

Your NORTH CAROLINA STATE HEALTH PLAN

2023 OPEN ENROLLMENT DECISION GUIDE

OCTOBER 10-28, 2022

"Thanks to our members' participation in the Humana Medicare Advantage plans, the State Health Plan and our Medicare Advantage plan members have already seen significant cost savings from our Humana contract, projected to save \$600 million over its three-year span. As State Treasurer, I'm thrilled at the opportunity to help you keep health costs under control and to offer some new cost reductions in these plans for 2023."

Eligible members continue to have the option to select premium-free coverage for the Humana Base Plan, with only a \$4 premium to add eligible dependents! These cost reductions continue to protect the State Health Plan's fiscal sustainability and provide significant savings back to you while still providing great benefits. We are honored to provide this coverage to those who have dedicated their careers to serving North Carolina."

Dale R. Folwell, CPA • State Treasurer

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 2023 benefit year. The choices you make during Open Enrollment are for benefits that will be effective January 1, 2023, through December 31, 2023.

All Medicare members currently enrolled in the Base PPO Plan (70/30) administered by Blue Cross NC will be automatically enrolled into the Humana® Group Medicare Advantage (PPO) Base Plan (90/10)* effective January 1, 2023.

All members currently enrolled in the Humana Medicare Advantage (Base or Enhanced) Plan (90/10)* will REMAIN on that plan for 2023.

IF YOU WANT TO CHANGE PLANS OR NEED TO MAKE CHANGES REGARDING YOUR DEPENDENTS, YOU WILL NEED TO TAKE ACTION DURING OPEN ENROLLMENT.

If you have non-Medicare Primary dependents on your plan, they have different options: the Enhanced PPO Plan (80/20) and the Base PPO Plan (70/30). If they are currently enrolled in the Enhanced PPO Plan (80/20), they will be moved to the Base PPO Plan (70/30) for the 2023 benefit year. **You will need to take action during Open Enrollment if your non-Medicare Primary dependents want to be enrolled in the Enhanced PPO Plan (80/20) for the 2023 benefit year.** More information regarding these plan options can be found at www.shpnc.org.

Please note: Although the 80/20 and 70/30 plan names have changed, they are the same plans offered previously to State Health Plan members.

A Look at Your 2023 Options


As a Medicare-eligible member, you have three plan options to choose from for 2023:

Humana® Group Medicare Advantage (PPO) Base Plan (90/10)*

Humana® Group Medicare Advantage (PPO) Enhanced Plan (90/10)*

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

IMPORTANT REMINDERS

- ▶ The fall is a busy time for Medicare enrollment, which means you will likely receive several solicitations in the mail, calls from insurance agents or notice more TV commercials about different plans. Be sure to look for the State Health Plan blue apple logo  to ensure that you are reading materials sent by the Plan.
- ▶ **Before** you enroll in anything other than the State Health Plan, please call the Eligibility and Enrollment Support Center (855-859-0966) for information regarding its impact to your State Health Plan coverage.
- ▶ It is critical that you have a valid address, phone number and email in the Plan's enrollment system, eBenefits, to ensure you receive important health plan information.

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

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

*The Humana Group Medicare Advantage Plans have a benefit value equivalent to a 90/10 plan.

Humana Group Medicare Advantage (PPO) Plans (90/10)*

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.

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. **Members must continue to pay Medicare premiums to remain eligible for the Medicare Advantage plans.**

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. These Humana plans have a benefit value equivalent of a 90/10 plan.

HUMANA GROUP MEDICARE ADVANTAGE (PPO) PLANS (90/10)* HIGHLIGHTS

Medicare Advantage plans offer simplicity, predictability, and a variety of services – like SilverSneakers, case management and Medicare Prescription Drug (Medicare Part D) coverage – that may add value to your health coverage.

- ▶ The formulary (drug list) may have had some changes for the 2023 benefit year. So, it is important to verify your medications are still covered and if there are any formulary changes for 2023.
- ▶ The plans offer lower premiums than the Base PPO Plan (70/30)—just \$4 in the Base Plan for Medicare-subscribers or a dependent
- ▶ The Humana Group Medicare Advantage (PPO) 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. The provider will need to be participating with Medicare and agree to file claims with Humana.

