When I was sworn in as the 28th State Treasurer of North Carolina, I promised to reduce complexity and add value to the State Health Plan. One of the ways that the Plan has been able to achieve this is through recent negotiations with UnitedHealthcare®, the Plan’s Medicare Advantage carrier. I’m pleased to say that those negotiations resulted in $55 million in savings. We were able to do this by using our “largeness” to get better deals and signing our contracts. **WE HAVE PASSED ON THESE SAVINGS TO YOU WITH A SIGNIFICANT REDUCTION IN PREMIUMS FOR OUR MEDICARE ADVANTAGE PLANS.**

I look forward to continuing to serve you as state treasurer, and I thank you for your service to the people of North Carolina.

- Dale R. Folwell, CPA
  State Treasurer
Open Enrollment is the time to re-evaluate your State Health Plan coverage. This Decision Guide will help you navigate your options for the 2019 benefit year.

For the second year in a row, the State Health Plan has renegotiated the contract with UnitedHealthcare® (UHC) and premium rates are lower for 2019 for both the Medicare Advantage Base and Enhanced Plans.

Attention 70/30 Plan members: UHC Medicare Advantage plans offer lower dependent premiums. Nearly 90% of Medicare-eligible retirees are already on these plans. Now is the perfect time to review if one of the UHC plans is a better option for you!

ACTION REQUIRED!
All Medicare members currently enrolled in the 70/30 Plan will be automatically enrolled into the UnitedHealthcare® Group Medicare Advantage (PPO) Base Plan effective January 1, 2019, if no action is taken during Open Enrollment. You will need to take action during Open Enrollment if you want to be enrolled in a different plan option.

If you are currently enrolled in a UnitedHealthcare® (UHC) Group Medicare Advantage Plan, you do NOT need to take any action during Open Enrollment unless you want to change plans or need to add dependents.
A LOOK AT YOUR 2019 OPTIONS

As a Medicare-eligible member, you have three plan options to choose from for 2019:

The UnitedHealthcare® Group Medicare Advantage (PPO) Base Plan

The UnitedHealthcare® Group Medicare Advantage (PPO) Enhanced Plan

The 70/30 Plan, administered by Blue Cross and Blue Shield of North Carolina (Blue Cross NC)

WE’RE HERE TO HELP. The Eligibility and Enrollment Support Center will offer extended hours during Open Enrollment. (Monday–Friday, 8 a.m.–10 p.m. ET, and Saturday, 8 a.m.–Noon ET)
The UHC Group Medicare Advantage (PPO) Plans are customized to combine Medicare Parts A and B along with Medicare Part D (prescription coverage) into one plan with additional benefits, services and discount programs. You must have both Medicare Parts A and B in effect to be enrolled in one of the UHC Group Medicare Advantage (PPO) Plans.

**UHC Group Medicare Advantage (PPO) Plans Key Facts**

The UHC Group Medicare Advantage (PPO) Plans offer simplicity:

- When you enroll, you have one plan, with one ID card, for both medical and prescription drug coverage.
- Although you remain in the Medicare program, UnitedHealthcare administers the Medicare Advantage plan, which includes all of the benefits of Original Medicare, along with additional features and programs.

**Advantages of the UHC Group Medicare Advantage (PPO) Plans:**

The UHC Group Medicare Advantage (PPO) Plans offer benefits in addition to the coverage offered under Medicare.

- The plans offer lower dependent premiums than the 70/30 Plan.
- The services covered under the plans are copay based and provide you with certainty in your out-of-pocket costs.
- There are no deductibles that have to be met for any covered benefits.
- For some benefits offered under the UHC Group Medicare Advantage (PPO) Plans, you pay less than you would under Original Medicare.
- Additional benefits and services offered under the UHC Group Medicare Advantage (PPO) Plans include:
  - Nurse help line
  - SilverSneakers® Fitness Program
  - Routine eye exams
  - Routine hearing exams
  - Hearing aids
  - Routine foot care

**NOTE:** The premiums for Medicare Part A (if applicable) and Medicare Part B are paid out of your Social Security benefits or direct billed to you by the federal government if you are not collecting Social Security benefits.

