

2016 New Employee Enrollment Kit High Deductible Health Plan (HDHP)



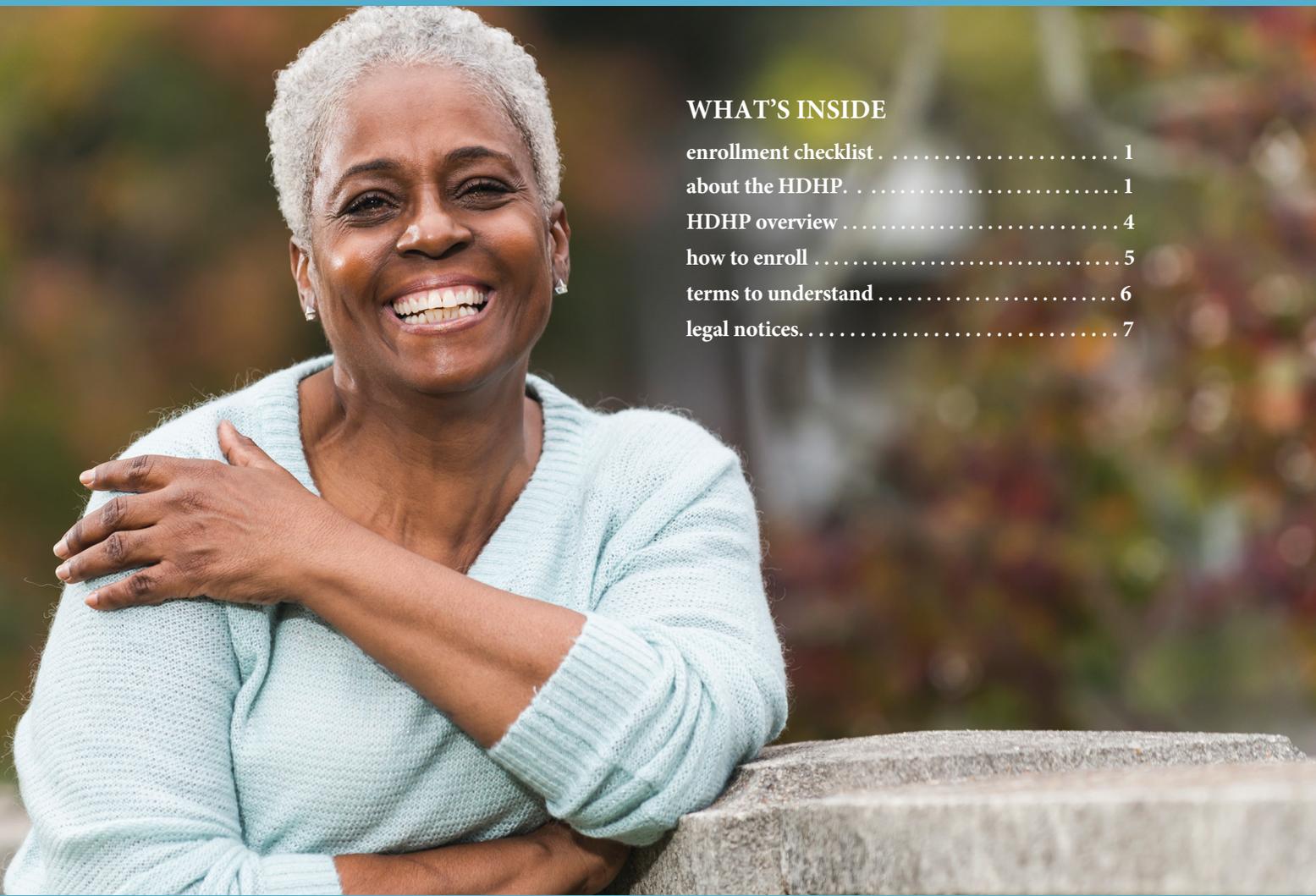
North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

A Division of the Department of State Treasurer

This is a brief summary of plan benefits. For a full description of benefits, refer to the applicable plan benefits booklet, which is available on the State Health Plan website at www.shpnc.org. In the event of a discrepancy between the information in this Guide and the plan benefits booklet, the information provided in the benefits booklet will govern.

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enrollment checklist

1. Read this guide carefully.
2. Understand what you need to do during enrollment. During enrollment, you can enroll yourself and any eligible dependents in the State Health Plan (Plan). Your eligible dependents include the following:

- Legal spouse.
- Children up to age 26, including natural, legally adopted, foster children, children for which the employee has legal guardianship and stepchildren of the employee.

Eligible dependents are also such children (described above) who are covered by the Plan when they turn age 26 to the extent that they are physically or mentally incapacitated on the date that they turn age 26. A child is physically or mentally incapacitated if they are incapable of earning a living due to a mental or physical condition. Coverage continues for such children as long as the incapacity exists or until the date coverage would otherwise end, whichever is earlier.

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

During enrollment, you can disenroll any currently covered dependents from the HDHP, if you choose, or you can disenroll yourself from coverage (in which case your enrolled dependents would also no longer be covered), without having a qualifying life event.

