Your NORTH CAROLINA STATE HEALTH PLAN

2021 OPEN ENROLLMENT DECISION GUIDE

OCTOBER 15-31, 2020

"As your state treasurer, I'm excited to announce our transition to Humana for our Medicare Advantage plans. While we appreciate the service that UnitedHealthcare (UHC) has provided to our members, we were REQUIRED to enter into a competitive bid process because the contract with UHC was expiring.

The result? Significant cost savings for you and taxpayers like you. The new contract saves approximately $600 million over its three-year span. Also, you will continue to have premium-free coverage for the Base Plan and to add eligible dependents will only be $4. That's a savings for you of almost $110 per month over current rates!

These cost reductions will help protect the State Health Plan's fiscal sustainability and provide significant savings back to you while still providing great benefits including no deductible, prescription drug coverage and no referral to see a specialist! The Plan's Board of Trustees, Plan staff and I are thrilled that we're able to provide this coverage to those who have dedicated their careers to serving North Carolina. I want to thank those that teach, protect and otherwise serve the people of North Carolina."

Dale R. Folwell, CPA • *State Treasurer*

North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
A Division of the Department of State Treasurer

Dale R. Folwell, CPA
STATE TREASURER OF NORTH CAROLINA

Open Enrollment is the time to evaluate your State Health Plan coverage and make any necessary changes. This Decision Guide will help you navigate your options for the 2021 benefit year. The choices you make during Open Enrollment are for benefits effective January 1, 2021, through December 31, 2021.

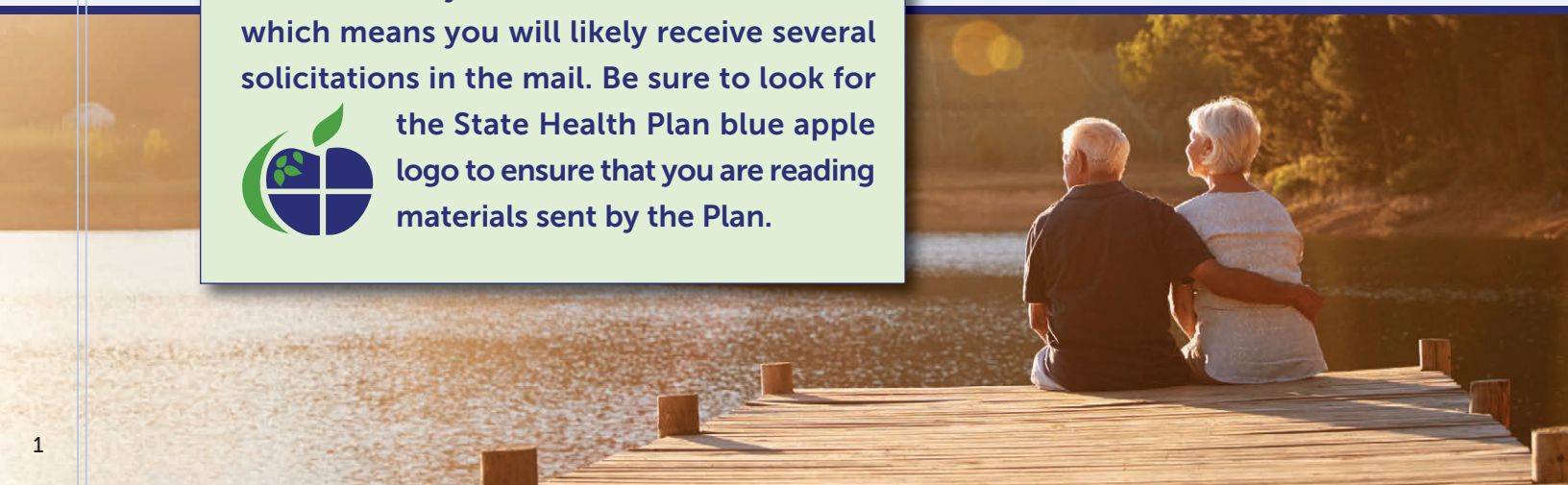
IMPORTANT NEWS ABOUT 2021

- **Medicare Advantage Plans will be transitioning from UnitedHealthcare to Humana effective January 1, 2021, with substantial savings in dependent premiums on the Medicare Advantage Base Plan!**
- **There are several positive benefit changes with the 70/30 Plan. Members who select Clear Pricing Project providers can enjoy cost savings on office visits. In addition, the copay for insulin has been waived, which means for a 30-day supply of insulin, members will have a $0 copay!**