**UHC GROUP MEDICARE ADVANTAGE (PPO) PLANS FACT**

UHC Group Medicare Advantage Plans offer lower dependent premiums than the 70/30 Plan. Nearly 90% of Medicare-eligible retirees are already on these plans.
Medicare Advantage Plan
Important Information

The medical benefits provided by the UHC Group Medicare Advantage (PPO) Plans in 2019 are the same as those provided by the plans in 2018.

If you choose to enroll in a UHC Group Medicare Advantage (PPO) Plan for 2019, you can see any provider (in-network or out-of-network) that participates in Medicare and accepts Medicare assignment. Your copays or coinsurance stay the same.

As a reminder, coverage of preferred brands of insulin is limited to Lilly products, and Novo products are not covered. Both products are considered to be equally medically effective, but use of Lilly products will enable further cost savings.

How UHC Group Medicare Advantage (PPO) Plans Coordinate with other Plans

- Your UHC Group Medicare Advantage (PPO) Plan coverage includes Medicare Prescription Drug coverage (Medicare Part D) with no coverage gap (meaning there is no donut hole). Therefore, you do not need a stand-alone Medicare Part D Plan.

- If you currently have a Medicare Part D or another Medicare Advantage Plan, and choose one of the State Health Plan’s UHC Group Medicare Advantage (PPO) Plan options, the Centers for Medicare and Medicaid Services (CMS) will disenroll you from the other plan(s) as of January 1, 2019.

- Medigap and UHC Group Medicare Advantage (PPO) Plans:
  - When you enroll in a Medicare Advantage Plan, you cannot use Medicare Supplement Insurance (Medigap) to pay for out-of-pocket costs, such as copays and coinsurance.
  - If you currently have a Medigap policy, and you choose one of the State Health Plan’s UHC Group Medicare Advantage (PPO) Plan options, you may want to consider canceling your Medigap policy, because it will not work with the Medicare Advantage Plans.

- If you have other retirement group health coverage (i.e., from another state or company):
  - Contact the administrator of that other plan to determine how it will or will not coordinate with the UHC Group Medicare Advantage (PPO) Plans.
  - If you have coverage under TRICARE for Life (TFL), evaluate your options carefully and contact your TFL administrator to ask how the plans will or will not coordinate.
**THE 70/30 PLAN**

The 70/30 Plan is a PPO Plan where you pay 30% coinsurance for eligible in-network services after you meet your deductible. For some services (i.e., office visits, urgent care or emergency room visits), you pay a copay. Affordable Care Act preventive services and medications require a copay for office services and a deductible for outpatient services under this plan.

Under this plan, Original Medicare is the primary payer for your hospital and medical insurance. That means that Medicare pays for your health care claims first and the 70/30 Plan will be secondary. After you meet the 70/30 annual deductible (if applicable), the plan pays its share toward your eligible expenses, up to the amount that would have been paid if the plan provided your primary coverage. You pay any copays or coinsurance, as applicable. The 70/30 Plan includes prescription drug coverage as well.

**The 70/30 Plan and Medicare**

As a Medicare-eligible subscriber if you enroll in the 70/30 Plan, it is also important that you enroll in Medicare Part B. If you do not enroll in Medicare Part B, you will be responsible for the amounts Medicare Part B would have paid, resulting in greater out-of-pocket costs.

Under this plan, you can receive care from providers in the Blue Cross NC Blue Options network. You can also go out-of-network for coverage, but your deductibles, copays and coinsurance will be higher.

The 70/30 Plan has no changes in medical benefits. The formulary, or drug list of covered medications, changes quarterly, so changes in drug coverage are possible.

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**70/30 Plan Pharmacy Benefit Reminders**

- Remember that the 70/30 Plan utilizes a closed formulary, or drug list. This means that certain drugs are not covered. The formulary is updated on a quarterly basis so there is always a possibility that your medication could become a non-covered drug.

- If you are taking a non-preferred brand name drug, specialty medication or a non-covered medication that was approved for coverage through an exceptions process, you will be subject to a Tier 3 or Tier 6 copay. Under the 70/30 Plan, a Tier 3 copay is $74 and Tier 6 is a 25% coinsurance to a maximum of $133.

- Medications that are subject to coinsurance in most cases will result in higher out-of-pocket costs to members. Be sure to check the tier level of any of your maintenance medications by calling the Plan’s Pharmacy Benefit Manager, CVS Caremark Customer Service at **888-321-3124**, prior to making your 2019 health plan choice. Remember to always discuss your prescription options with your provider.