- ▶ When you are enrolled in a Medicare Advantage plan, you have one plan, with one ID card, for both medical and prescription drug coverage.
- ▶ 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.
- ▶ Most services covered under the plans are copay based and provide you with certainty and predictability in your out-of-pocket costs, in most situations.

Don't forget, both Humana Medicare Advantage Plan (90/10)* options include:

- ▶ **NO** deductible
- ▶ **NO** referral needed to see a specialist
- ▶ **Lower premiums** than the Base PPO Plan (70/30)
- ▶ Preventive services covered at 100%
- ▶ Coverage for medical services from providers, clinics, hospitals, and prescriptions in one plan
- ▶ The ability to see providers outside the network for the same copay or coinsurance as in-network providers as long as the provider accepts Medicare, accepts your plan and will file claims with Humana
- ▶ **Lower copays** for Urgent Care and ER services than the Base PPO Plan (70/30)
- ▶ **Lower costs** for Preferred Blood Glucose Meters (BGM) and supplies than the Base PPO Plan (70/30)
- ▶ **\$0 copay** for Medicare-covered Therapeutic Continuous Glucose Monitors (CGM) and supplies
- ▶ **\$0 copay** for Part D vaccines (e.g., Shingrix, Zostavax), excluding foreign travel vaccines
- ▶ **Free** enrollment in the SilverSneakers® fitness program
- ▶ **\$0 copay** for post-discharge benefits including transportation and personal home care
- ▶ **Well Dine Program** which includes up to 28 meals delivered following an overnight hospital or skilled nursing facility stay
- ▶ **Go365 by Humana®** initiative to earn rewards for making healthier choices and redeem for gift cards
- ▶ **Extra benefits** such as a routine eye exam, routine chiropractic services, routine hearing exam, and a hearing aid allowance

NEW FOR 2023 IN THE HUMANA GROUP MEDICARE ADVANTAGE PLANS (90/10)*

Take a look below at some benefit changes that you may enjoy in the new year!

Benefit	Base Plan Current 2022 Coverage	Enhanced Plan Current 2022 Coverage	Base & Enhanced Plans 2023 Plan Year Coverage
Lab Services at Urgent Care Facility	\$40 copay	\$10 copay	\$0 copay
Dialysis Services at Outpatient Facility	20% coinsurance	20% coinsurance	\$0 copay
Dialysis Services at Dialysis Center	20% coinsurance	20% coinsurance	\$0 copay

HOW HUMANA GROUP MEDICARE ADVANTAGE (PPO) (90/10)* PLANS COORDINATE WITH OTHER PLANS

Your Humana Group Medicare Advantage (PPO) (90/10)* 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, 2023.

Remember: You cannot be enrolled in multiple Medicare Health Plans (Medicare Part D and/or Medicare Advantage). Should you or your spouse choose to enroll in an outside Medicare Health Plan, you will be disenrolled from your Humana Group Medicare Advantage (PPO) Plan and automatically moved to the Base PPO Plan (70/30). This could significantly impact premiums for yourself and/or covered spouses and dependents.

MEDIGAP AND HUMANA GROUP MEDICARE ADVANTAGE (PPO) (90/10)* PLANS

When you are enrolled in a Medicare Advantage Plan, you cannot use a Medigap (Medicare Supplement) plan 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 Humana Group Medicare Advantage Plans have a benefit value equivalent to a 90/10 plan.

The Base PPO Plan (70/30)

The Base PPO Plan (70/30) 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, administered by Blue Cross NC, 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 Base PPO Plan

(70/30) will be secondary. After you meet the Base PPO Plan (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.

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.**

THE BASE PPO PLAN (70/30) AND MEDICARE PART B

If you enroll in the Base PPO Plan (70/30) 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.

CLEAR PRICING PROJECT

As a State Health Plan member on the Base PPO Plan (70/30), you have access to the North Carolina State Health Plan Network, which is made up of providers who signed up for the Plan's Clear Pricing Project (CPP), and Blue Cross NC's Blue Options network. CPP providers are North Carolina providers that have agreed to make health care more affordable and transparent. The Plan continues to offer either no-copay visits or significant copay reductions for members who visit a CPP provider in 2023. Remember, the CPP does not apply to the Humana Medicare Advantage plans.

