

Your North Carolina State Health Plan

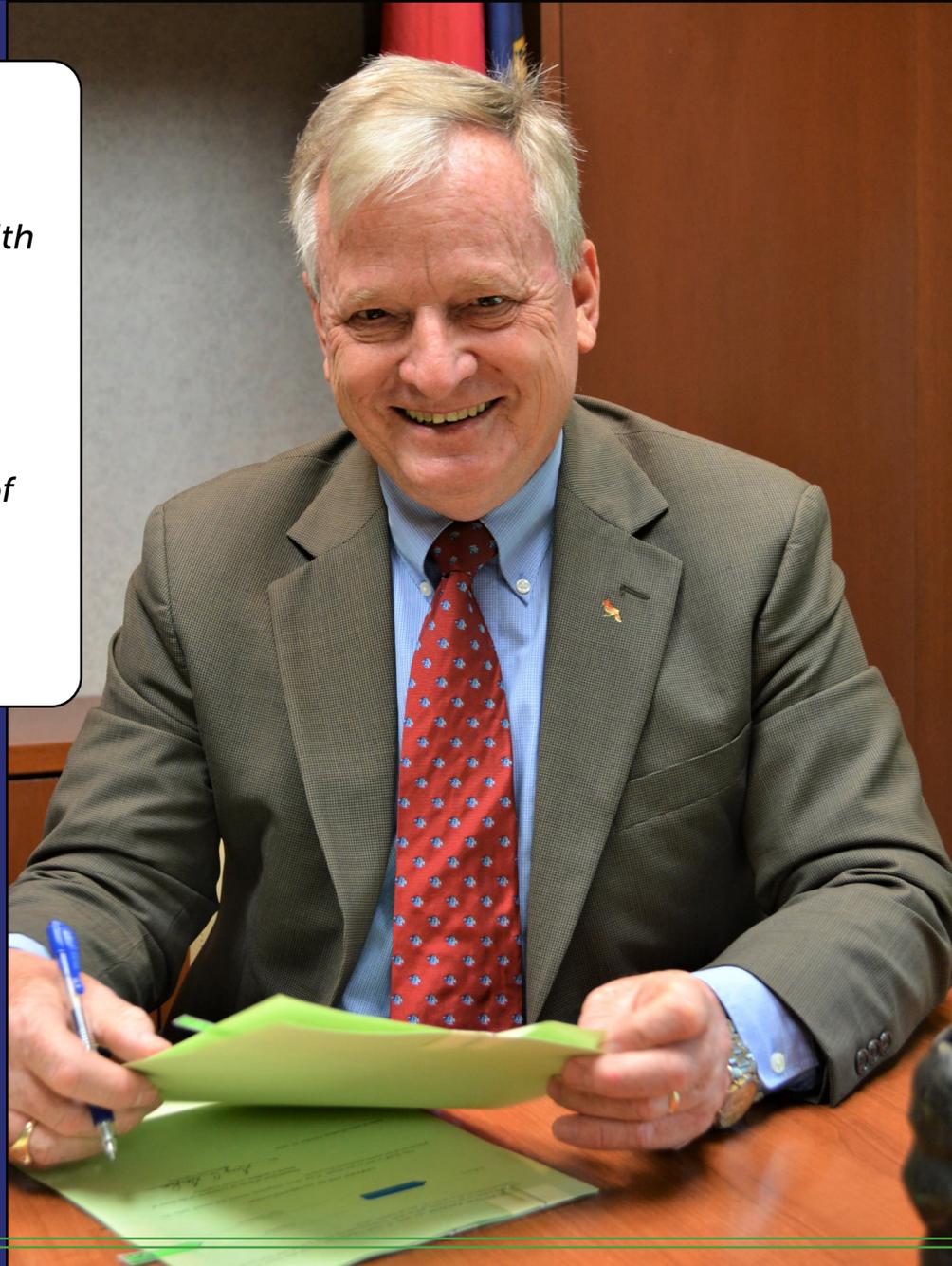
2024 NEW EMPLOYEE ENROLLMENT GUIDE

JANUARY 1, 2024 - DECEMBER 31, 2024

"Welcome to the State Health Plan! We value your service. Let us help you evaluate your options to select the best health plan for you and your family. See inside for an introduction to the Plan and important information about benefits, plan comparisons and how to enroll. We wish you the best of health throughout 2024."