“For every member that moves from the 70/30 Plan to the Medicare Advantage Base Plan, the Plan saves $2,145 per member annually. Be good stewards of taxpayer funds and take the time to learn more about our Medicare Advantage Plans.”

- Dale R. Folwell, State Treasurer

- Before the end of the year, all members in the 70/30 Plan will receive the new 2019 State Health Plan ID card.

See the plan comparison chart on pages 8-9 for a detailed comparison of 2019 benefits under all three of your plan options.
2019 MONTHLY PREMIUMS

**UHC rates will be lower for 2019 than 2018!** The premiums shown below apply to retirees and disabled members for whom the State of North Carolina pays 100% of the cost of non-contributory coverage based on years of service, where the retiree or disabled member and dependents are eligible for Medicare. Keep in mind that if you do not have enough years of service to qualify for non-contributory coverage, or you pay 100% of your coverage for other reasons, you are responsible for any premium owed. The premium owed will be deducted from your pension check or billed to you. To find all rates for all plans, go to [www.shpnc.org](http://www.shpnc.org).

### UHC GROUP MEDICARE ADVANTAGE (PPO) BASE PLAN

<table>
<thead>
<tr>
<th>COVERAGE TYPE</th>
<th>2019 MONTHLY PREMIUM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subscriber Only</td>
<td>$0</td>
</tr>
<tr>
<td>Subscriber + Child(ren)</td>
<td>$89.00</td>
</tr>
<tr>
<td>Subscriber + Spouse</td>
<td>$89.00</td>
</tr>
<tr>
<td>Subscriber + Family</td>
<td>$178.00</td>
</tr>
</tbody>
</table>

### UHC GROUP MEDICARE ADVANTAGE (PPO) ENHANCED PLAN

<table>
<thead>
<tr>
<th>COVERAGE TYPE</th>
<th>2019 MONTHLY PREMIUM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subscriber Only</td>
<td>$63.00</td>
</tr>
<tr>
<td>Subscriber + Child(ren)</td>
<td>$215.00</td>
</tr>
<tr>
<td>Subscriber + Spouse</td>
<td>$215.00</td>
</tr>
<tr>
<td>Subscriber + Family</td>
<td>$367.00</td>
</tr>
</tbody>
</table>

### 70/30 PLAN

<table>
<thead>
<tr>
<th>COVERAGE TYPE</th>
<th>2019 MONTHLY PREMIUM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subscriber Only</td>
<td>$0</td>
</tr>
<tr>
<td>Subscriber + Child(ren)</td>
<td>$155.00</td>
</tr>
<tr>
<td>Subscriber + Spouse</td>
<td>$425.00</td>
</tr>
<tr>
<td>Subscriber + Family</td>
<td>$444.00</td>
</tr>
</tbody>
</table>