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

CLEAR PRICING PROJECT PROVIDER COPAY CHART

PROVIDER	BASE PPO PLAN (70/30)
Primary Care Provider (PCP)	CPP PCP on ID card \$0 Non-CPP PCP on ID card \$30 Other PCP \$45
Behavioral Health Provider	CPP Provider \$0 Non-CPP Provider \$45
Specialist	CPP Specialists \$47 Non-CPP Specialists \$94
Speech, Occupational, Chiropractor and Physical Therapy	CPP Providers \$36 Non-CPP Providers \$72

BASE PPO PLAN (70/30) PLAN PHARMACY BENEFIT REMINDERS

- ▶ The formulary (drug list), which determines what medications are covered and what tier they fall under, **changes on a quarterly basis**, so there is a possibility that you will have changes in your prescription coverage in 2023.
- ▶ 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.
- ▶ Remember, preferred and non-preferred insulin will have a \$0 copay!
- ▶ 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 2023 health plan choice. Remember to always discuss your prescription options with your provider.

ID CARD UPDATE: ALL members enrolled in the Base PPO Plan (70/30) will receive a new State Health Plan ID card prior to January 1, 2023.

Quick Comparison of Your Health Plan Options

	Humana Group Medicare Advantage (90/10)* Plans	Base PPO Plan (70/30)
NO Medical or Pharmacy deductibles	✓	
Spousal Coverage for \$4 (Humana Base Plan)	✓	
Customized plan for you combining Medicare Parts A and B along with Medicare Part D (prescription coverage) into one plan	✓	
Ability to see providers outside the network for the same copay or coinsurance as in-network providers as long as the provider participates in Medicare and agrees to file claims with Humana	✓	
Free enrollment in SilverSneakers	✓	
Hearing aid benefit	✓	
Routine eye exams	✓	
Lower Urgent Care and ER Copays	✓	
Humana Well Dine Meal Program where you can receive 2 meals per day for 14 days (total of 28 meals) delivered after an inpatient stay in a hospital or nursing facility	✓	
In-home Personal Care for \$0; a minimum of 3 hours per day, up to a maximum of 6 hours for certain in-home support services following a discharge from a skilled nursing facility or from an inpatient hospitalization	✓	
Prescription Drug coverage	✓	✓
No referral needed to see a specialist	✓	✓
Preventive services covered at 100%	✓	✓
Disease and case management services	✓	✓
Preferred and non-preferred insulin has a \$0 copay for a 30-day supply		✓

*The Humana Group Medicare Advantage Plans have a benefit value equivalent to a 90/10 plan.

2023 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 monthly premiums listed apply to members that are responsible for 100% of their premium.

To find all rates for all plans, visit www.shpnc.org.

HUMANA GROUP MEDICARE ADVANTAGE (PPO) (90/10)* BASE PLAN

COVERAGE TYPE	2023 MONTHLY PREMIUM
Subscriber Only	\$4.00
Subscriber + Child(ren)	\$8.00
Subscriber + Spouse	\$8.00
Subscriber + Family	\$12.00

HUMANA GROUP MEDICARE ADVANTAGE (PPO) (90/10)* ENHANCED PLAN

COVERAGE TYPE	2023 MONTHLY PREMIUM
Subscriber Only	\$73.00
Subscriber + Child(ren)	\$146.00
Subscriber + Spouse	\$146.00
Subscriber + Family	\$219.00

BASE PPO PLAN (70/30)

COVERAGE TYPE	2023 MONTHLY PREMIUM
Subscriber Only	*\$472.08
Subscriber + Child(ren)	\$627.08
Subscriber + Spouse	\$897.08
Subscriber + Family	\$916.08

*Assumes Tobacco Attestation is complete. For more information regarding this credit, refer to the Plan's website at www.shpnc.org.

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 a 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.

*The Humana Group Medicare Advantage Plans have a benefit value equivalent to a 90/10 plan.

