STATE HEALTH PLAN CHANGE SUMMARY 2015

DISCLAIMER: The summary of information provided here and in all other attachments is provided solely to assist SEANC members and/or the reader in a general understanding of changes to the State Health Plan and the various options being offered for calendar year 2015. Where discrepancies occur between this and official documents issued by the State Health Plan, the Plan member should rely solely on those official documents. Information may change and the most current information is available at the State Health Plan website: www.shpnc.org

IDENTIFICATION OF OFFICIAL STATE HEALTH PLAN MAILINGS=APPLE LOGO

ANNUAL ENROLLMENT: CALENDAR YEAR 2015

1. Enrollment for Calendar Year 2015 will be conducted **October 1, 2014 and ends October 31, 2014**.
2. The Benefit Year will be effective January 1, 2015 through December 31, 2015.
3. Notification of Enrollment
   a. Decision Guide Mailer in early September
   b. State Health Plan Medicare Primary Outreach Events (Refer to State Health Plan Mailer). **If planning to attend, please call 800-850-1992 Monday through Friday, from 8:00 a.m. to 5:00 p.m. to ensure adequate planning by State Health Plan staff!**
4. If you are satisfied with the plan in which you are currently enrolled:
   a. No further action is required for Medicare retirees or those electing the Traditional PPO 70/30 Plan
   b. Active employees and early retirees taking the Enhanced PPO 80/20 Plan must complete the wellness activities below to avoid premium surcharges and obtain the premium credits.
      (1) Attest to abstaining from tobacco products or enroll in a tobacco cessation program
      (2) Complete a Health Assessment
      (3) Designate a Primary Care Physician
5. If you wish to change your State Health Plan option or make other changes such as adding or dropping dependents, you may do so online or by phone. It is recommended that you complete any enrollment activities as early in October as possible. The State Health Plan has taken action to enhance enrollment this year and minimize the problems experienced last year.
   a. ONLINE
      (1) Active Employees: eEnroll or Beacon
      (2) Retirees: Orbit
   b. PHONE: Toll Free: 855-859-0966
6. Once Annual Enrollment is completed, plan changes remain in effect until the next Annual Enrollment unless a "qualifying life event" occurs. Qualifying life events include death, marriage, divorce, birth/adoption of a child, becoming Medicare eligible due to age or disability, qualifying for Medicaid due to income changes, change of employer and similar situations. Note that employees **only have 30 days to enter transactions in eEnroll due to a qualified life event.** Some Health Benefit Representatives have not approved these changes in a timely manner. This will result in the employee and/or dependents being forced to remain in their current status until the next Annual Enrollment. Check with your Health Benefits Representative or Human Resources Officer for other situations which may qualify as life events.
7. Read, Study and Save ALL mailings from the State Health Plan **indicated by the Apple logo!**
8. Buy the best State Health Plan Option you can afford! Medical bills are the single largest cause of bankruptcy in the United States, even for people with health insurance.
9. Sign up for the State Health Plan electronic newsletter "Member Focus" at www.shpnc.org

PREMIUMS

Premiums for employees and dependents will remain the same for 2015 due to lower claims payments and action by the State Health Plan Board of Trustees. **Active employees enrolled in the PPO 80/20 Option OR the Consumer Driven Health Plan (CDHP) must complete the wellness activities (designation of primary care provider, completion of a Health Risk Assessment, and completion of the Tobacco Attestation/Enrollment in Tobacco Cessation to continue to avoid premium surcharges and maintain premiums at the lowest possible level.**

BENEFIT CHANGES

RETIREES COULD LOSE HEALTH COVERAGE RETURNING TO WORK FOR THE STATE

Due to changes mandated by the General Assembly to save state funds, retirees returning to work as temporary state employees could lose their retiree health insurance benefits – if they work more than 30 hours a week.

According to the changes, if retirees are reasonably expected to work more than 30 hours a week when rehired as temporary state employees, or find themselves actually averaging more than 30 hours a week, they will be forced into a new State Health Plan option titled the High Deductible Health Plan (HDHP), which was created to meet the Affordable Care Act (ACA) requirement that employers provide health insurance to fulltime temporary employees.

The High Deductible Health Plan is the equivalent of the lowest level health insurance benefits under the ACA (Bronze Plan) and has extremely high deductibles, copays and coinsurance.

Under this plan, deductibles are $5,000 per individual and $10,000 per family, with co-insurance ranging from 50 percent in-network to 60 percent out-of-network. Annual out-of-pocket maximums range from $6,450 per person in-network to $12,900 per person out-of-network, while family maximums range from $12,900 in-network to $25,800 out-of-network.

SEANC is urging retirees to think carefully before they jeopardize their earned retiree health insurance benefits and financial security by returning to state employment in a manner that forces them onto the HDHP.

