

DECISION GUIDE FOR OPEN ENROLLMENT

October 1–31, 2016

Open Enrollment is the perfect time to review your State Health Plan coverage and take note of any changes for the coming year. Then you can decide if YOU want to make a change, such as:

- Change your dependent coverage, or
- Disenroll yourself from coverage.

Take a look through this Open Enrollment Decision Guide to learn more about the High Deductible Health Plan (HDHP).

2017

WHAT YOU NEED TO DO



- Read this Open Enrollment Decision Guide for the High Deductible Health Plan (HDHP) carefully and decide if the HDHP is right for you.
- Understand what you need to do. During **Open Enrollment (October 1–October 31, 2016)**, you can enroll or disenroll yourself and any eligible dependents in the State Health Plan (Plan). Your eligible dependents include the following:
 - Your legal spouse.
 - Your children up to age 26, including natural, legally adopted, foster children, children for which you have legal guardianship and stepchildren.

Eligible dependents are also children such as those described who may continue after age 26 if, on the date they turn age 26, they are covered by the Plan and are physically or mentally incapacitated. A child is physically or mentally incapacitated if he or she is incapable of earning a living due to a mental or physical condition. Coverage continues for such children as long as the incapacity exists or until the date coverage would end for other reasons, whichever is earlier.

Please remember that when you add dependents to the HDHP, you may be asked to provide **documentation of dependent eligibility under the State Health Plan**.

Don't forget, if you disenroll yourself from coverage, your enrolled dependents will also no longer be covered under the HDHP.

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

The choices you make during Open Enrollment are for benefits effective January 1, 2017–December 31, 2017, as long as you remain eligible for this plan. Once you make your coverage choices, you may not change them until the next Open Enrollment period. Your coverage will stay in effect until the following benefit plan year, unless you experience a qualifying life event such as marriage, birth, death or retirement. You have 30 days from the date of the qualifying event to change your coverage.

You can find a complete list of qualifying life events in your Benefits Booklet, which is available online. Visit the State Health Plan website, www.shpnc.org, and under “Plans for Active Employees” click “High Deductible Health Plan.” Qualifying life events are listed in the Benefits Booklet for HDHP Participants in the section “Timely Enrollees.”

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

The deadline for enrolling or making changes is October 31, 2016.

ABOUT THE HDHP

A High Deductible Health Plan (HDHP) features a higher deductible than other traditional medical and pharmacy benefit plans. This means that you will pay more up front and out-of-pocket for your medical and pharmacy expenses before your plan starts paying benefits.

With the HDHP, you can seek care from providers in the MedCost Preferred Provider Organization (PPO) network or go out-of-network. If you stay in-network, the plan pays a greater portion of the cost of your care, and you pay less. (See the HDHP overview chart on page 5.)

Locating a Provider in the MedCost Network

Go to **Medcost.com**, click Locate a Provider and select MedCost/MedCost ULTRA.

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

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



New for
2017

Pharmacy Benefits Under the HDHP

Beginning January 1, 2017, CVS Caremark will be the new Pharmacy Benefit Manager.

The HDHP will use the 2017 CVS Caremark National Formulary (preferred drug list). The pharmacy benefit also includes the CVS Caremark broad retail pharmacy network.

The 2017 CVS Caremark National Formulary is a national drug list of the most commonly prescribed drugs that may be covered by the Plan for members of the HDHP. The list is not an all-inclusive list. The formulary represents an abbreviated version of the list of drugs that may be covered. Not all the drugs listed are covered by the Plan and certain brand name medications with covered preferred alternatives are not covered.

You will be responsible for the full cost of your prescription until your deductible is met for all covered prescription drugs, except ACA Preventive Medications. After your deductible is met, you will pay the 50% coinsurance if your prescription is filled at an in-network pharmacy until your out-of-pocket maximum is met. Medications on the ACA Preventive Medication list are covered at 100% with no member cost share when filled with a prescription at an in-network pharmacy, as long as medical management requirements are met.