Dale R. Folwell, CPA
State Treasurer

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



Understanding the Value of Your State Health Plan Coverage

You are now a valued state employee. In return, the taxpayers of North Carolina invest in you and your health by offering eligible employees full medical and pharmacy benefits through the State Health Plan. It's important to remember that the state pays for the majority of your benefit, with you subsidizing the coverage for any dependents you choose to add on to the Plan. Please read this guide carefully before enrolling.

The State Health Plan offers two health plan options: The Enhanced PPO Plan (80/20) and the Base PPO Plan (70/30).

Both the Enhanced PPO Plan (80/20) and the Base PPO Plan (70/30) are administered by Blue Cross and Blue Shield of North Carolina (Blue Cross NC) but benefits are paid by the state, not Blue Cross NC. You can seek care from providers in the NC State Health Plan Network or go out-of-network. However, if you stay in-network, your deductibles, copays and coinsurance will be lower. Both plans cover the same medical and pharmacy services. However, the member cost share varies by each plan

CVS Caremark is the Plan's pharmacy manager, but your pharmacy benefits are paid by the state. Members should note that this does NOT mean members will have to go to a CVS pharmacy location for their prescriptions.

The State Health Plan utilizes a custom, closed formulary or drug list. Under a custom, closed formulary, certain drugs are not covered. If you find that your prescription is not covered, speak to your provider about possible alternatives. There is an exception process available to providers who believe that, based on medical necessity, it is in the member's best interest to remain on a non-covered drug.

Please note:

- Permanent employees working a minimum of 30 hours per week may enroll in the State Health Plan. Some part-time employees are also eligible but on a fully contributory basis.
- For you and other permanent employees, your employing agency contributes over \$600 to your health benefit each month.
- For employee-only coverage each month, you pay \$25 on the Base PPO Plan (70/30), or \$50 on the Enhanced PPO Plan (80/20), if you complete a tobacco attestation, plus any dependent premiums, if you choose to cover dependents.
- Non-permanent employees working a minimum of 30 hours per week can also enroll in State Health Plan benefits. However, they are different benefits and these employees should work with their HR department regarding that option.

Enhanced PPO Plan (80/20)

This plan has higher premiums than the Base PPO Plan (70/30) in exchange for lower copays and lower coinsurance. In addition, the deductible is lower on this plan than the Base PPO Plan (70/30). With this plan, Affordable Care Act preventive services and medications are covered at 100%, which means there is no charge to you. An example of such a service includes an annual physical.

Base PPO Plan (70/30)

This plan has lower premiums in exchange for higher copays and coinsurance. Affordable Care Act preventive services and medications are also covered at 100%, which means there is no charge to you. An example of such a service includes an annual physical.

Affordable Care Act Preventive Services and Medications lists are located on the Plan's website at www.shpnc.org.

2025 Aetna Transition

The State Health Plan will be transitioning to a new third-party administrator, Aetna, effective January 1, 2025. Members will start getting more information about this change in 2024. It is important to ensure that you receive announcements and messages about this change so please:

- Make sure you have the correct address, email address and phone number in eBenefits, the Plan's enrollment system, which can be accessed on the Plan's website at www.shpnc.org and your employer.
- Sign up for the Plan's monthly e-newsletter, Member Focus, which can be accessed on the Plan's website at www.shpnc.org.
- Follow the Plan on Facebook.

Lower Your Monthly Premiums

By completing the tobacco attestation, you can earn a wellness premium credit that will reduce your monthly premium in both plan options. The wellness premium credit only applies to the employee-only premium. In order to receive the premium credit, you must complete the tobacco attestation within 30 days of your hire date. The tobacco attestation can be completed online through eBenefits, the Plan's enrollment system.