As amended, G.S. 135-48-41(j) states that "If a retiree has been hired by an employing unit and is eligible for coverage under the [ACA High Deductible Health Plan], then the rehired retiree shall not, during the time of employment, be eligible for the retiree coverage."

Under this definition, those rehire retirees are deemed ACA Full-Time Employees if they are hired with the reasonable expectation of working 30 or more hours per week or if they average working 30 or more hours per week during a one year measurement period.

For those retirees who are currently back working for the state as temporary employees, the measurement period is November 1, 2013, to October 31, 2014. Those retirees should immediately compute their average weekly hours worked and if the average is over 30, consider stop working for the rest of this month in an attempt to bring their average below 30 hours per week for the past 12 months. If a retiree should determine that it is not possible to bring their average below 30 hours, then the only way to continue to keep their SHP retiree coverage will be to resign from their temporary job with the state at the end of 2014. Then, after an appropriate break in service *(see below)* they can try to return to work with the agreement that they will work less than 30 hours part week.

For those retirees with a break in service who are currently planning to return to work for the state as temporary employees, there is a way for a rehire retiree can be considered an ACA Non-Full-Time Employee, and as such can maintain their retiree coverage: the break in service must be 13 weeks or more (26 or more for educational organizations) and the rehire retiree must not be reasonably expected to work at least 30 hours a week.

However, even when rehired under such an expectation, the retiree must make certain they do not actually average more than 30 hours per week, because if they do over a year's time they will be put into the HDHP.

If you have any questions, contact SEANC's General Counsel Tom Harris or State Health Plan specialist Chuck Stone.

AUTOMATIC ENROLLMENT FOR EMPLOYEES PLANNING RETIREMENT

Employees planning to retire from state service will **automatically be enrolled** in the State Health Plan upon retirement unless they opt out for themselves and any covered dependents. If the employee is not fully vested for retiree health insurance benefits, the full amount of the health insurance premium will be deducted from their pension check. **Once members are automatically enrolled, they will not be able to drop State Health Plan benefits until the next Annual Enrollment period or they experience a qualifying life event.**

Employees thinking of retiring should:

1. Determine whether they must pay only a minimal premium for themselves. Employees hired prior to October 1, 2006 will have only a small premium or no premium.
2. Meet with their Health Benefits Representative up to 6 months prior to retirement and submit paperwork 120 days prior to retirement to ensure all deadlines are met.
3. Attend a Seminar for Pre-Retirees to maximize their health benefit options
4. Employees hired on or after October 1, 2006 with less than 20 years service are responsible for 50-100% of the premium even for employee only coverage. Retirees responsible for 50-100% of the premium and not yet eligible for Medicare, should carefully consider the cost and benefits of the State Health Plan options. Then compare this to the cost and benefits of health insurance products available under the Affordable Care Act through the Federal Health Benefits Exchange, since you may qualify for federal tax credits to pay part of the premium costs for yourself. However, be careful to compare Plan benefits!
5. **Please note that dependents of retirees are eligible for health insurance products available under the Affordable Care Act through the Federal Health Benefits Exchange and may qualify for federal tax credits to pay part of the premium costs depending on family income. This applies even for employees who pay little or no premium for the State Health Plan.**
6. Note that retirees who are eligible for TriCare for Life (retired military veterans), CHAMPUS-VA and/or other employer sponsored retiree health insurance benefits need to carefully consider which State Health Plan option to take to best coordinate with their other retiree health insurance benefits.

Notes:

1. **Retiring members under 65 will be automatically enrolled in the health plan they were enrolled in as an active employee** along with any covered dependents. You must take action if you wish to switch to a different option.
2. **Retiring members and/or dependents who are Medicare-eligible and whose retirement paperwork (6E and any other required documents) is processed and approved 60 days or greater from your health plan benefit effective date will be automatically enrolled into a Group Medicare Advantage Base plan with either Humana or UnitedHealthcare**. These base plans are premium-free for retiree-only coverage. Retirees will have up to 30 days *prior* to their benefit effective date to change plans.
3. **Retiring members who are Medicare-eligible and whose retirement paperwork (6E Form and any other required documents) is processed less than 60 days prior to your health plan benefit effective date will be automatically enrolled in the Traditional PPO 70/30 Plan** for the remaining portion of the plan year.
4. **Reminder: All state retirees must enroll in both Medicare Parts A and B when eligible for Medicare due to age 65 or Social Security Disability (do three months prior to age 65). Failure to do so results in major financial penalties of 10% additional Medicare premium per year for each year of delay (maximum of 120%) AND the State Health Plan will treat claims as if the retiree were enrolled in Medicare.** One Exception for Enrollment: State retirees who continue to work, **but are eligible for continued health insurance through an employer**, may delay enrollment in Medicare Part B. Members should be aware of the Medicare primacy change and the **need to elect Medicare Part B to be effective the date of their retirement. Medicare Advantage Plans do not allow exceptions for late enrollments,** which will result in the retiree only having the option to enroll in the Traditional 70/30 Plan option until Open Enrollment.