To view the 2017 CVS Caremark National Formulary, visit the State Health Plan's website at www.shpnc.org and click High Deductible Health Plan. For questions about your pharmacy benefit and participating pharmacies, call CVS Caremark Customer Service at **888-321-3124**.

NEW PHARMACY BENEFIT MANAGER

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



HDHP OVERVIEW

This chart provides an overview of what you will pay if you enroll in the HDHP.

PLAN DESIGN FEATURES	IN-NETWORK (Individual Coverage)	IN-NETWORK (Family Coverage)	OUT-OF-NETWORK (Individual Coverage)	OUT-OF-NETWORK (Family Coverage)
MEDICAL COVERAGE				
Deductible	\$5,000	\$10,000	\$10,000	\$20,000
Coinsurance	50%	50%	60%	60%
Out-of-Pocket Maximum (Medical and Pharmacy)	\$6,450	\$12,900	\$12,900	\$25,800
ACA Preventive Care Services	\$0 (covered at 100%)	\$0 (covered at 100%)	60% after deductible	60% after deductible
Office Visits	50% after deductible	50% after deductible	60% after deductible	60% after deductible
Teladoc	\$40 per each use	\$40 per each use	\$40 per each use	\$40 per each use
Specialist Visit	50% after deductible	50% after deductible	60% after deductible	60% after deductible
Inpatient Hospital	50% after deductible	50% after deductible	60% after deductible	60% after deductible
PRESCRIPTION COVERAGE				
Covered Prescription Drugs in 2017 CVS Caremark Formulary	50% after deductible	50% after deductible	60% after deductible	60% after deductible
ACA Preventive Medications	\$0 (covered at 100% with a prescription)	\$0 (covered at 100% with a prescription)	50% after deductible	50% after deductible

USING THE HDHP WITH A HEALTH SAVINGS ACCOUNT (HSA)

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

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

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

OTHER SPECIAL FEATURES AND BENEFITS OF THE HDHP

If you enroll in the HDHP, you'll have access to a number of resources to help you receive medical care and maintain a healthy lifestyle:



Personal Care Management offers you customized health education and one-on-one nurse mentoring and coaching for people who need living assistance due to aging or a health condition. It is designed to encourage self-empowerment and self-management, including transitional care management.



Teladoc 24/7 is a “telehealth” service that makes health care more easily accessible by connecting you with U.S. board-certified doctors and pediatricians via phone or online video consultations. When you have questions about common conditions such as allergies, infections, etc., medical expertise is only a call or click away. Your out-of-pocket cost will be \$40 per use of the service. For more information about Teladoc services, visit www.teladoc.com. You will receive information from Teladoc that provides an overview of this service and a separate ID card for using this service.



Personal Health Suite is an online collection of health and wellness tools and information, including a Health and Productivity Assessment (HPA), Healthy Living Programs, a personal health portal and health trackers. More information about these services will be available in the information packet that will be sent with your new plan ID card.

Member ID Cards

Before January 1, 2017, you will receive a new ID card for the HDHP. This card will also allow you to access your pharmacy benefits. This is the ID card that you **MUST** start using as of January 1, 2017—the old card will not work at the pharmacy or provider’s office.

Your card will arrive in the mail with information about additional benefits available under this plan. You will also receive a Welcome Kit from CVS Caremark. In addition, you will also have access to a virtual ID card, accessible on any smart device via a mobile app or a secure website. This can be printed or emailed for immediate use. You will receive additional information about how to register and download the mobile app.