2024 PREMIUM CREDIT SAVINGS	Enhanced PPO Plan (80/20)	Base Plan (70/30)
Employee-only Monthly Premium	\$110	\$85
Attest that you are tobacco-free or agree to visit a Primary Care Provider that offers counseling for at least one tobacco cessation counseling session.*	-\$60	-\$60
Total Monthly Employee-Only Premium: (With Credit)	\$50	\$25

**Tobacco attestation must be completed each year. For tobacco users that agree to visit a Primary Care Provider for a tobacco cessation counseling session, only one visit is required to receive your premium credit. One session must be completed within 90 days of your enrollment.*

NC STATE HEALTH PLAN NETWORK

As a State Health Plan member, you will have access to the North Carolina State Health Plan Network, which is made up of providers who signed up for the Plan's Clear Pricing Project (CPP), and Blue Cross NC's Blue Options network. CPP providers have agreed to get rid of secret contracts, making health care more affordable and transparent. In an effort to lower health care costs for members and to support CPP providers, the Plan will be offering significant copay reductions for members who visit a CPP provider in 2024.

To locate a CPP provider, visit the Plan's website and click "Find a Doctor." Then look for "Clear Pricing Project Provider" next to a provider's name. Compare the difference and check out the savings!

CLEAR PRICING PROJECT PROVIDER COPAY COMPARISON CHART

CLEAR PRICING PROJECT PROVIDER COPAY COMPARISON CHART		
PROVIDER	Enhanced PPO Plan (80/20)	Base PPO Plan (70/30)
Primary Care Provider (PCP)	CPP PCP on ID card \$0 Non-CPP PCP on ID card \$10 Other PCP \$25	CPP PCP on ID card \$0 Non-CPP PCP on ID card \$30 Other PCP \$45
Behavioral Health Provider	CPP Provider \$0 Non-CPP Provider \$25	CPP Provider \$0 Non-CPP Provider \$45
Specialist	CPP Specialists \$40 Non-CPP Specialists \$80	CPP Specialists \$47 Non-CPP Specialists \$94
Speech, Occupational, Chiropractor and Physical Therapy	CPP Providers \$26 Non-CPP Providers \$52	CPP Providers \$36 Non-CPP Providers \$72

As noted above, you can also save money under the Enhanced PPO (80/20) and the Base PPO (70/30) plans when you visit your selected Primary Care Provider, even if that provider is not a CPP provider.

Health & Wellness Resources

The State Health Plan offers telephonic coaching for disease and case management for members with the following conditions

- chronic obstructive pulmonary disease (COPD)
- asthma
- congestive heart failure
- cerebrovascular disease
- coronary artery disease
- peripheral artery disease
- diabetes

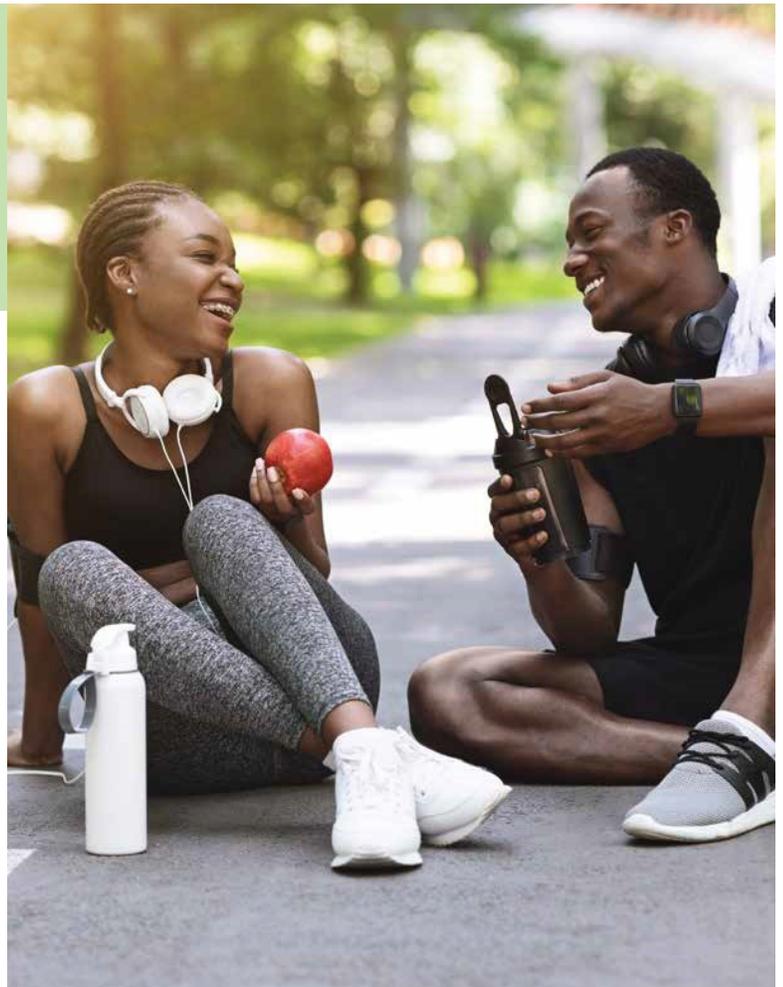
Case management will also be provided for members with complex health care needs and with conditions such as chronic and end stage renal disease. Eligible members will receive more information about these services.