2023 State Health Plan Comparison

PLAN DESIGN FEATURES	HUMANA GROUP MEDICARE ADVANTAGE BASE PLAN	HUMANA GROUP MEDICARE ADVANTAGE ENHANCED PLAN	BASE PPO PLAN (70/30)*
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 (may be charged a copay if other services are provided and billed during visit).
Office Visits	\$20 for PCP \$40 for Specialist	\$10 for PCP \$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, urgent care \$0 copay	\$10 copay; if lab test is performed and processed in doctor's office, urgent care \$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

PLAN DESIGN FEATURES	HUMANA GROUP MEDICARE ADVANTAGE BASE PLAN	HUMANA GROUP MEDICARE ADVANTAGE ENHANCED PLAN	BASE PPO PLAN (70/30)*
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	\$35 per 30-day supply		\$0 per 30-day supply

* When enrolled in the Base PPO Plan (70/30), cost-sharing amounts between you and the State Health Plan will vary. Medicare pays benefits first. Then, the Base PPO Plan (70/30) 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).

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

Medicare Outreach Events

The State Health Plan will be offering a variety of outreach events for you to learn more about your 2023 benefits. These will include in-person events, webinars and Telephone Town Halls! **For a complete list of in-person events, visit the Plan's website.** To register for in-person events, webinars and Telephone Town Halls, visit the Plan's website at **www.shpnc.org**.

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

OPEN ENROLLMENT MEDICARE WEBINAR & TELEPHONE TOWN HALL EVENT SCHEDULE

Webinar Events	
September 15	10AM
September 23	2PM
September 26	10AM
September 30	2PM
October 4	10AM
October 7	2PM
October 10	6PM
October 14	2PM
October 21	10AM
October 24	2PM

Telephone Town Hall Events	
October 4	7PM
October 25	2PM

Stay in Touch

Don't miss out on State Health Plan information! We have several ways you can stay informed!



**FOLLOW US
ON FACEBOOK**

facebook.com/SHPNC/



**TEXT "JOIN"
TO 76971**

to receive State Health Plan
general information via text



**SIGN UP FOR
MEMBER FOCUS,**

the State Health Plan's monthly
e-newsletter, on the Plan's
website at **www.shpnc.org**

Open Enrollment Checklist

You can enroll in or change your plan any time from October 10 through October 28, 2022, either online or by phone by calling the Eligibility and Enrollment Support Center.

	Review your information and 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.
	Visit www.shpnc.org for more information about your 2023 benefits. Utilize the resources to assist you with your decision making. You'll find a plan comparison, rate sheets, videos and Benefits Booklets.
	When you're ready to enroll or change your plan, starting October 10, 2022, visit www.shpnc.org and click eBenefits. Or you can call the Eligibility and Enrollment Support Center for assistance.
	In eBenefits, confirm that you have a physical address and not just a PO Box to ensure your enrollment into the Humana plan is completed.
	Review the benefits you've selected.
	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.
	Print your confirmation statement for your records.

For assistance during Open Enrollment call the Plan's Eligibility and Enrollment Support Center at 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

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

Original Effective Date: April 14th, 2003

Revised Effective Date: June 10, 2021

Introduction

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

Your Rights

You have the right to:

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

Your Choices

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

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

Our Uses and Disclosures

We may use and share your information as we:

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

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you. Get a copy of health and claims records.

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- Ask us to correct health and claims records
- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.
- Request confidential communications
- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.
- Ask us to limit what we use or share
- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.
- Get a list of those with whom we've shared information
- You can ask for a list (accounting) of the times we've shared your health information (including medical records, billing records, and any other records used to make decisions regarding your health care benefits) for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except: (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.
- To request an accounting, you must submit a written request to the Privacy Contact identified in this Notice. Your request must state a time period of no longer than six (6) years.

Get a copy of this privacy notice

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

Choose someone to act for you

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

File a complaint if you feel your rights are violated

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

Your Choices

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

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

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

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

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

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

Our Uses and Disclosures

How do we typically use or share your health information?

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

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: The Plan may disclose your health information so that your doctors, pharmacies, hospitals, and other health care providers may provide you with medical treatment.

Run our organization

We can use and disclose your information to run our organization (healthcare operations), improve the quality of care we provide, reduce healthcare costs, and contact you when necessary.

Example: The Plan may use and disclose your information to determine the budget for the following year, or to set premiums. We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with CVS Caremark to coordinate payment for your prescriptions.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your employer's Health Benefit Representative is provided information to help you understand your health benefits, and help make sure you are enrolled.

How else can we use or share your health information?