<p>Member</p>  <p>Group # S001TEST JOHN SAMPLE ID: SMPL0001</p>	<p>Plan at a Glance</p> <p style="text-align: center;">High Deductible Health Plan</p> <table style="width: 100%; text-align: center;"> <thead> <tr> <th></th> <th colspan="2">Individual</th> <th colspan="2">Family</th> </tr> <tr> <th></th> <th>Ded</th> <th>OOP</th> <th>Ded</th> <th>OOP</th> </tr> </thead> <tbody> <tr> <td>Network</td> <td>\$5000</td> <td>\$6450</td> <td>\$10000</td> <td>\$12900</td> </tr> <tr> <td>Non-Net</td> <td>\$10000</td> <td>\$12900</td> <td>\$20000</td> <td>\$25800</td> </tr> </tbody> </table> <p>Teladoc available 24/7/365, \$40 copay 1-800-Teladoc or www.Teladoc.com</p> <p><small>This card does not guarantee coverage. To verify benefits and eligibility, view claims or find a provider visit www.medcost.com or call customer service at 1-866-740-3881.</small></p>		Individual		Family			Ded	OOP	Ded	OOP	Network	\$5000	\$6450	\$10000	\$12900	Non-Net	\$10000	\$12900	\$20000	\$25800
	Individual		Family																		
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Network	\$5000	\$6450	\$10000	\$12900																	
Non-Net	\$10000	\$12900	\$20000	\$25800																	
<p>Claims Submission</p> <p>Medical EDI 56162</p> <p>State Health Plan c/o MedCost Benefit Services PO Box 25307 Winston Salem, NC 27114-5307</p> <p><small>For questions regarding enrollment, call toll free: 1-855-442-6272.</small></p> <p><small>MedCost Benefit Services d/b/a MBS Third Party Administrators in California</small></p>	<p>Precertification</p> <p>PROVIDER: INPATIENT ADMISSION AND CERTAIN OUTPATIENT PROCEDURES, including advanced imaging and dialysis, REQUIRE PRE-AUTHORIZATION, as specified by the benefit plan. Provider must call 1-866-740-3881 to obtain. Failure to do so may affect benefits. For an emergency, patient should seek care immediately, and then call within 48 hours.</p> <p>MEMBER: You will be asked to participate in case management for certain conditions; failure to do so may affect benefits.</p>																				
<p>Pharmacy Plan</p> <p>RxBIN: 004336 RxPCN: ADV RxGRP: RX0275</p>  <p>Customer Care (888) 321-3124 Pharmacy Help Desk (800) 364-6331 Submit paper claims to: CVS Caremark Claims Department P.O.Box 52136, Phoenix, AZ 85072-2136</p>	<p>Travel Access</p> <p>When seeking emergency medical care outside of your primary PPO service area, you may have access to a travel network through AHA/First Health. Contact MBS for more information on network providers.</p> <div style="display: flex; justify-content: space-around; align-items: center;">    </div>																				

MONTHLY PREMIUM RATES

Monthly premiums for the HDHP are listed in the table below. You will be billed monthly for your premiums by the Plan's direct billing administrator, COBRAGuard. This is a pre-paid plan; therefore, you will be billed a month in advance. For instance, you will receive a bill in December for January coverage. **You will be responsible for paying your bill on time. If you don't pay on time, your coverage under the plan will end.**

COVERAGE TYPE	MONTHLY PREMIUM
Employee Only	\$95.92
Employee + Child(ren)	\$276.46
Employee + Spouse	\$496.42
Employee + Family	\$596.38

Below is a sample of the bill that you will receive for your premium each month. The bill will come from COBRAGuard, as a vendor serving the State Health Plan, and will include the State Health Plan logo.



HDHP State Health Plan Coverage Invoice

Visit our website at <http://www.shphdhp.com>
Need Help? Call our Direct Bill Member Hotline at (855) 442-6272

Invoice Date: 01/01/2017
Account Number: 0000000000
Total Amount Due: **\$95.92**

IMPORTANT: This is a monthly invoice for your healthcare coverage. The table below shows the coverage period(s) currently due with the premium amount(s) and due date(s). **Premium payments must be postmarked on or before the corresponding grace period end date to be valid.**

Benefit Premium Payment Balance Detail					
Payment Period	Premium Amount	Credit/Subsidy	Amount Due	Due Date	Grace Period End Date
Medical Premium 12/01/2016 - 12/31/2016	\$93.16	\$93.16	<u>\$0.00</u>	12/01/2016	12/30/2016
Medical Premium 01/01/2017 - 01/31/2017	\$95.92	\$0.00	<u>\$95.92</u>	01/01/2017	01/30/2017

\$95.92 is the total amount due.

