS "NON-ENGAGED"*			
Premium Payments	$3,316	$4,742	$3,098
Out-of-Pocket Costs	$0*	$280	$702
Non-Engaged Member Total	**$3,316**	**$5,022**	**$3,800**

**Holly's HRA will cover all of her out-of-pocket expenses, and Holly could have an estimated $1,200 in her HRA to use in 2018 if she is engaged, or approximately $930 if she is not.*

Rolling Up the Score: Which Option Is Best for Holly?

As you can see, the CDHP (85/15) has lower dependent premiums, and Holly's projected 2017 out-of-pocket costs are less than the initial HRA starting balance of $1,800. **Based on the calculations, the CDHP (85/15) is Holly's best option.**

Meet Pete

Pete is a State Health Plan member with employee-only coverage, who visits doctors regularly, and is trying to decide which plan is right for him.

A year of medical and pharmacy services for Pete might include:

- 1 preventive care visit with PCP
- 3 additional Primary Care visits
- 2 specialist visits
- 2 chiropractor visits
- 1 urgent care visit
- 4 Tier 1 prescriptions
- 2 Tier 2 prescriptions

"I don't have any major conditions, but I do get sick and visit the doctor more often than I used to. I'm trying to determine how much I will have to pay under each plan option."

Pete's Health Plan Costs

		CDHP (85/15)				ENHANCED 80/20 PLAN				TRADITIONAL 70/30 PLAN			
		NON-ENGAGED		ENGAGED		NON-ENGAGED		ENGAGED		NON-ENGAGED		ENGAGED	
		UNIT COPAY/ COST	TOTAL COST	UNIT COPAY/ COST	TOTAL COST	UNIT COPAY/ COST	TOTAL COST	UNIT COPAY/ COST	TOTAL COST	UNIT COPAY/ COST	TOTAL COST	UNIT COPAY/ COST	TOTAL COST
MEDICAL SERVICES	**#**												
Preventive Visits with PCP	1	$0	$0	$0	$0	$0	$0	$0	$0	$40	$40	$40	$40
Primary Care Visits	3	$150	$450	$150	$450	$25	$75	$10	$30	$40	$120	$40	$120
Specialist Visits	2	$210	$420	$210	$420	$85	$170	$45	$90	$94	$188	$94	$188
Mid-Level Office Visits	2	$85	$170	$85	$170	$52	$104	$52	$104	$72	$144	$72	$144
Urgent Care Visits*	1	$160	$143	$160	$143	$70	$70	$70	$70	$100	$100	$100	$100
DRUGS													
Tier 1 Prescription	4	$40	$160	$40	$160	$5	$20	$5	$20	$16	$64	$16	$64
Tier 2 Prescription	2	$80	$160	$80	$160	$30	$60	$30	$60	$47	$94	$16	$94
Total (before considering HRA)			**$1,503**		**$1,503**		**$499**		**$374**		**$750**		**$750**
HRA FUNDS PROVIDED BY STATE HEALTH PLAN													
Starting Balance			$600		$600								
HRA Incentive Dollar													
Identified PCP			$0		$100								
Blue Options Designated Specialist			$0		$40								
Blue Options Designated Hospital			$0		$0								
Healthy Lifestyle Program			$0		$125								
Total HRA Dollars to Use			**$600**		**$865**								

**Assumes Pete has met his deductible.*

Pete's Projected Health Care Costs for 2017

ANNUAL MEMBER COSTS	CDHP (85/15)	ENHANCED 80/20 PLAN	TRADITIONAL 70/30 PLAN
IF PETE IS "ENGAGED"			
Premium Payments	$0	$180	$0
Out-of-Pocket Costs	$638	$374	$750
Engaged Member Total	**$638**	**$554**	**$750**
IF PETE IS "NON-ENGAGED"			
Premium Payments	$960	$1,260	$480
Out-of-Pocket Costs	$903	$499	$750
Non-Engaged Member Total	**$1,863**	**$1,759**	**$1,230**

Rolling Up the Score: Which Option Is Best for Pete?

Because Pete uses a relatively large number of services that are subject to copays in the 70/30 and 80/20 plans, **Pete does best in the Enhanced 80/20 Plan if he is engaged or the Traditional 70/30 Plan if he is non-engaged**.

Note: The year of services described for Pete would bring him to the $1,500 deductible in the CDHP (85/15), so one major health event would likely make the CDHP (85/15) a lower-cost option for him due to the lower coinsurance and the combined medical and pharmacy out-of-pocket maximum.