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

Help with public health and safety issues

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

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

Do research

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

Comply with the law

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

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

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

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

We can use or share health information about you:

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

Respond to lawsuits and legal actions

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

Other Uses and Disclosures

Some uses and disclosures of your will be made only with your written authorization. For example, your written authorization is required in the following instances: (i) any use or disclosure of psychotherapy notes, except as otherwise permitted in 45 C.F.R. 164.508(a)(2); (ii) any use or disclosure for "marketing," except as otherwise permitted in 45 C.F.R. 164.508(a)(3); (iii) any disclosure which constitutes a sale of PHI. If you authorize the Plan to use or disclose your PHI, you may revoke the authorization at any time in writing. However, your revocation will only stop future uses and disclosures that are made after the Plan receive your revocation. It will not have any effect on the prior uses and disclosures of your PHI.

Our Responsibilities

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

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

Changes to the Terms of this Notice

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

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the Plan or with the Secretary of the Department of Health and Human Services. You will not be penalized or retaliated against for filing a complaint.

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

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

U.S. Department of Health and Human Services
200 Independence Avenue SW.
Room 509F, HHH Building
Washington, DC 20201
1-800-368-1019, 800-537-7697 (TDD)

File complaint electronically at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>
Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>

Privacy Contact

The Privacy Contact at the Plan is:
State Health Plan
Attention: HIPAA Privacy Officer
3200 Atlantic Avenue Raleigh, NC 27604
919-814-4400

Enrollment in the Flexible Benefit Plan (under IRS Section 125) for the State Health Plan

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

- Your marital status changes due to marriage, death of spouse, divorce, legal separation, or annulment.
- You increase or decrease the number of your eligible dependents due to birth, adoption, placement for adoption, or death of the dependent.
- You, your spouse, or your eligible dependent experiences an employment status change that results in the loss or gain of group health coverage.
- You, your spouse, or your dependents become entitled to Medicare, or Medicaid.
- Your dependent ceases to be an eligible dependent (e.g., the dependent child reaches age 26).
- You, your spouse, or your dependents commence or return from an unpaid leave of absence such as Family and Medical Leave or military leave.
- You receive a qualified medical child support order (as determined by the plan administrator) that requires the plan to provide coverage for your children.
- If you or your dependents change your country of permanent residence by moving to or from the United States, you or your dependents will have 30 days from the date of entering or exiting the United States to change your health benefit plan election.
- If you, your spouse or dependents experience a cost or coverage change under another group health plan for which an election change was permitted, you may make a corresponding election change under the Flex Plan (e.g., your spouse's employer significantly increases the cost of coverage and as a result, allows the spouse to change his/her election).
- If you change employment status such that you are no longer expected to average 30 hours of service per week but you do not lose eligibility for coverage under the State Health Plan (e.g., you are in a stability period during which you qualify as full time), you may still revoke your election provided that you certify that you have or will enroll yourself (and any other covered family members) in other coverage providing minimum essential coverage (e.g., the marketplace) that is effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.
- You may prospectively revoke your State Health Plan election if you certify your intent to enroll yourself and any covered dependents in the marketplace for coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.
- You or your children lose eligibility under Medicaid or a state Children's Health Insurance Program. In this case you must request enrollment within 60 days of losing eligibility.
- If you, your spouse or your dependent loses eligibility for coverage (as defined by HIPAA) under any group health plan or health insurance coverage (e.g., coverage in the individual market, including the marketplace), you may change your participation election.

In addition, even if you have one of these events, your election change must be "consistent" with the event, as defined by the IRS. Consequently, the election change that you desire may not be permitted if not consistent with the event as determined by IRS rules and regulations. When one of these events occurs, you must complete your request through your online enrollment system within 30 days of the event (except as described above). If you do not process the request within 30 days, you must wait until the next Open Enrollment to make the coverage change.

Notice of HIPAA Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must

request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for assistance.

To request special enrollment or obtain more information, contact the Eligibility and Enrollment Support Center at 855-859-0966.

Notice Regarding Mastectomy-Related Services

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

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

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

Notice of Patient Protections for Non-Grandfathered Plans

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

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

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

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

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

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

It is important to note, if you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution to the employer-offered coverage. Also, this employer contribution, as well as your employee contribution to employer-offered coverage,

is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

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

Notice Regarding Your Rights and Protections Against Surprise Medical Bills

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

What is "balance billing" (sometimes called "surprise billing")?