**UNDERSTANDING IRMAA:** Some people with higher annual incomes must pay an additional amount to Social Security when they enroll in a Medicare plan that provides Medicare Part D prescription drug coverage (e.g., a Medicare Advantage Plan). If you have higher income, federal law requires an adjustment to premiums for Medicare Part B (medical insurance) and Medicare prescription drug coverage. This additional amount is called the “income-related monthly adjustment amount” or IRMAA. This extra amount, if applicable, is deducted from your Social Security check or direct billed to you by the federal government if you are not collecting Social Security benefits. If you have questions about this extra amount, please contact Social Security at [800-772-1213](tel:800-772-1213).
<table>
<thead>
<tr>
<th>Plan Design Features</th>
<th>UHC Group Medicare Advantage Base Plan</th>
<th>UHC Group Medicare Advantage Enhanced Plan</th>
<th>70/30 PLAN*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use of Network Providers</td>
<td>You can see any provider (in-network or out-of-network) that participates in Medicare and accepts Medicare assignment. Your copays or coinsurance stay the same.</td>
<td></td>
<td>You pay less when you use Blue Cross NC network providers.</td>
</tr>
<tr>
<td>Annual Deductible</td>
<td>$0</td>
<td></td>
<td>Individual: $1,080 in-network $2,160 out-of-network Family: $3,240 in-network $6,480 out-of-network</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>Most covered services require only a copay; however, some services require coinsurance (usually 20%).</td>
<td></td>
<td>Individual: $4,388 in-network $8,776 out-of-network Family: $13,164 in-network $26,328 out-of-network</td>
</tr>
<tr>
<td>Annual Out-of-Pocket Maximum or Coinsurance Maximum</td>
<td>$4,000 Individual No Family Maximum (An out-of-pocket maximum applies for this plan; it includes copays and coinsurance).</td>
<td>$3,300 Individual No Family Maximum (An out-of-pocket maximum applies for this plan; it includes copays and coinsurance).</td>
<td></td>
</tr>
<tr>
<td>ACA Preventive Services</td>
<td>See plan materials for information about ACA covered services, as some require a copay.</td>
<td></td>
<td>In-network: $40 for primary doctor; $94 for specialist</td>
</tr>
<tr>
<td>Office Visits</td>
<td>$20 for primary doctor; $40 for specialist</td>
<td>$15 for primary doctor; $35 for specialist</td>
<td>In-network: $40 for primary doctor; $94 for specialist</td>
</tr>
<tr>
<td>Lab Services</td>
<td>$40 copay; if lab test performed and processed in doctor’s office, $0 copay</td>
<td>$20 copay; if lab test is performed and processed in doctor’s office, $0 copay</td>
<td>In-network: 30% coinsurance, Out-of-network: 50% coinsurance; if performed during PCP or Specialist office visit, no additional fee if in-network lab used.</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>$50</td>
<td>$40</td>
<td>$100</td>
</tr>
<tr>
<td>Emergency Room (Copay waived with admission or observation stay)</td>
<td></td>
<td></td>
<td>In-network: $337 copay plus 30% coinsurance after deductible is met</td>
</tr>
<tr>
<td>Inpatient Hospital</td>
<td>Days 1-10: $160/day Days 11+: $0</td>
<td>Days 1-10: $150/day Days 11+: $0</td>
<td>In-network: $337 copay plus 30% coinsurance after deductible is met</td>
</tr>
<tr>
<td>Outpatient Hospital</td>
<td>$125</td>
<td>$100</td>
<td>In-network: 30% coinsurance after deductible is met</td>
</tr>
<tr>
<td>Diagnostic (e.g., CT, MRI)</td>
<td></td>
<td>$100</td>
<td>In-network: 30% coinsurance after deductible is met</td>
</tr>
</tbody>
</table>
### PLAN DESIGN FEATURES

<table>
<thead>
<tr>
<th></th>
<th>UHC GROUP MEDICARE ADVANTAGE BASE PLAN</th>
<th>UHC GROUP MEDICARE ADVANTAGE ENHANCED PLAN</th>
<th>70/30 PLAN*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled Nursing Facility</td>
<td>Days 1–20: $0  Days 21-100: $50/day</td>
<td>In-network: 30% coinsurance after deductible is met</td>
<td>In-network: $72</td>
</tr>
<tr>
<td>Chiropractic Visits</td>
<td>$20</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>20% Coinsurance</td>
<td></td>
<td>In-network: 30% coinsurance after deductible is met</td>
</tr>
<tr>
<td>SilverSneakers® Fitness Program</td>
<td>Included</td>
<td></td>
<td>Not Covered</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>$50</td>
<td>$40</td>
<td>$100</td>
</tr>
</tbody>
</table>

### PHARMACY BENEFITS

<table>
<thead>
<tr>
<th></th>
<th>Pharmacy Out-of-Pocket Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$2,500 Individual</td>
</tr>
<tr>
<td></td>
<td>$3,360 Individual</td>
</tr>
<tr>
<td></td>
<td>$10,080 Family</td>
</tr>
</tbody>
</table>