If you are currently on the Medicare Advantage Base Plan or the 70/30 Plan, you will REMAIN on that plan and do not need to take action during Open Enrollment, unless you wish to change your plan election or add a dependent. If you are currently on the Medicare Advantage Enhanced Plan, you will be moved to the Medicare Advantage Base Plan for the 2021 benefit year. Action will be required to select the Medicare Advantage Enhanced Plan!

If you have non-Medicare Primary dependents on your plan, they have different options: the 80/20 Plan and the 70/30 Plan. **If they are currently enrolled in the 80/20 Plan, they will be moved to the 70/30 Plan for the 2021 benefit year.** You will need to take action during Open Enrollment if your non-Medicare Primary dependents want to be enrolled in the 80/20 Plan for the 2021 benefit year. More information regarding these plan options can be found at **www.shpnc.org.**

The fall is a busy time for Medicare enrollment, which means you will likely receive several solicitations in the mail. Be sure to look for the State Health Plan blue apple logo to ensure that you are reading materials sent by the Plan.



A Look at Your 2021 Options

As a Medicare-eligible member, you have three plan options to choose from for 2021:

Humana® Group Medicare Advantage (PPO) Base Plan

Humana® Group Medicare Advantage (PPO) Enhanced Plan

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

The Eligibility and Enrollment Support Center, at 855-859-0966, will offer extended hours during Open Enrollment to assist you with your questions.

Monday-Friday, 8 a.m.-10 p.m., and Saturdays, 8 a.m.-5 p.m. (ET)

Humana Group Medicare Advantage (PPO) Plans

The Medicare Advantage contract was awarded to Humana after a required and competitive bidding process per state contracting and procurement rules. As a result of the procurement process, the Plan's Board of Trustees awarded the contract to Humana, which resulted in the Plan being able to drastically reduce dependent premiums for eligible dependents on these plans.

The Humana 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 Humana Group Medicare Advantage (PPO) Plans.

With up to a 96% reduction in dependent premiums rates and nearly all Medicare-eligible retirees already taking advantage of these plans, now is the time to take a closer look at these plans!

HUMANA GROUP MEDICARE ADVANTAGE (PPO) PLANS KEY FACTS

- 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, Humana administers the Medicare Advantage plan, which includes all of the benefits of Original Medicare, along with additional features and programs.
- 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.
- The Humana Group Medicare Advantage (PPO) Plans offer benefits in addition to the coverage offered under Medicare and, in some cases, you pay less for certain services than you would under Original Medicare.
- The plans offer lower dependent premiums than the 70/30 Plan. Just $4 in the Base Plan for Medicare-eligible dependents!
- Most services covered under the plans are copay based and provide you with certainty in your out-of-pocket costs.
- There are no deductibles that must be met for any covered benefits.

HUMANA GROUP MEDICARE ADVANTAGE (PPO) PLANS IMPORTANT HIGHLIGHTS

The Medicare Advantage Base Plan will offer the same benefits members enjoy today. The Medicare Advantage Enhanced Plan does have a few changes, and, in both plans, medication coverage may differ slightly from what you experience today.

The Medicare Advantage plans will continue to offer a "passive" network which allows members to continue seeing their current providers regardless of being in or out of Humana's network. Similar to the way Medicare Advantage plans work today, the provider will need to be participating with Medicare and agree to bill the Medicare Advantage plan carrier.

HUMANA GROUP MEDICARE ADVANTAGE (PPO) ADDITIONAL BENEFITS

- SilverSneakers® Fitness Program
- Routine eye exams
- Routine hearing exams
- Hearing aids
- Routine foot care

HOW HUMANA GROUP MEDICARE ADVANTAGE (PPO) PLANS COORDINATE WITH OTHER PLANS

Your Humana Group Medicare Advantage (PPO) Plan coverage includes Medicare Prescription Drug coverage (Medicare Part D). 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 Humana 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, 2021.