AFFORDABLE CARE ACT TAX PENALTIES FOR TAX YEAR 2015

Effective with Calendar and Tax Year 2015, all citizens of the United States **are required to have health insurance coverage or pay a tax penalty when filing 2015 taxes!** There are a few exceptions to this requirement such as Medicaid eligibility which can be found at https://healthcare.gov Penalties in the first year of 2015 will range from $95 for an individual to $295 or 1% of Adjusted Gross Income for a family.

While the State provides employee health insurance coverage, you are still required to have health insurance coverage for your dependents. Unfortunately, dependents of active employees do **NOT** qualify for Premium Tax Credits in the Federal Health Benefit Exchange due to a ruling by the IRS and refusal of the U.S. House to agree to an amendment to the Affordable Care Act. **Please note that dependents of retired employees do potentially qualify for the Premium Tax Credits.**

The primary exemption for state employees to avoid the tax penalty for failing to have coverage on dependents is: There is no tax penalty if the premiums for dependent coverage would exceed 8.05% of Adjusted Gross Income (this includes the income of both the employee and their spouse). Because the State provides no premium assistance for dependent coverage, payment of dependent premiums would exceed 8.05% of Adjusted Gross Income, thus exempting many state employees from the tax penalties. To avoid tax penalties for failing to cover dependents, employees should still apply for dependent health care coverage on the Federal Health Benefit Exchange.

APPLIED BEHAVIORAL ANALYSIS THERAPY (ABA)

Effective January 1, 2015, the State Health Plan will begin to cover Applied Behavioral Analyst Therapy (ABT) for State Health Plan dependent children up to age 26. Coverage is subject to medical diagnosis of Autism Spectrum Disorder, managed similar to Mental Health Care benefits and a $36,000 annual cap. This is a great benefit for any state employee with an eligible dependent covered by the State Health Plan. Applied Behavioral Analyst Therapy has been shown to be highly effective in treatment of Autism Spectrum Disorder allowing more than 50% of those treated to be mainstreamed into regular classrooms and achieve academic normalcy, eliminating adverse behaviors and preventing institutionalization which would be far more costly.

ELIMINATION OF VISION DISCOUNTS FOR THOSE WITHOUT VISION INSURANCE

1. SB477: This bill will raise eyeglass prices for any North Carolina citizen without vision insurance. It prevents health insurance companies from negotiating discounts for their members when the health insurance does not pay for the eyeglasses. Previously, health insurance companies, including Blue Cross/Blue Shield NC, negotiated with Optometrists to provide discounts of 20-25+% for their members. It was special interest legislation requested by the NC Optometric Association. Opthalmologists (physicians who specialize in eye diseases) asked to be removed from the bill.
2. Eyeglasses already have a 250-300+% profit margin, so discounts still allowed profits of 200-250%.
3. The bill eliminated language that required Optometrists to provide written notice of a patient's right under federal law to receive the eyeglass prescription and have it filled anywhere one desires. Many consumers are embarrassed or intimidated if they have to ask their Optometrist for the prescription, and some Optometrists or their staff have been known to refuse even though this violates ethics and federal law.
4. It is an inherent conflict of interest since most Optometrists have their assistant take you straight to the Optical Shop in their office. This would be like your physician having a Pharmacy in their office and writing you a prescription to get filled in their office.

Consumers should protect themselves by using the following strategies:

1. Purchasing vision insurance **OR** if you can't afford vision insurance:

2. State employees may purchase eyeglasses for themselves and dependents from NC Department of Correction Enterprises at discounts of 60-65% off retail prices and this includes high index progressive lenses and brand name frames.
3. Demand your eyeglass prescription and get it filled elsewhere!
4. Purchase your eyeglass prescription at Costco, Sam's or BJ's Warehouse Clubs which have prices approximately half of the Optometrist Optical shop and have higher ratings for customer satisfaction per Consumer Reports.
5. Purchase eyeglasses off the Internet at discounts as high as 60+%. Some companies will mail as many as five different frames at a time.
   http://www.consumerreports.org/cro/eyeglass-stores/buying-guide.htm

   http://www.consumerreports.org/cro/money/shopping/eyeglass-stores/eyeglass-stores-ratings/ratings-overview.htm

PRESCRIPTION DRUG TIERS INCREASED

Tier 1 Most cost-effective medications, which includes mostly generic drugs
Tier 2 Preferred brand medications, including some high-cost generic drugs and compound drugs**
Tier 3 Non-preferred brand drugs
Tier 4 Preferred specialty medications, including some Biosimilars*
Tier 5 Non-preferred specialty medications including some Biosimilars*

*Specialty Drugs and Biosimilar are medications that are often used to treat complex diseases, require special administration, dosing and handling, and typically prescribed by a specialist provider and are high in cost. For a complete listing of Specialty Drugs, please visit www.shpnc.org and click on "Pharmacy."
**Traditionally all generic medications have been in Tier 1. With the introduction of many high-cost generics with lower cost alternatives, some high-cost generics may be placed in Tier 2.