### RETAIL PURCHASE FROM AN IN-NETWORK PROVIDER

<table>
<thead>
<tr>
<th>Tier (Generic)</th>
<th>Tier 1 (Preferred Brand &amp; High-Cost Generic)</th>
<th>Tier 2 (Non-preferred Brand)</th>
<th>Tier 3 (Low-Cost Generic Specialty)</th>
<th>Tier 4 (Preferred Specialty)</th>
<th>Tier 5 (Non-preferred Specialty)</th>
<th>Tier 6 (Preferred Specialty)</th>
<th>Tier 7 (Preferred Specialty)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$10 copay per 31-day supply</td>
<td>$40 copay per 31-day supply</td>
<td>$64 copay per 31-day supply</td>
<td>25% coinsurance up to $100 per 31-day supply</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>$16 copay per 30-day supply</td>
<td>$35 copay per 31-day supply</td>
<td>$50 copay per 31-day supply</td>
<td>10% coinsurance up to $100 per 31-day supply</td>
<td>$25% coinsurance up to $100 per 30-day supply</td>
<td>$25% coinsurance up to $133 per 30-day supply</td>
<td>$25% coinsurance up to $133 per 30-day supply</td>
</tr>
<tr>
<td>Preferred Diabetic Testing Supplies**</td>
<td>$0 copay**</td>
<td>$0 copay**</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### ACA Preventive Medications

<table>
<thead>
<tr>
<th></th>
<th>See plan materials for information about ACA covered services, as some require a copay.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N/A</td>
</tr>
</tbody>
</table>

### MAINTENANCE DRUGS FROM AN IN-NETWORK PROVIDER—UP TO A 90-DAY SUPPLY

<table>
<thead>
<tr>
<th>Tier</th>
<th>Tier 1</th>
<th>Tier 2</th>
<th>Tier 3</th>
<th>Tier 4***</th>
<th>Tier 5</th>
<th>Tier 6</th>
<th>Tier 7</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$24 copay</td>
<td>$20 copay</td>
<td>$128 copay</td>
<td>25% coinsurance up to $300</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$80 copay</td>
<td>$70 copay</td>
<td>$100 copay</td>
<td>25% coinsurance up to $200</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td></td>
<td>** Some specialty drugs are limited to a 30- or 31-day supply (depending on the plan).**</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*When enrolled in the 70/30 Plan, cost-sharing amounts between you and the State Health Plan will vary. Medicare pays benefits first. Then, the 70/30 Plan may help pay some of the costs that Medicare does not cover.

**Preferred brand is the OneTouch Test Strips. Non-preferred diabetic testing supplies are not covered. Non-preferred diabetic testing supplies are considered a Tier 3 member copay (if approved).

***Some specialty drugs are limited to a 30- or 31-day supply (depending on the plan).

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**Please Note:** Some high-cost generic drugs will be covered in a different tier than in 2018. For questions about the coverage of a specific drug, call UHC at **866-747-1014**, TTY 711, 8 a.m. - 8 p.m. local time, 7 days a week.
Outreach Events Coming to a Location Near You!

The Plan will hold Medicare Outreach Events at various locations this fall to tell you about your 2019 health plan options. The meeting schedule was sent to your home mailbox in August. Visit www.shpnc.org for more information.

Learn More by Phone

You can also participate in a Telephone Town Hall meeting.

Reserve your spot now by visiting www.shpnc.org and clicking the Telephone Town Hall button at the bottom of the home page.

<table>
<thead>
<tr>
<th>DATE</th>
<th>TIME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sept. 13, 2018</td>
<td>7 p.m.</td>
</tr>
<tr>
<td>Sept. 18, 2018</td>
<td>2 p.m.</td>
</tr>
</tbody>
</table>

RESOURCES TO HELP YOU UNDERSTAND YOUR PLANS AND YOUR CHOICES

Making Changes to Your Plan

You can enroll in or change your plan any time from Sept. 29 through Oct. 31, 2018—either online or by phone. The choices you make during Open Enrollment are for benefits effective Jan. 1, 2019, through Dec. 31, 2019.

To enroll online:

- Retirees and disabled members should visit the State Health Plan’s website (www.shpnc.org), click eBenefits and select Log into eBenefits through ORBIT.
  - Once you are logged into ORBIT, locate the eBenefits button.
- Other Medicare Primary subscribers should also visit the State Health Plan’s website (www.shpnc.org), and click eBenefits, but they should select Log into eBenefits and then select “Access Your Benefits via eBenefits” to enroll.

To enroll by phone:

- During Open Enrollment, call 855-859-0966, Monday–Friday, 8 a.m.–10 p.m. ET, or Saturday, 8 a.m.–noon ET.

Remember to note for your records the date and time of your call, and the person you spoke with.