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

You are protected from balance billing for:

Emergency services

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

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

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

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

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

If you believe you've been wrongly billed, you may contact the U.S. Department of Health and Human Services (Phone: 800-985-3059) regarding enforcement of federal balance or surprise billing protection laws and the North Carolina Department of Insurance regarding enforcement of North

Carolina balance or surprise billing protection laws (Phone: 855-408-1212; Address: 325 N. Salisbury Street, Raleigh, NC 27603).

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

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

Nondiscrimination and Accessibility Notice

The State Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The State Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. The State Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
 - The State Health Plan website is Americans with Disabilities Act (ADA) compliant for the visually impaired.
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact the Civil Rights Coordinator identified below (the "Coordinator"): State Health Plan Compliance Officer at 919-814-4400.

If you believe that the State Health Plan has failed to provide these services or discriminated against you, you can file a grievance with the Coordinator. You can file a grievance in person or by mail (Section 1557 Coordinator, 3200 Atlantic Avenue, Raleigh, NC 27604) or email (1557Coordinator@nctreasurer.com).

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, available at:

U.S. Department of Health and Human Services
200 Independence Avenue SW Room 509F,
HHH Building
Washington, DC 20201
1-800-368-1019, 800-537-7697 (TDD)

File complaint electronically at:
<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Complaint forms are available at:
<http://www.hhs.gov/ocr/office/file/index.html>

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, 2022. Contact your State for more information on eligibility –

ALABAMA – Medicaid		CALIFORNIA – Medicaid	
Website: http://myalhipp.com/ Phone: 1-855-692-5447		Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov	
ALASKA – Medicaid		COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx		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-health-plan-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	
ARKANSAS – Medicaid		FLORIDA – Medicaid	
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)		Website: https://www.flmedicaidprecovery.com/flmedicaidprecovery.com/hipp/index.html Phone: 1-877-357-3268	
GEORGIA – Medicaid		MASSACHUSETTS – Medicaid and CHIP	
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2		Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102	
INDIANA – Medicaid		MINNESOTA – 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		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	
IOWA – Medicaid and CHIP (Hawki)		MISSOURI – Medicaid	
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562		Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	

KANSAS – Medicaid		MONTANA – Medicaid	
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884		Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HSHIPPProgram@mt.gov	
KENTUCKY – Medicaid		NEBRASKA – 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: KIHIPPROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov		Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178	
LOUISIANA – Medicaid		NEVADA – Medicaid	
Website: www.medicaid.la.gov or www.ldh.la.gov/la hipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)		Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	
MAINE – Medicaid		NEW HAMPSHIRE – 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		Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218	
NEW JERSEY – Medicaid and CHIP		SOUTH DAKOTA – Medicaid	
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		Website: http://dss.sd.gov Phone: 1-888-828-0059	
NEW YORK – Medicaid		TEXAS – Medicaid	
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831		Website: http://gethipptexas.com/ Phone: 1-800-440-0493	
NORTH CAROLINA – Medicaid		UTAH – Medicaid and CHIP	
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100		Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	
NORTH DAKOTA – Medicaid		VERMONT – Medicaid	
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825		Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	
OKLAHOMA – Medicaid and CHIP		VIRGINIA – Medicaid and CHIP	
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742		Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924	
OREGON – Medicaid		WASHINGTON – Medicaid	
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075		Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	
PENNSYLVANIA – Medicaid		WEST VIRGINIA – Medicaid and CHIP	
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462		Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)	
RHODE ISLAND – Medicaid and CHIP		WISCONSIN – Medicaid and CHIP	
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rlte Share Line)		Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	
SOUTH CAROLINA – Medicaid		WYOMING – Medicaid	
Website: https://www.scdhhs.gov Phone: 1-888-549-0820		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, 2022, or for more information on special enrollment rights, contact either:

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

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

2023 Open Enrollment Decision Guide

SHP204-Direct Bill Medicare

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**.

دعاً لاسم الله تادمخ نإف، رلغلل رلكذا شدحتت تنك اذإ: تظوجللم
قرب لصتا نإجلاب كل رفاوتت قيوغلل
919-814-4400.

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

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

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

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

ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សូមព្រមទទួលបានសេវាជំនួយភាសាដោយមិនគិតថ្លៃឡើយ ឥឡូវនេះ។ ទូរស័ព្ទទៅ **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**.

ໄປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໄດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 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
(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