MEDIGAP AND HUMANA GROUP MEDICARE ADVANTAGE (PPO) PLANS

When you enroll in a Medicare Advantage Plan, you cannot use Medigap (Medicare Supplement) Insurance 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 Humana Group Medicare Advantage (PPO) Plan options, you may want to consider canceling your Medigap policy. It will not work with 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 Humana Group Medicare Advantage (PPO) Plans.

If you have coverage under TRICARE for Life (TFL) or CHAMPVA, evaluate your options carefully and contact your TFL or CHAMPVA administrator to ask how the plans will or will not coordinate.

The 70/30 Plan

The 70/30 Plan is a Preferred Provider Organization (PPO) plan where you pay 30% coinsurance for eligible in-network expenses after you meet your deductible. For some services (i.e., office visits, urgent care), you pay a copay.

Under this plan, Original Medicare is the primary payer for your hospital and medical coverage. 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 Plan 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.

Preventive services are covered at 100% with this plan! This means that for your next annual physical or preventive screenings, like a colonoscopy, **THERE WILL BE NO COPAYS FOR THOSE SERVICES.**

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.

CLEAR PRICING PROJECT

The goal of the Clear Pricing Project (CPP) is to ensure that members have this valuable medical benefit for years to come, while eliminating secret contracts, bringing transparency to health care costs and addressing the rising health costs that the Plan and members face. This effort resulted in more than 25,000 providers partnering with the Plan for transparent and affordable health care.

In a continuing effort to lower health care costs for members and to support CPP providers, who believe in affordability and transparency, the Plan will be offering significant copay reductions in 2021 for members who visit a CPP provider.

Clear Pricing Project Provider Copay Comparison Chart

CPP PROVIDER COPAY	NON-CPP PROVIDER
Selected Primary Care Provider (PCP) copay - $0	Selected Primary Care Provider (PCP) copay - $30
Specialist copay - $47	Specialist copay - $94
Speech, occupational, chiropractor and physical therapy copay - $36	Speech, occupational, chiropractor and physical therapy copay - $72

To locate a CPP provider, visit the Plan's website and click "Find a Doctor." Look for "Clear Pricing Project Provider."

THE 70/30 PLAN AND MEDICARE PART B

If you enroll in the 70/30 Plan as a Medicare eligible subscriber, it is important to know that 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.

70/30 PLAN PHARMACY BENEFIT REMINDERS

- 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 change tier levels or become a non-covered drug.
- **New for 2021, preferred and non-preferred insulin will have a $0 copay!**
- For drugs that fall into Tier 3 and Tier 6 non-preferred medications, these tiers do not have a defined copay but are subject to a deductible/coinsurance. This means that you will have to pay the full cost of the medication until you meet your deductible. **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 2021 health plan choice. Remember to always discuss your prescription options with your provider.

2021 Monthly Premiums

IMPORTANT REMINDER

Under all plans, you must pay a monthly premium to cover eligible family members. You also must pay the federal government for your premiums for Medicare Part A (if any) and Medicare Part B.

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, visit **www.shpnc.org.**

HUMANA GROUP MEDICARE ADVANTAGE (PPO) BASE PLAN

COVERAGE TYPE	2021 MONTHLY PREMIUM
Subscriber Only	**$0**
Subscriber + Child(ren)	**$4.00**
Subscriber + Spouse	**$4.00**
Subscriber + Family	**$8.00**

HUMANA GROUP MEDICARE ADVANTAGE (PPO) ENHANCED PLAN

COVERAGE TYPE	2021 MONTHLY PREMIUM
Subscriber Only	**$73.00**
Subscriber + Child(ren)	**$146.00**
Subscriber + Spouse	**$146.00**
Subscriber + Family	**$219.00**