As you enroll, be sure to:

- Review your dependent information and make changes, if needed. Remember, if you are adding a new dependent you will need to provide a Social Security and if applicable, a Medicare ID number, and will be prompted to upload required documentation. You may find it convenient to prepare electronic versions of these documents, if needed, before starting the enrollment process.
- Confirm that you have a physical address and not just a PO Box to ensure you receive all mailings.
- Review the benefits you’ve selected.
- Print your confirmation statement for your records, or ask your phone representative for your reference case number.

Important: Make Sure Your Information Is Saved

After you have made your choices online in eBenefits and they are displayed for you to review and print out, you MUST scroll down to the bottom to click SAVE or your choices will not be recorded! Don’t overlook this critical step! You will see a green congratulations notice when you have successfully completed your enrollment election.
LEGAL AND PRIVACY 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 and how you can get access to this information. Please review it carefully.

Original Effective Date: April 14, 2003
Revised Effective Date: January 20, 2018

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. For a print-friendly version of this notice visit, www.shpnc.org.

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.
• 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: (i) disclosures for purposes of treatment, payment, or health care operations; (ii) disclosures made to you; (iii) disclosures made pursuant to your authorization; (iv) disclosures made to friends or family in your presence or because of an emergency; (v) disclosures for national security purposes; and (vi) 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 provided in this document.
• 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
• 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.

continued on the next page
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 your 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 information 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 protected health information (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.

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/noticcepp.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
1-800-368-1099, 800-537-7697 (TDD)
File a complaint electronically at
https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at

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 (de- pendents 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 and a dependent’s death.
• You, your spouse, or your eligible dependent experiences an employment status change that results in the loss or gain of group health coverage.
• You, your spouse, or your dependents become entitled to coverage under Part A or Part B of Medicare, or Medicaid.
• Your dependent ceases to be an eligible dependent (e.g., the dependent child reaches age 26).
• Your, your spouse, or your dependents commence or return from an unpaid leave of absence such as Family and Medical Leave or military leave.
• You receive a qualified medical child support order (as determined by the plan administrator) that requires the plan to provide coverage for your children.
• If you, your spouse or dependents experience a cost or coverage change under another group health plan for which an election change was permitted, you may make a corresponding election change under the Flex Plan (e.g., your spouse’s employer significantly increases the cost of coverage and as a result, allows the spouse to change his/her election).
• If you change employment status such that you are no longer expected to average 30 hours of service per week but you do not lose eligibility for coverage under the State Health Plan (e.g., you are in a stability period during which you qualify as full time), you may still revoke your election provided that you certify that you have or will enroll yourself (and any other covered family members) in other coverage providing minimum essential coverage (e.g., the marketplace) that is effective no later than the first day of the second month following the month that includes the date that 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 defined 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. For more information, contact your Plan’s Customer Service.

Disclosure of Grandfathered Plan Status
The 70/30 Plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered plan does not mean, however, that the health plan is 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 your Plan’s Customer Service.

Mental Health Parity and Addiction Equity Act Opt-Out Notice
This notice only applies to the 70/30 Plan. If electing benefit coverage under the UnitedHealthcare® Group Medicare Advantage Base or the UnitedHealthcare® Group Medicare Advantage (PPO) Enhanced Plan, those Plans are compliant with the Mental Health Parity and Addiction Equity Act and are not electing an exemption.

Group health plans sponsored by State and local governmental employers must generally comply with Federal law requirements in Title XXVII of the Public Health Service Act. However, these employers are permitted to elect to exempt a plan from the requirements listed below for any part of the plan that is “self-funded” by the employer, rather than provided through a health insurance policy.

The North Carolina State Health Plan for Teachers and State Employees has elected to exempt the 70/30 Plan from the Mental Health Parity and Addiction Equity Act, that includes protections against having benefits for mental health and substance use disorders be subject to more restrictions than apply to medical and surgical benefits covered by the 70/30 Plan.

The exemption from this Federal requirement will be in effect for the Plan benefit year beginning January 1, 2019 and ending December 31, 2019. The election may be renewed for subsequent plan years.

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 your Plan’s 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.

Employer CHIP (Children’s Health Insurance Program) Notice
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 currently enrolled in Medicaid or CHIP and you live in a State listed in the chart on the next two pages, 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 (5272).

continued on the next page
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 January 31, 2018. Contact your State for more information on eligibility.