BLUE365: A WELLNESS RESOURCE AND DISCOUNT PROGRAM FOR HEALTHY LIVING

As State Health Plan members, you can save money, live healthier and find great member discounts on fitness and health tools through Blue365®. Staying healthy and active is easy and affordable. It's the best investment you can make in your future. Blue365, offered through Blue Cross NC, is a simple way to access trusted wellness resources, and valuable offers like these:

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

To access more information on these saving opportunities, please visit BlueConnect. To access BlueConnect, visit the State Health Plan's website at www.shpnc.org and click eBenefits to log into eBenefits, the Plan's enrollment system. Once you're logged into eBenefits, you will see a BlueConnect Quick Link. Once you are in BlueConnect, look for the Blue365 tab. Members must register to use Blue365 services. You can also find more information in your Benefit Booklet and by calling 855-511-2583, 8 a.m. - 6 p.m., Monday-Friday.



New Member Enrollment

You can enroll yourself as well as eligible family members in health plan coverage. Eligible family members include:

- Your spouse.
- Your or your spouse's biological, legally adopted or foster child up to age 26 (including a child for whom you are the court-appointed guardian and a stepchild if you are married to the child's biological parent).
- A dependent child over the age of 26 if he or she is disabled to the extent that he or she is incapable of earning a living. The handicap must have either developed or begun to develop before the dependent's 19th birthday, or the handicap must have developed or begun to develop before the dependent's 26th birthday if the dependent was covered by the State Health Plan.

Dependent verification documentation is required for all dependents. You can upload these documents

in eBenefits, the Plan's enrollment system. A list of required documents is available on the website. New members may find it helpful to gather these documents before beginning their enrollment.

Effective Date

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

How Do I Enroll?

To enroll, visit the State Health Plan's website at www.shpnc.org and click "eBenefits" at the top of the website to access the Plan's enrollment system. If you need assistance call 855-859-0966.

Decision Support Tools

Selecting The Plan That Is Best For You

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

Visit www.shpnc.org for details about the 2024 Health Plan options, including:

- Links to the CVS Caremark drug lookup tool to assist you with determining your out-of-pocket costs for medications
- Benefit Booklets
- Plan Comparison
- Informational Videos

Premium rate information is available on the State Health Plan's website at www.shpnc.org. If you are a less than 12-month employee or the employee of a Local Government Employer, please ask your Health Benefits Representative for your applicable rates.

Special Enrollment

If you decline coverage for yourself or your eligible dependents and you later experience a qualifying event, you and/or your dependents may be eligible to enroll. You must enroll within 30 days of the qualifying event outside of the annual Open Enrollment period.

Effective January 1, 2021, members first hired on and after this date will not be eligible for retiree medical benefits.

Stay Informed

Subscribe to the State Health Plan's Member Focus free e-newsletter to keep up to date on your pharmacy and health benefits. Sign up today at www.shpnc.org. Just scroll down the page and click on the "Sign Up for Our Monthly e-Newsletter" block.