IMPORTANT: Once you choose your benefit plan, you may not elect to switch plans until the next Open Enrollment period. The coverage type you select (for example, employee only or employee-spouse) will remain in effect until the next Open Enrollment period. You will not be able to add a spouse or dependents until the next benefit plan year unless you experience a qualifying event.

3. Decide if the HDHP is right for you and your family.

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 for your medical and pharmacy expenses before your plan starts paying benefits.

With this High Deductible Health Plan, 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 care, and you pay less.

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

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” (under Plans for Active Employees).

PRESCRIPTION DRUG COVERAGE UNDER THE HDHP

The pharmacy benefit is managed by Express Scripts and will use the 2016 Express Scripts’ National Preferred Formulary (preferred drug list). The pharmacy benefit also includes Express Scripts’ broad retail pharmacy network. The 2016 Express Scripts’ National Preferred 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 will be excluded from coverage. 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 2016 Express Scripts’ National Preferred Formulary, visit the State Health Plan website at www.shpnc.org and click “High Deductible Health Plan” (under Plans for Active Members). For questions about your Pharmacy benefit and participating pharmacies, call Express Scripts Customer Service at 800-336-5933.

HEALTH SAVINGS ACCOUNT COMPATIBLE

The HDHP is compatible with a Health Savings Account (HSA). An HSA is a tax-deductible savings account with tax-free withdrawals for qualified medical and pharmacy expenses. Having an HSA is not required to be enrolled in this plan. An HSA can be helpful in reaching the deductible and ease the out-of-pocket burden on an HDHP. You will be responsible for setting up your own HSA through a financial institution, if you would like to have one.

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	EMPLOYEE MONTHLY PREMIUM
Employee	\$93.16
Employee + Child(ren)	\$267.74
Employee + Spouse	\$480.38
Employee + Family	\$577.04



LOCATE A PROVIDER IN THE MEDCOST NETWORK

Go to Medcost.com and click “Locate a Provider” and select “MedCost/MedCost ULTRA.”

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



High Deductible Health Plan (HDHP) Coverage Invoice

Invoice Date: 01/01/2016
Account Number: 123568
Total Amount Due: \$186.32

IMPORTANT: This is a monthly invoice for your continuation of 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.

HDHP Premium Payment Balance Detail

Payment Period	Premium Amount	Credit/Subsidy	Amount Due	Due Date	Grace Period End Date
01/01/2016 - 01/31/2016	\$93.16	\$0.00	<u>\$93.16</u>	01/01/2016	01/31/2016
02/01/2016 - 02/28/2016	\$93.16	\$0.00	<u>\$93.16</u>	02/01/2016	03/02/2016
			\$186.32 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. You may be eligible to convert your group health coverage. For more information of potential conversion options, contact the State Health Plan and/or your State's Department of Insurance.

Save Time, Postage & Ensure No Late Benefit Continuation Payments by Enrolling in Electronic Premium Payment Service!
 visit www.shphdhp.com to sign up today

HDHP PREMIUM PAYMENT REMITTANCE COUPON

Please Make Checks Payable To **North Carolina State Health Plan**.

AMOUNT ENCLOSED \$

IMPORTANT: (Box A) Check here if your name or address has changed, and complete Section A on the reverse side.

North Carolina State Health Plan
 Attention: **HDHP Premium Payments**
 PO Box
 St. Louis, Missouri 63150

Account Details
Account Number:



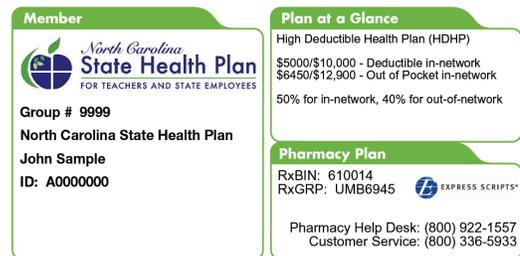
High Deductible Health Plan overview

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

PLAN 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	\$40	\$40	\$40
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				
2016 Express Scripts National Formulary Covered Prescription Drugs	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)	60% after deductible	60% after deductible

MEMBER ID CARDS

This card will allow you to access your pharmacy benefits. A sample of the card is shown at right. Your card will arrive in the mail along with a package that includes information about additional benefits available under this plan. 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.



PERSONAL CARE MANAGEMENT

If you enroll in the HDHP, you'll have access to customized health education and one-on-one nurse mentoring and coaching to encourage self-empowerment and self-management, which includes transitional care management.

ADDITIONAL BENEFITS

By enrolling in the HDHP, you'll have access to Teladoc and Personal Health Suite to assist you in maintaining a healthy lifestyle. More information about these services will be available in the information packet that will be sent with your new ID card.