<table>
<thead>
<tr>
<th>State</th>
<th>Program</th>
<th>Website</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALASKA - MEDICAID</td>
<td>The AK Health Insurance Premium Payment Program</td>
<td>Website: <a href="http://myakhipp.com/">http://myakhipp.com/</a></td>
<td>1-866-251-4861</td>
</tr>
<tr>
<td>GEORGIA - MEDICAID</td>
<td>Medicaid Eligibility:</td>
<td><a href="http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx">http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx</a></td>
<td></td>
</tr>
<tr>
<td>COLORADO - HEALTH FIRST COLORADO (COLORADO’S MEDICAID PROGRAM) &amp; CHILD HEALTH PLAN PLUS (CHP+)</td>
<td>Health First Colorado Website: <a href="https://www.healthfirstcolorado.com/">https://www.healthfirstcolorado.com/</a></td>
<td>Phone: 1-800-359-1991/ State Relay 711</td>
<td></td>
</tr>
<tr>
<td>NEW HAMPSHIRE - MEDICAID</td>
<td>Medicaid Eligibility:</td>
<td><a href="http://www.insureoklahoma.org">http://www.insureoklahoma.org</a></td>
<td>1-800-365-3742</td>
</tr>
<tr>
<td>KENTUCKY - MEDICAID</td>
<td>Medicaid Website:</td>
<td><a href="http://www.state.nj.us/humanservices/dmahas/clients/medicaid/">http://www.state.nj.us/humanservices/dmahas/clients/medicaid/</a></td>
<td>609-631-2392</td>
</tr>
<tr>
<td>LOUISIANA - MEDICAID</td>
<td>CHIP Website:</td>
<td><a href="http://www.state.nj.us/humanservices/dmahas/clients/medicaid/">http://www.state.nj.us/humanservices/dmahas/clients/medicaid/</a></td>
<td>1-800-701-0710</td>
</tr>
<tr>
<td>NORTH CAROLINA - MEDICAID</td>
<td>Medicaid Eligibility:</td>
<td><a href="http://www.state.nj.us/humanservices/dmahas/clients/medicaid/">http://www.state.nj.us/humanservices/dmahas/clients/medicaid/</a></td>
<td>1-800-541-2831</td>
</tr>
<tr>
<td>State</td>
<td>Medicaid Website</td>
<td>Medicaid Phone</td>
<td>CHIP Website</td>
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<tr>
<td>Missouri</td>
<td><a href="https://www.dss.mo.gov/mhd/participants/pages/hipp.htm">Missouri Medicaid Website</a></td>
<td>573-751-2005</td>
<td><a href="http://healthcare.oregon.gov/Pages/index.aspx">Oregon Medicaid Website</a></td>
</tr>
<tr>
<td>Oregon</td>
<td><a href="http://healthcare.oregon.gov/Pages/index-es.html">Oregon Medicaid Website</a></td>
<td><a href="http://www.oregonhealthcare.gov/index-es.html">Oregon Medicaid Website</a></td>
<td>1-800-699-9075</td>
</tr>
<tr>
<td>Montana</td>
<td><a href="http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP">Montana Medicaid Website</a></td>
<td>1-800-694-3084</td>
<td><a href="http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm">Pennsylvania Medicaid Website</a></td>
</tr>
<tr>
<td>Nebraska</td>
<td><a href="http://www.ACCESSNebraska.ne.gov">Nebraska Medicaid Website</a></td>
<td>(855) 632-7633</td>
<td><a href="http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm">Pennsylvania Medicaid Website</a></td>
</tr>
<tr>
<td>South Dakota</td>
<td><a href="http://dss.sd.gov">South Dakota Medicaid Website</a></td>
<td>1-888-828-0059</td>
<td><a href="http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm">Pennsylvania Medicaid Website</a></td>
</tr>
<tr>
<td>Texas</td>
<td><a href="http://gethipptexas.com/">Texas Medicaid Website</a></td>
<td>1-800-250-8427</td>
<td><a href="http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm">Pennsylvania Medicaid Website</a></td>
</tr>
<tr>
<td>Utah</td>
<td><a href="https://medicaid.utah.gov/">Utah Medicaid Website</a></td>
<td>1-877-543-7669</td>
<td><a href="http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm">Pennsylvania Medicaid Website</a></td>
</tr>
<tr>
<td>Vermont</td>
<td><a href="http://www.greenmountaincare.org/">Vermont Medicaid Website</a></td>
<td>1-800-250-8427</td>
<td><a href="http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm">Pennsylvania Medicaid Website</a></td>
</tr>
<tr>
<td>Virginia</td>
<td><a href="http://www.coverva.org/programs_premium_assistance.cfm">Virginia Medicaid Website</a></td>
<td>1-800-432-5924</td>
<td><a href="http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm">Pennsylvania Medicaid Website</a></td>
</tr>
</tbody>
</table>