70/30 PLAN

COVERAGE TYPE	2021 MONTHLY PREMIUM
Subscriber Only	**$0**
Subscriber + Child(ren)	**$155.00**
Subscriber + Spouse	**$425.00**
Subscriber + Family	**$444.00**

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 Part D 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.**

2021 State Health Plan Comparison

PLAN DESIGN FEATURES	HUMANA GROUP MEDICARE ADVANTAGE BASE PLAN	HUMANA GROUP MEDICARE ADVANTAGE ENHANCED PLAN	70/30 PLAN*
Use of Network Providers	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.		You pay less when you use providers in-network
Annual Deductible	$0		**Individual:** $1,500 in-network $3,000 out-of-network **Family:** $4,500 in-network $9,000 out-of-network (Combined Medical and Pharmacy)
Coinsurance	Most covered services require only a copay; however, some services require coinsurance (usually 20%).		**In-network:** 30% of eligible expenses after deductible is met **Out-of-network:** 50% of eligible expenses after deductible is met and the difference between the allowed amount and the charge
Annual Out-of-Pocket Maximum	$4,000 Individual No Family Maximum (An out-of-pocket maximum applies for this plan; it includes medical copays and coinsurance).	$3,300 Individual No Family Maximum (An out-of-pocket maximum applies for this plan; it includes medical copays and coinsurance).	**Individual:** $5,900 in-network $11,800 out-of-network **Family:** $16,300 in-network $32,600 out-of-network **(Combined Medical and Pharmacy)**
Preventive Services	$0 (may be charged a copay if other services are provided and billed during visit).		**In-network:** $0 (free) **Out-of-network:** Dependent on service
Office Visits	$20 for primary care provider; $40 for specialist	$10 for primary care provider; $35 for specialist	**In-network:** $0 for CPP PCP on ID card; $30 non-CPP PCP on ID card; $45 for other PCP; $47 CPP Specialist; $94 for non-CPP Specialist **Out-of-network:** 50% after deductible is met
Lab Services	$40 copay; if lab test performed and processed in doctor's office, $0 copay	$10 copay; if lab test is performed and processed in doctor's office, $0 copay	**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.
Emergency Room (Copay waived w/admission or observation stay)	$65		**In-network:** $337 copay plus 30% coinsurance after deductible is met
Inpatient Hospital	Days 1-10: $160/day Days 11+: $0	Days 1-10: $125/day Days 11+: $0	**In-network:** $337 copay plus 30% coinsurance after deductible is met
Outpatient Hospital	$125	$100	**In-network:** 30% coinsurance after deductible is met
Outpatient Surgery - Ambulatory Surgical Center	$250		**In-network:** 30% coinsurance after deductible is met
Diagnostic (e.g., CT, MRI)	$100		**In-network:** 30% coinsurance after deductible is met

CPP=Clear Pricing Project Provider

2021 State Health Plan Comparison

PLAN DESIGN FEATURES	HUMANA GROUP MEDICARE ADVANTAGE BASE PLAN	HUMANA GROUP MEDICARE ADVANTAGE ENHANCED PLAN	70/30 PLAN*
Skilled Nursing Facility	Days 1-20: $0 Days 21-100: $50/day		**In-network:** 30% coinsurance after deductible is met
Chiropractic Visits	$20		**In-network:** $36 CPP; $72 non-CPP
Durable Medical Equipment	20% Coinsurance		**In-network:** 30% coinsurance after deductible is met
SilverSneakers® Fitness Program	Included		Not Included
Urgent Care	$50	$40	$100
PHARMACY BENEFITS			
Pharmacy Out-of-Pocket Maximum	$2,500 Individual No Family Maximum		N/A
RETAIL PURCHASE FROM AN IN-NETWORK PROVIDER			
Tier 1 *(Generic)*	$10 copay per 30-day supply		$16 copay per 30-day supply
Tier 2 *(Preferred Brand & High–Cost Generic)*	$40 copay per 30-day supply		$47 copay per 30-day supply
Tier 3 *(Non-preferred Brand)*	$64 copay per 30-day supply	$50 copay per 30-day supply	Deductible/coinsurance
Tier 4 *(Low-Cost Generic Specialty)*	25% coinsurance up to $100 per 30-day supply		$200 copay per 30-day supply
Tier 5 *(Preferred Specialty)*	N/A		$350 copay per 30-day supply
Tier 6 *(Non-preferred Specialty)*	N/A		Deductible/coinsurance
Preferred Diabetic Testing Supplies**	$0 copay		$10 copay per 30-day supply **
MAINTENANCE DRUGS FROM AN IN-NETWORK PROVIDER—UP TO A 90-DAY SUPPLY			
Tier 1	$24 copay		$48 copay
Tier 2	$80 copay		$141 copay
Tier 3	$128 copay	$100 copay	Deductible/coinsurance
Tier 4***	25% coinsurance up to $300	25% coinsurance up to $200	$600 copay
Tier 5	N/A		$1,050 copay
Tier 6	N/A		Deductible/coinsurance
Preventive Medications	See plan materials for information about preventive covered services, as some require a copay.		$0 (covered by the Plan at 100%)
Insulin	$40 per 30-day supply		$0 per 30-day supply