TELADOC 24/7

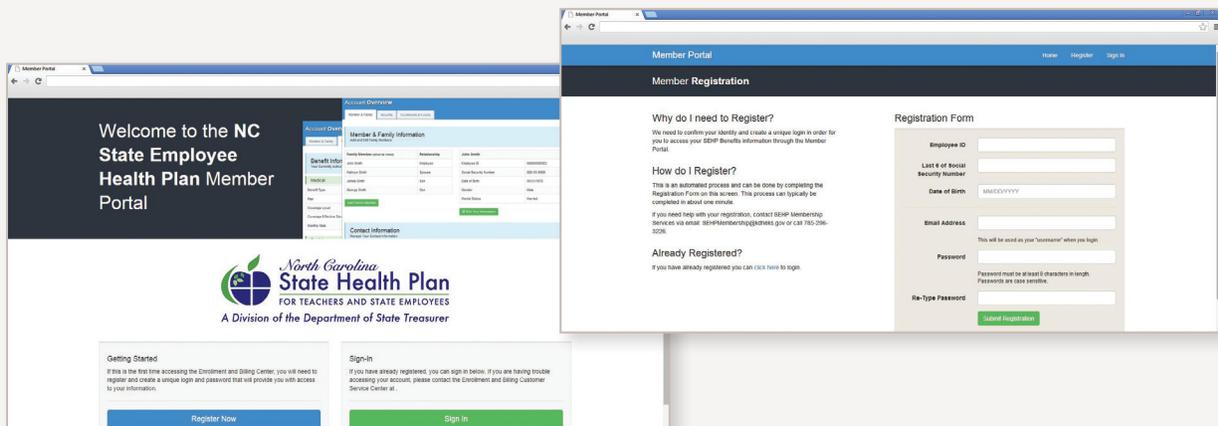
Teladoc provides access to U.S. board-certified doctors and pediatricians via phone or online video consultations. Telehealth services are only a call or click away for common conditions such as allergies, infections, etc. The out-of-pocket cost to the member will be \$40.00 per use of the service. For 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

If you enroll in the HDHP, you have access to the Personal Health Suite, which 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.

how to enroll

Enrollment for the HDHP is only available online. You will need to register with COBRAGuard at www.shphdhp.com. You will be prompted to create a user name and password. Once you have registered, you can follow the necessary steps to complete your enrollment. Below are the screens you will see once you have registered at www.shphdhp.com.





terms to understand

ACA PREVENTIVE MEDICATIONS

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

ALLOWED AMOUNT

The amount on which the HDHP determines benefits and cost sharing. The amount billed by the provider is reduced to an allowed amount by the PPO network. Payment is based on this allowed amount. 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 a member reaches their deductible, members 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. This plan has an individual and family deductible. If the family deductible is satisfied, all individual deductibles are also satisfied.

HEALTH SAVINGS ACCOUNT

A tax-deductible savings account with tax-free withdrawals for qualified medical and pharmacy expenses. You will be responsible for setting up your own HSA through a financial institution.

HIGH DEDUCTIBLE HEALTH PLAN

A High Deductible Health Plan features a higher deductible than other traditional medical and pharmacy benefit plans. Members must meet the deductible first, and then the coinsurance applies to the applicable service.

EXPRESS SCRIPTS' 2016 NATIONAL PREFERRED FORMULARY

A national drug list of the most commonly prescribed drugs that may be covered by the HDHP for members of the HDHP. The list is not an all-inclusive list. The formulary represents an abbreviated version of a list of drugs that may be covered under the HDHP. Not all the drugs listed are covered by the plan.

OUT-OF-POCKET MAXIMUM

Under the HDHP, this is the most you pay for covered expenses (medical and pharmacy) in a calendar year. It includes deductibles and coinsurance but excludes premiums.

TELEHEALTH

The practice of medicine using electronic communication, information technology or other means between a physician in one location and a patient in another physical location. This typically involves secure video conferencing or store-and-forward technology that replicates the traditional physician-patient interaction.

LEGAL NOTICES

Notice of Privacy Practices for the State Health Plan for Teachers and State Employees

This notice describes how medical information about you may be used and disclosed by the Plan and how you can get access to this information. Please review it carefully. The privacy of your medical information is important to us.

Original Effective Date: April 14, 2003

Revised Effective Date: February 22, 2016

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 to participate in the Flexible Benefit Plan and have your health benefit plan premium payments deducted on a before-tax basis. Retirees and members with COBRA continuation coverage are not eligible to participate because they must have current payroll 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. You will have the opportunity to change your participation election during each Open Enrollment period.

The Flexible Benefit Plan offered by the State 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 mid-year, when you experience one of the qualifying events listed in your Benefits Booklet (available online at www.shpnc.org). In all cases, the requested change in coverage must be consistent with the status change event that you experienced (e.g., add new dependent to coverage due to birth).

Your request for a change in coverage due to a status change event must be completed online within 30 days of the event. If you do not process the request within 30 days, you must wait until the next Open Enrollment to make the coverage change (unless you experience another status change event during the year). Employees who terminate a dependent's coverage mid-year may only re-enroll their dependent during that year if another status change event occurs mid-year, or at the next Open Enrollment.

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.