To see if any other states have added a premium assistance program since January 31, 2018, or for more information on special enrollment rights, contact either:

- U.S. Department of Labor
  Employee Benefits Security Administration
  [www.dol.gov/agencies/ebsa](http://www.dol.gov/agencies/ebsa) (3272)

- U.S. Department of Health and Human Services
  Centers for Medicare & Medicaid Services
  [www.cms.hhs.gov](http://www.cms.hhs.gov) (1-800-368-1019, 800-537-7697 (TDD))

**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 919-814-4400

If you believe that the State Health Plan has failed to provide these services or discriminated against you, you can file a grievance with the Coordinator. You can file a grievance in person or by mail, fax, or email. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, available at:

- U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201
- [https://occrportal.hhs.gov/ccr/portal/lobby.jsf](https://occrportal.hhs.gov/ccr/portal/lobby.jsf)

**If you believe that the State Health Plan has failed to**

- [Missouri Medicaid Website](https://www.dss.mo.gov/mhd/participants/pages/hipp.htm) | [Oregon Medicaid Website](http://healthcare.oregon.gov/Pages/index-es.html)
- [Montana Medicaid Website](http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP) | [Pennsylvania Medicaid Website](http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm)
- [Nebraska Medicaid Website](http://www.ACCESSNebraska.ne.gov) | [Pennsylvania Medicaid Website](http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm)
- [South Dakota Medicaid Website](http://dss.sd.gov) | [Pennsylvania Medicaid Website](http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm)
- [Texas Medicaid Website](http://gethipptexas.com/) | [Pennsylvania Medicaid Website](http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm)
- [Utah Medicaid Website](https://medicaid.utah.gov/) | [Pennsylvania Medicaid Website](http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm)
- [Vermont Medicaid Website](http://www.greenmountaincare.org/) | [Pennsylvania Medicaid Website](http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm)
- [Virginia Medicaid Website](http://www.coverva.org/programs_premium_assistance.cfm) | [Pennsylvania Medicaid Website](http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm)

- [Missouri Medicaid Website](https://www.dss.mo.gov/mhd/participants/pages/hipp.htm) | [Oregon Medicaid Website](http://healthcare.oregon.gov/Pages/index-es.html)
- [Montana Medicaid Website](http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP) | [Pennsylvania Medicaid Website](http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm)
- [Nebraska Medicaid Website](http://www.ACCESSNebraska.ne.gov) | [Pennsylvania Medicaid Website](http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm)
- [South Dakota Medicaid Website](http://dss.sd.gov) | [Pennsylvania Medicaid Website](http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm)
- [Texas Medicaid Website](http://gethipptexas.com/) | [Pennsylvania Medicaid Website](http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm)
- [Utah Medicaid Website](https://medicaid.utah.gov/) | [Pennsylvania Medicaid Website](http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm)
- [Vermont Medicaid Website](http://www.greenmountaincare.org/) | [Pennsylvania Medicaid Website](http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm)
- [Virginia Medicaid Website](http://www.coverva.org/programs_premium_assistance.cfm) | [Pennsylvania Medicaid Website](http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm)

**continued on the next page**
CONTACT US

Eligibility and Enrollment Support Center (eBenefits questions): 855-859-0966
(Extended hours during Open Enrollment: Monday–Friday, 8 a.m.–10 p.m. ET, and Saturday, 8 a.m.–Noon ET)

Medicare Outreach Event RSVP Phone Line: 866-720-0114

UnitedHealthcare (benefits and claims): 866-747-1014 (TTY 711, 8 a.m. - 8 p.m. local time, 7 days a week)
(If you are not currently a UHC member, press 1 when prompted for assistance.)

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

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

OPEN IMMEDIATELY!

2019 OPEN ENROLLMENT

State Health Plan
3200 Atlantic Avenue
Raleigh, NC 27604

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.

개의: 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. Appelz le 919-814-4400.