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

The coverage type you select (for example, employee-only or employee-spouse) will remain in effect until the next Open Enrollment period. You will not be able to add or drop a spouse or dependents until the next benefit plan year unless you experience a qualifying event. These events include changes such as marriage, birth and retirement. For a complete list of qualifying events, refer to the Benefits Booklet located on the Plan's website at www.shpnc.org, or ask your Health Benefits Representative. Open Enrollment is typically held in the fall.

Have Questions?

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

2024 State Health Plan Comparison

WHAT YOU PAY				
PLAN DESIGN FEATURES	ENHANCED PPO PLAN (80/20)		BASE PPO PLAN (70/30)	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible	\$1,250 Individual \$3,750 Family	2,500 Individual \$7,500 Family	\$1,500 Individual \$4,500 Family	\$3,000 Individual \$9,000 Family
Coinsurance	20% of eligible expenses after deductible is met	40% of eligible expenses after deductible is met and the difference between the allowed amount and the charge	30% of eligible expenses after deductible is met	50% of eligible expenses after deductible is met and the difference between the allowed amount and the charge
Out-of-Pocket Maximum (Combined Medical and Pharmacy)	\$4,890 Individual \$14,670 Family	\$9,780 Individual \$29,340 Family	\$5,900 Individual \$16,300 Family	\$11,800 Individual \$32,600 Family
Preventive Services	\$0 (covered by the Plan at 100%)	N/A	\$0 (covered by the Plan at 100%)	N/A
Office Visits	CPP PCP on ID card \$0 Non-CPP PCP on ID card \$10 Other PCP \$25	40% after deductible is met	CPP PCP on ID card \$0 Non-CPP PCP on ID card \$30 Other PCP \$45	50% after deductible is met
Specialist Visits	CPP Specialist \$40 Other Specialists \$80	40% after deductible is met	CPP Specialist \$47 Other Specialists \$94	50% after deductible is met
Speech, Occupational, Chiro & Phys. Therapy	CPP Provider \$26 Other Provider \$52	40% after deductible is met	CPP Provider \$36 Other Provider \$72	50% after deductible is met
Urgent Care	\$70		\$100	
Emergency Room (Copay waived w/admission or observation stay)	\$300 copay, then 20% after deductible is met		\$337 copay, then 30% after deductible is met	
Inpatient Hospital	\$300 copay, then 20% after deductible is met	\$300 copay, then 40% after deductible is met	\$337 copay, then 30% after deductible is met	\$337 copay, then 50% after deductible is met
Tier 1 (Generic)	\$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		Deductible/coinsurance	
Tier 4 (Low-Cost Generic Specialty)	\$100 copay per 30-day supply		\$200 copay per 30-day supply	
Tier 5 (Preferred Specialty)	\$250 copay per 30-day supply		\$350 copay per 30-day supply	
Tier 6 (Non-preferred Specialty)	Deductible/coinsurance		Deductible/coinsurance	
Preferred Blood Glucose Meters (BGM) and Supplies*	\$5 copay per 30-day supply		\$10 copay per 30-day supply	
Preferred and Non-Preferred Insulin	\$0 copay per 30-day supply		\$0 copay per 30-day supply	
Preventive Medications	\$0 (covered by the Plan at 100%)		\$0 (covered by the Plan at 100%)	

PCP: Primary Care Provider

*This does not include Continuous Glucose Monitoring Systems or associated supplies. Preferred Continuous Glucose Monitoring Systems and associated supplies are considered a Tier 2 member copay.

Legal Notices

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Original Effective Date: April 14th, 2003

Revised Effective Date: June 10th, 2021

Introduction

A federal law, the Health Insurance Portability and Accountability Act (HIPAA), requires that we protect the privacy of identifiable health information that is created or received by or on behalf of the Plan. This notice describes the obligations of the Plan under HIPAA, how medical information about you may be used and disclosed, your rights under the privacy provisions of HIPAA, and how you can get access to this information. Please review it carefully.