Coverage will be cancelled if valid premium payments are not postmarked on or before the Grace Period End Date as shown above. If coverage is cancelled for non-payment of premium, reinstatement of coverage is not permitted. No partial payments or late payments will be accepted. Acceptance of payments by CobraGuard, as collection agent for State Health Plan, is without prejudice and with reservation of all rights.

ENROLLING IN THE HDHP OR MAKING CHANGES

1. Visit www.shpnc.org and click Enroll Now. Click Login to COBRAGuard for High Deductible Health Plan.
2. You'll be prompted to create a user name and password if you do not already have one.
3. Once registered, follow the steps to enroll. (Below are the screens you'll see.)

The screenshot shows the 'Registration' page. It includes a 'Member Registration' header and a 'Registration Form' with fields for Last Name, First Name, Date of Birth, Email Address, Password, and Pin-Type Password. There are also sections for 'Why do I need to Register?' and 'How do I Register?'.

The screenshot shows the 'Main Enrollment Screen' for '2017 Open Enrollment'. It features a 'Welcome' message and a 'Current Benefits' table. The table lists 'Year Starting' as 01/01 and 'Cost' as \$0.00. There is also a 'Pending Elections' section with a 'Continue' button.

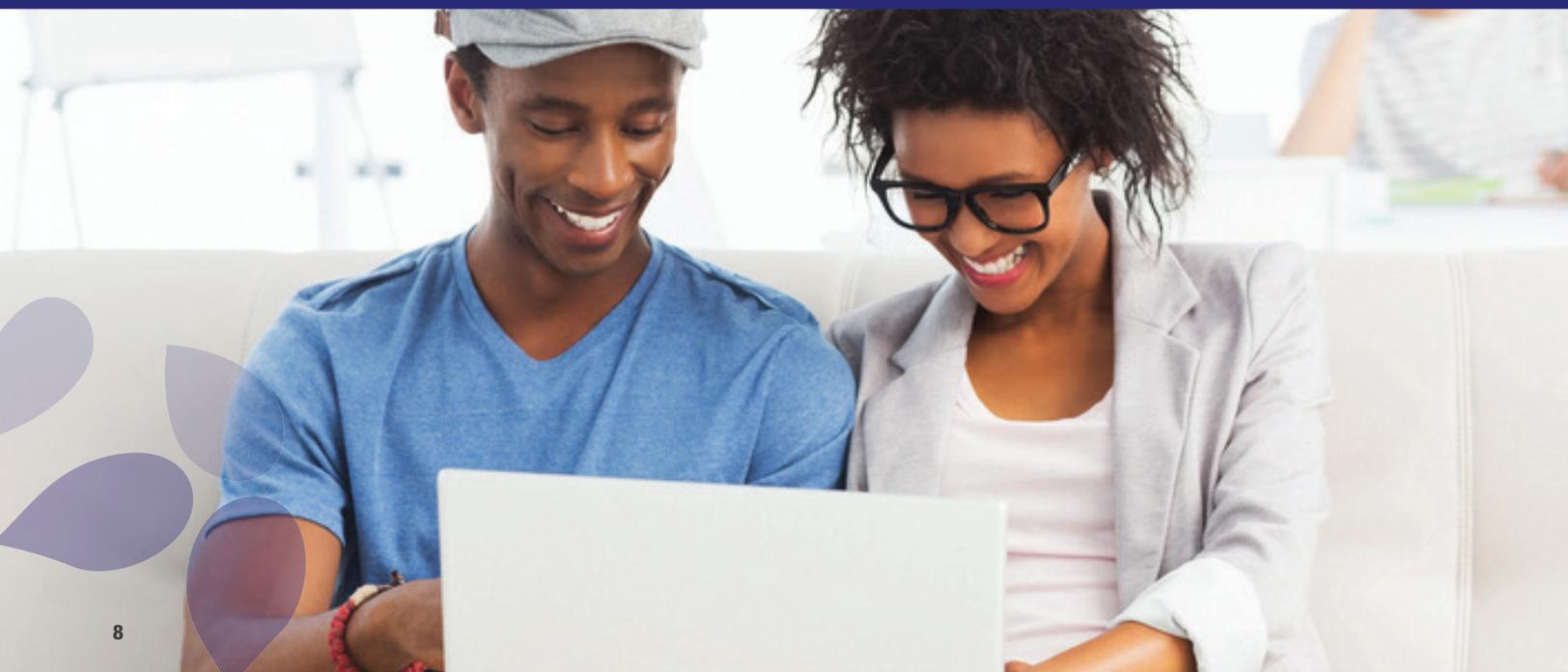
The screenshot shows the 'Submit Benefit' screen. It includes a 'Submit Benefits' section with a table for 'Electable' benefits. The table has columns for 'Electable', 'Member Only', and 'Cost'. The 'Electable' column lists 'Medical High Deductible Health Plan' and 'Continued Care Strategy'. The 'Member Only' column lists 'John Doe Employee' and 'John Doe Employee'. The 'Cost' column lists '\$0.00' and '\$0.00'. There is a 'Continue' button at the bottom right.