** 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).*

70/30 Plan Member Note: Any coverage for prescriptions provided by copay assistance programs will not be applied to deductibles or out-of-pocket maximums.

Virtual Medicare Outreach Events

Due to the COVID-19 pandemic and for the safety of our members and staff, the Plan will not be hosting onsite events this year. However, the Plan will be offering various ways for you to learn more about your 2021 benefits.

If you need assistance with registering for a webinar or a Telephone Town Hall event, please call the RSVP Hotline at 866-720-0114, Monday - Friday, between 8 a.m. - 5 p.m. ET.

TELEPHONE TOWN HALLS

Telephone Town Halls are a lot like listening to a radio show over the phone. Participating is easy! You can register your phone number by visiting the State Health Plan's website at **www.shpnc.org** to reserve your spot or you can simply call **800-303-1480** at one of the dates and times below that works for your schedule!

MEDICARE TELEPHONE TOWN HALL EVENT SCHEDULE	
DATE	TIME
Tuesday, September 29	2:00 p.m.
Thursday, October 1	4:00 p.m.
Monday, October 12	2:00 p.m.
Tuesday, October 13	7:00 p.m.
Wednesday, October 21	7:00 p.m.

WEBINARS

Online webinars will be offered and will include information on all of your 2021 benefit options including any changes in benefits. Representatives from the State Health Plan and Humana will present. To register, visit the Plan's website at **www.shpnc.org.**

OPEN ENROLLMENT MEDICARE WEBINAR SCHEDULE	
DATE	TIME
Tuesday, September 22	10:00 a.m. & 2:00 p.m.
Wednesday, September 23	10:00 a.m. & 2:00 p.m.
Thursday, September 24	2:00 p.m. & 7:00 p.m.
Wednesday, September 30	10:00 a.m. & 2:00 p.m.
Thursday, October 1	7:00 p.m.
Tuesday, October 6	10:00 a.m. & 2:00 p.m.
Wednesday, October 7	10:00 a.m. & 2:00 p.m.
Thursday, October 8	10:00 a.m. & 2:00 p.m.
Tuesday, October 13	10:00 a.m.
Wednesday, October 14	2:00 p.m.
Friday, October 16	10:00 a.m. & 2:00 p.m.
Monday, October 19	10:00 a.m. & 2:00 p.m.
Tuesday, October 20	10:00 a.m. & 2:00 p.m.
Thursday, October 22	10:00 a.m. & 2:00 p.m.
Tuesday, October 27	10:00 a.m. & 2:00 p.m.
Wednesday, October 28	10:00 a.m. & 2:00 p.m.

Open Enrollment Checklist

You can enroll in or change your plan any time from October 15 through October 31, 2020 — either online or by phone. The choices you make during Open Enrollment are for benefits effective January 1, 2021, through December 31, 2021.