PREFERRED INSULIN BRANDS: NovoNordisk's Novolin® and Novolog® to be Preferred Insulin

Effective July 1, 2014, NovoNordisk became the State Health Plan's only preferred brand of insulin on Tier 2 of the Preferred Drug List ($40 copay per 30-day supply), and a Step Therapy Program will be implemented.
Members enrolled in the Traditional 70/30 and Enhanced 80/20 plans will be impacted by the preferred drug list change. Lilly brand insulins (Humulin® and Humalog®) and Sanofi-Aventis brand insulin (Apidra®) will move to Tier 3 ($64 copay per 30-day supply).

The Step Therapy Program will apply to members enrolled in the Traditional 70/30 Plan, Enhanced 80/20 Plan and Consumer-Directed Health Plan (CDHP). The Step Therapy program is developed to encourage the use of the preferred medication prior to the use of a non-preferred medication. This program DOES NOT impact the long-acting insulins Lantus or Levemir.

It is important for members to speak to their provider before July 1 to see what options are best for them. Members must have provider approval prior to the switch between insulin brands. Affected members will be notified in advance with letters outlining the coverage changes so they can discuss options with their provider. Members who wish to remain on the Lilly or Sanofi brand insulins will require a coverage review. To request a coverage review, providers may call Express Scripts at 800-417-1764, from 8 a.m. to 9 p.m., Eastern Time, Monday through Friday. If approved, the copay in the 70/30 and 80/20 plans will be $64 per 30-day supply, and the CDHP will have a 15% coinsurance. Members will be responsible for the full cost of the prescription if the provider does not receive approval during the coverage review. For questions, please contact Express Scripts Customer Service at 800-336-5933.

INPATIENT HOSPITAL PRE-ADMISSION CERTIFICATION RULE CHANGE

Effective July 1, 2014, the Blue Cross and Blue Shield Association is requiring that pre-authorization of inpatient admissions be the responsibility of participating providers. This means that receiving a prior authorization for **an out-of-state, in-network** inpatient stay will no longer be the member's responsibility. If the participating facility does not obtain the proper authorization, the member will be held harmless.

This change does not impact outpatient services or professional services that require any type of approvals. Due to this change, there will need to be a slight change to the wording on the back of the State Health Plan ID card.

Claims may be subject to review. ***For non-participating providers, members are responsible for ensuring the prior review/certification is obtained. For non-North Carolina providers, members are responsible for ensuring the prior review/certification is obtained for professional and/or outpatient services.***

OTHER

STATE HEALTH PLAN MEDICARE ADVANTAGE PLANS UNIQUE

Medicare Advantage Plans offered through the State Health Plan are UNIQUE and different from Medicare Advantage Plans sold to the general public! Those sold to the general public generally have closed networks meaning you pay more if you go out of network. **State Health Plan Medicare Advantage Plans have a passive network!** This allows you to go to any provider who accepts Traditional Medicare, even if the provider (physician/specialist/hospital) is NOT a member of Humana or United HealthCare's network, and you are only responsible for the copay that you would normally pay! This is a major difference from Medicare Advantage plans sold to the general public.

CONTACT INFORMATION AND RESOURCES

ENROLLMENT/ELIGIBILITY-BENEFITFOCUS: 855-859-0966
HUMANA: 800-944-9442
UNITEDHEALTHCARE: 866-747-1014
BLUE CROSS/BLUE SHIELD NC (PPO 70/30; PPO 80/20): 888-234-2416

STATE HEALTH PLAN OFFICE: (919) 881-2300
STATE HEALTH PLAN WEBSITE: www.shpnc.org
STATE HEALTH PLAN FACEBOOK: Facebook.com/shpnc

NORTH CAROLINA DEPARTMENT OF INSURANCE
Seniors Health Insurance Information Program (SHIIP):
Web: http://www.ncdoi.com/SHIIP/
CONSUMER ISSUES/COMPLAINTS:
SmartNC: TOLL FREE: 877-885-0231 Website: http://www.ncdoi.com/Smart/

FEDERAL GOVERNMENT: AFFORDABLE CARE ACT: 1-800-318-2596;
https://www.healthcare.gov
SEANC: Raleigh Local (919) 833-6436 Toll Free 800-222-2758