Meet Maxine

Maxine is a State Health Plan member with employee-only coverage, who is on an expensive monthly specialty medication, and is trying to decide which plan is right for her.

A year of medical and pharmacy services for Maxine might include:

- 1 preventive care visit with PCP
- 3 additional Primary Care visits
- 6 diagnostic laboratory tests as part of her PCP visits
- 1 monthly Tier 1 prescription
- 1 monthly Tier 5 (specialty) prescription

"I take a specialty medication, which can be expensive—so given that, I'm not sure what would be the best plan for me."

Maxine's Health Plan Costs

		CDHP (85/15)*				ENHANCED 80/20 PLAN				TRADITIONAL 70/30 PLAN			
		NON-ENGAGED		ENGAGED		NON-ENGAGED		ENGAGED		NON-ENGAGED		ENGAGED	
		UNIT COPAY/ COST	TOTAL COST	UNIT COPAY/ COST	TOTAL COST	UNIT COPAY/ COST	TOTAL COST	UNIT COPAY/ COST	TOTAL COST	UNIT COPAY/ COST	TOTAL COST	UNIT COPAY/ COST	TOTAL COST
MEDICAL SERVICES	**#**												
Preventive Visits with PCP	1	$0	$0	$0	$0	$0	$0	$0	$0	$40	$40	$40	$40
Primary Care Visits	3	$150	$173	$150	$173	$25	$75	$10	$30	$40	$120	$40	$120
Diagnostic Labs	6	$25	$58	$25	$58	$0	$0	$0	$0	$0	$0	$0	$0
DRUGS													
Tier 1 Prescriptions	12	$40	$64	$40	$64	$5	$50	$5	$50	$16	$192	$16	$192
Tier 5 Prescriptions	12	$2,700	$3,205	$2,700	$3,205	$250	$2,450	$250	$2,450	$103	$1,236	$103	$1,236
Total (before considering HRA)			**$3,500**		**$3,500**		**$2,575**		**$2,530**		**$1,588**		**$1,588**
HRA FUNDS PROVIDED BY STATE HEALTH PLAN													
Starting Balance			$600		$600								
HRA Incentive Dollar													
Identified PCP			$0		$100								
Blue Options Designated Specialist			$0		$0								
Blue Options Designated Hospital			$0		$0								
Healthy Lifestyle Program			$0		$125								
Total HRA Dollars to Use			**$600**		**$825**								

**Assumes a certain order of Maxine's services until she reaches the out-of-pocket maximum.*

Maxine's Projected Health Care Costs for 2017

ANNUAL MEMBER COSTS	CDHP (85/15)	ENHANCED 80/20 PLAN	TRADITIONAL 70/30 PLAN
IF MAXINE IS "ENGAGED"			
Premium Payments	$0	$180	$0
Out-of-Pocket Costs	$2,675	$2,530	$1,588
Engaged Member Total	**$2,675**	**$2,710**	**$1,588**
IF MAXINE IS "NON-ENGAGED"			
Premium Payments	$960	$1,260	$480
Out-of-Pocket Costs	$2,900	$2,575	$1,588
Non-Engaged Member Total	**$3,860**	**$3,835**	**$2,068**

Rolling Up the Score: Which Option Is Best for Maxine?

As a result of the lower copay for her specialty medication drug, **Maxine does best in the Traditional 70/30 Plan**.

Under the Enhanced 80/20 Plan, Maxine hits her pharmacy out-of-pocket maximum of $2,500, but she still pays more out-of-pocket with that plan than with the Traditional 70/30 Plan (as well as paying a higher premium).

Under the CDHP (85/15), Maxine would quickly reach her deductible and would hit her out-of-pocket maximum before finishing the year because of the high cost of the specialty drug she takes.

LEGAL NOTICES

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**, 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
800-868-1019, 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**.

ملحوظة: إذا كنت تتحدث اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **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**.

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

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសម្រាប់បំរើអ្នក។ 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, ໂດຍບໍເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ **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 (eEnroll questions): **855-859-0966**
(Extended hours during Open Enrollment: Monday–Friday, 8 a.m.–10 p.m. ET and Saturday, 8 a.m.–3 p.m. ET)

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

CVS Caremark (2017 pharmacy benefits questions): **888-321-3124**
(Phone line opens October 1)

NC Health*Smart* (Health Assessment): **800-817-7044**

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

State Health Plan
Eligibility and Support Center
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