- ☑ 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 number 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.
- ☑ Visit **www.shpnc.org** for more information about your 2021 benefits. Utilize the resources to assist you with your decision making. You'll find a plan comparison, rate sheets, videos and Benefit Booklets.
- ☑ When you're ready to enroll or change your plan, starting October 15, visit **www.shpnc.org** and click eBenefits. Retirees and disabled members should visit the State Health Plan's website **www.shpnc.org,** click eBenefits and select Log into eBenefits through ORBIT. Or you can call the Eligibility and Enrollment Support Center at **855-859-0966** to make any changes.
- ☑ 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.
- ☑ 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.**
- ☑ 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.

For assistance during Open Enrollment, call **855-859-0966,** Monday-Friday, 8 a.m.-10 p.m., Saturdays, 8 a.m.-5 p.m. (ET). Remember to note for your records the date and time of your call, and the person you spoke with.

LEGAL NOTICES

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

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED 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.**

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 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.

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 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 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 coverage under 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.

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 ("the 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 com ply 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

continued on the next page

HealthCare.gov for more information, including an online application for health insurance coverage and contact.

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, 2020. Contact your State for more information on eligibility.

ALABAMA – Medicaid

Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA – Medicaid

The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS – Medicaid

Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid

Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx
Phone: 916-440-5676

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/ State Relay 711
CHP+: https://www.colorado.gov/pacific/hcpf/child-healthplan-plus
CHP+ Customer Service: 1-800-359-1991/ State Relay 711
Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid

Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – Medicaid

Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162 ext 2131

INDIANA – Medicaid

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

IOWA – Medicaid and CHIP (Hawki)

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

KANSAS – Medicaid

Website: http://www.kdheks.gov/hcf/default.htm
Phone: 1-800-792-4884

KENTUCKY – Medicaid

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

LOUISIANA – Medicaid

Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid

Enrollment Website:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: http://www.mass.gov/eohhs/gov/departments/masshealth/
Phone: 1-800-862-4840

MINNESOTA – Medicaid

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

MISSOURI – Medicaid

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MISSOURI – Medicaid

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid

Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

NEBRASKA – Medicaid

Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000 **Omaha:** 402-595-1178

NEVADA – Medicaid

Medicaid Website: https://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

Website: https://www.dhhs.nh.gov/oii/hipp.htm
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP

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

NEW YORK – Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP

Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid

Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid

Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/ HIPP-Program.aspx
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid and CHIP

Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347 or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid

Website: https://www.scdhhs.gov **Phone:** 1-888-549-0820

SOUTH DAKOTA - Medicaid

Website: http://dss.sd.gov **Phone:** 1-888-828-0059

TEXAS – Medicaid

Website: http://gethipptexas.com/ **Phone:** 1-800-440-0493

UTAH – Medicaid and CHIP

Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT– Medicaid

Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

Medicaid Website: https://www.coverva.org/hipp/
Medicaid Phone: 1-800-432-5924
CHIP Phone: 1-855-242-8282

WASHINGTON – Medicaid

Website: https://www.hca.wa.gov/ **Phone:** 1-800-562-3022

WEST VIRGINIA – Medicaid

Website: http://mywvhipp.com/
Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP

Website: https://www.dhs.wisconsin.gov/badger-careplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid

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, 2020, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
U.S. Department of Health and Human Services
Employee Benefits Security Administration
Centers for Medicare & Medicaid Services
www.dol.gov/agencies/ebsa www.cms.hhs.gov
1-866-444-EBSA (3272)
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
(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,
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.**

continued on the next page

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.**

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **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.**

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

ប្រយ័ត្ននៈ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សូវោជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ **919-814-4400.**

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **919-814-4400.**

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **919-814-4400.**

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັ້ງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ **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

Extended hours during Open Enrollment:
Monday-Friday: 8 a.m.-10 p.m.
Saturdays: 8 a.m.-5 p.m.

Humana (2021 benefits):
888-700-2263

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

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

SHP211-Medicare

OPEN ENROLLMENT
OCTOBER 15-31, 2020

OPEN IMMEDIATELY!

2021 Open Enrollment Decision Guide

State Health Plan
3200 Atlantic Avenue
Raleigh, NC 27604

North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
A Division of the Department of State Treasurer

Dale R. Folwell, CPA
State Treasurer of North Carolina