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information if we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services or sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your

rights and some of our responsibilities to help you. Get a copy of health and claims records.

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- Ask us to correct health and claims records
- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.
- Request confidential communications
- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.
- Ask us to limit what we use or share
- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.
- Get a list of those with whom we've shared information
- You can ask for a list (accounting) of the times we've shared your health information (including medical records, billing records, and any other records used to make decisions regarding your health care benefits) for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except: (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

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes, including when you provide your mobile phone number for the express purpose of enrolling in the Plan's texting program. See "SMS Texting Terms and Conditions" for details.
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you. Example: The Plan may disclose your health information so that your doctors, pharmacies, hospitals, and other health care providers may provide you with medical treatment.

Run our organization

We can use and disclose your information to run our organization (healthcare operations), improve the quality of care we provide, reduce healthcare costs, and contact you when necessary. Example: The Plan may use and disclose your information to determine the budget for the following year, or to set premiums.

We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans. Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services. Example: We share information about you with CVS Caremark to coordinate payment for your prescriptions.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration. Example: Your employer's Health Benefit Representative is provided information to help you understand your health benefits, and help make sure you are enrolled.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research. Research done using Plan information must go through a special review process. We will not use or disclose your information unless we have your authorization, or we have determined that your privacy is protected.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Other Uses and Disclosures

Some uses and disclosures of your will be made only with your written authorization. For example, your written 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 receive your revocation. It will not have any effect on the prior uses and disclosures of your PHI.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

The Plan has the right to change this notice at any time. The Plan also has the right to make the revised or changed notice effective for medical information the Plan already has about you as well, as any information received in the future. The Plan will post a copy of the current notice at www.shpnc.org. You may request a copy by calling 919-814-4400.

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. You will not be penalized or retaliated against for filing a complaint.

To file a complaint with the Plan, contact the Privacy Contact identified in this Notice.

To file a complaint with the Secretary of the Department of Health and Human Services Office for Civil rights use this contact information:

U.S. Department of Health and Human Services
200 Independence Avenue SW.
Room 509F, HHH Building
Washington, DC 20201
1-800-368-1019, 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>

Privacy Contact

The Privacy Contact at the Plan 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

Your health benefit coverage can only be changed (dependents added or dropped) during the Open Enrollment period or following a qualifying life event. These events include, but are not limited to the following.

- 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 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 or your dependents change your country of permanent residence by moving to or from the United States, you or your dependents will have 30 days from the date of entering or exiting the United States to change your health benefit plan election.
- 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.

Notice of HIPAA Special Enrollment Rights

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 Eligibility and Enrollment Support Center at 855-859-0966.

Notice Regarding Mastectomy-Related Services

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under your elected plan. If you would like more information on WHCRA benefits, call Customer Service.

Notice of Patient Protections for Non-Grandfathered Plans

The following notice applies to plans offered by the North Carolina State Health Plan for Teachers and State Employees ("Plan") that are not considered to be a "grandfathered health plan" under the Patient Protection and Affordable Care Act. The Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Customer Service.

You do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Customer Service.

Notice Regarding Availability of Health Insurance Marketplace Coverage Options (Employer Exchange Notice)

To assist you as you evaluate options for you and your family, this notice provides basic information about the Health Insurance Marketplace ("Marketplace"). The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium.

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you are eligible for depends on your household income. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer

coverage to you at all or does not offer coverage that meets certain standards.

If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60% of such costs.

It is important to note, if you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution to the employer-offered coverage. Also, this employer contribution, as well as your employee contribution to employer-offered coverage, is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

For more information about your coverage offered by your employer, please review the summary plan description or contact Customer Service. The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

Notice Regarding Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

[What is "balance billing" \(sometimes called "surprise billing"\)?](#)

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network. "Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit. "Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed. If you get other types of services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network.

You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly. Generally, your health plan generally must:
 - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
 - Cover emergency services by out-of-network providers.
 - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
 - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact the U.S. Department of Health and Human Services (Phone: 800-985-3059) regarding enforcement of federal balance or surprise billing protection laws and the North Carolina Department of Insurance regarding enforcement of North Carolina balance or surprise billing protection laws (Phone: 855-408-1212; Address: 325 N. Salisbury Street, Raleigh, NC 27603).

Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

Visit ncdoi.gov for more information about your rights under North Carolina law.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP) If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.** If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272).**

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility –

ALABAMA – Medicaid		ALASKA – Medicaid	
Website: http://myalhipp.com/ Phone: 1-855-692-5447		The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx	
ARKANSAS – Medicaid		CALIFORNIA – Medicaid	
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)		Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov	
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)		FLORIDA – Medicaid	
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442		Website: https://www.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html Phone: 1-877-357-3268	

GEORGIA – Medicaid	INDIANA – Medicaid
<p>GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2</p>	<p>Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584</p>
IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid
<p>Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562</p>	<p>Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660</p>
KENTUCKY – Medicaid	LOUISIANA – Medicaid
<p>Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov</p>	<p>Website: www.medicicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)</p>
MAINE-Medicaid	MASSACHUSETTS-Medicaid and CHIP
<p>Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711</p>	<p>Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711</p>
MINNESOTA – Medicaid	MISSOURI – Medicaid
<p>Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739</p>	<p>Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005</p>
MONTANA – Medicaid	NEBRASKA – Medicaid
<p>Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HSHIPPProgram@mt.gov</p>	<p>Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178</p>
NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
<p>Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900</p>	<p>Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218</p>
NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
<p>Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710</p>	<p>Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831</p>
NORTH CAROLINA – Medicaid	NORTH DAKOTA – Medicaid
<p>Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100</p>	<p>Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825</p>
OKLAHOMA – Medicaid and CHIP	OREGON – Medicaid
<p>Website: http://www.insureoklahoma.org Phone: 1-888-365-3742</p>	<p>Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075</p>

PENNSYLVANIA – Medicaid and CHIP		RHODE ISLAND – Medicaid and CHIP	
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children’s Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)		Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RlTe Share Line)	
SOUTH CAROLINA-Medicaid		SOUTH DAKOTA – Medicaid	
Website: https://www.scdhhs.gov Phone: 1-888-549-0820		Website: http://dss.sd.gov Phone: 1-888-828-0059	
TEXAS – Medicaid		UTAH – Medicaid and CHIP	
Website: Health Insurance Premium Payment (HIPP) Program Texas Health and Human Services Phone: 1-800-440-0493		Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	
VERMONT – Medicaid		VIRGINIA – Medicaid and CHIP	
Website: Health Insurance Premium Payment (HIPP) Program Department of Vermont Health Access Phone: 1-800-250-8427		Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924	
WASHINGTON – Medicaid		WEST VIRGINIA – Medicaid and CHIP	
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022		Website: https://dhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)	
WISCONSIN – Medicaid and CHIP		WYOMING – Medicaid	
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002		Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269	

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
 Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
 1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
 Centers for Medicare & Medicaid Services
www.cms.hhs.gov
 1-877-267-2323, Menu Option 4, Ext. 61565

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)
 - The State Health Plan website is Americans with Disabilities Act (ADA) compliant for the visually impaired.
- 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 at 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 (Section 1557 Coordinator, 3200 Atlantic Avenue, Raleigh, NC 27604) or email (1557Coordinator@nctreasurer.com).

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
 1-800-368-1019, 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**.

تدعى اسم الما تا مدخ ناف، تغللا ركذا تدرجت تنك اذا عظوجل
مقرب لصتا ناجملاب لكل رفاوتت تيوعلللا
919-814-4400.

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau **919-814-4400**.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **919-814-4400**.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **919-814-4400**.

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

ប្រយ័ត្ន: ប៊ីស៊ីនជាអ្នកនិយាយភាសាខ្មែរ, សូមព្រមព្រៀងនឹងក្រុមការងារ ដោយមិនគិតល្មន្ទល គឺអាចមានសំណុំប៊ីស៊ីនអនឺម។ ចូរទូរស័ព្ទ **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**.

ໄປດຊາຍ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໄດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທສ **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
(eBenefits questions):
855-859-0966

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

CVS Caremark
(pharmacy benefit questions):
888-321-3124