4. Decide which dependents you wish to cover. (You'll need their Social Security numbers.)
5. Print your confirmation statement for your records.

For questions about enrollment, contact the Enrollment and Billing Support Center at **855-422-6272**.

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

Remember, the deadline for enrolling or making changes is October 31, 2016.



TERMS TO UNDERSTAND

ACA Preventive Medications

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

Allowed Amount

The amount the HDHP and its PPO network allows an in-network provider to charge, or determines to be reasonable. This is the amount on which the plan bases its cost sharing and payment of benefits.

If the amount charged by an in-network provider exceeds the allowed amount, the PPO network reduces the charge to an allowed amount on which payment is based. If the provider or facility is out-of-network, the allowed amount will typically be based on the lower of the billed charge or a reasonable charge established by MedCost.

Coinsurance

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

Deductible

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

Formulary

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

Health Savings Account (HSA)

A special savings account that offers you certain tax advantages: Money you place into the account, and then withdraw to spend on qualified medical and pharmacy expenses, is not taxed. You have the option of using an HSA to help pay for your qualified expenses before you meet the HDHP's deductible.

Your HSA belongs to you. If you would like to have an HSA, you are responsible for setting one up through a financial institution.

High Deductible Health Plan (HDHP)

A High Deductible Health Plan features a higher deductible than other traditional medical and pharmacy benefit plans. You must meet the deductible before a coinsurance applies and the plan helps pay for applicable expenses.

Out-of-Pocket Maximum

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

Telehealth

The practice of medicine that allows physicians and patients to interact in a way that is similar to a traditional visit, despite being at different locations, through electronic means such as secure video conferencing or other information technology or telecommunications.

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 privacy 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 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 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 in this Notice. 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, it 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 make a 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. 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

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 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**.

Notice of HIPAA Special Enrollment

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

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

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

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

To request special enrollment or obtain more information, contact the Enrollment and Billing Support Center at **855-422-6272**.

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**.

تدعاسمالم لتادخ نإف ةفغلا رلندا تدرجت تنك اذا تظولم
مقرب لصتا 919-814-4400 ناجم لاب لكل رضاوت تيوغلا

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**.

සුඛනා: ඔබ තම මූලාසන බවටා ඔබේ මව් බසින් ඔබට සහාය සේවාවක් නොමැති නම් ඔබට අවබෝධයක් ඇත. දුරකථන අංකය **919-814-4400**.

ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយភាសាខ្មែរ, ស្រុកដើម្បីជួយផ្នែកភាសា ដោយមិនគិតល្បឿន គិតថាមានសេវាឥតគិតថ្លៃ។ 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**।

ໂປດຊາຍ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີຜ່ອມໃຫ້ທ່ານ. 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

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)

MedCost (medical benefits): **866-740-3881**

CVS Caremark (2017 pharmacy benefits questions): **888-321-3124**



State Health Plan
Eligibility and Support Center
100 Benefitfocus Way
Charleston, SC 29492

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