Your North Carolina State Health Plan

2025 Open Enrollment Decision Guide
SEPTEMBER 30 – OCTOBER 25, 2024

"As State Treasurer, it's been my honor to serve you for the past eight years. Working together with State Health Plan members, we have fought to provide quality, accessible and affordable health care for our all of our participants.

Starting Jan. 1, 2025, the State Health Plan is transitioning Third-Party Administrator (TPA) services from Blue Cross NC to Aetna. This change ***does not affect*** *Humana Medicare Advantage Plan members, but it does impact members and dependents on the Base PPO Plan (70/30).*

For that reason, I encourage you to carefully review your options in this Decision Guide, note the changes that come with a new TPA, and take action where necessary. However, I hope you will join the 90% of post-65 retirees who are currently on the Humana Medicare Advantage Plan."

– 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
Dale R. Folwell, CPA

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 2025 benefit year. The choices you make during Open Enrollment are for benefits that will be effective Jan. 1, 2025, through Dec. 31, 2025.

For the 2025 benefit year, members in the Humana Group Medicare Advantage Base and Enhanced (PPO) plans will remain in that plan unless you enroll in a different plan during Open Enrollment.

Medicare members enrolled in the Base PPO Plan (70/30) will be moved to the Humana Medicare Advantage Base (PPO) Plan. You will need to take action during Open Enrollment if you want to be enrolled in a different plan option or if you need to make any changes regarding your dependents. Please note that the Base PPO Plan (70/30) currently administered by Blue Cross NC will be administered by Aetna as of Jan. 1, 2025.

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), which will be administered by Aetna beginning Jan. 1, 2025. 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 2025 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 2025 benefit year. More information regarding these plan options can be found at **www.shpnc.org.**

A Look at Your 2025 Options

As a Medicare-eligible member, you continue to have three plan options to choose from for 2025:

- **Humana Group Medicare Advantage (PPO) Base Plan (90/10)***
- **Humana Group Medicare Advantage (PPO) Enhanced Plan (90/10)***
- **Base PPO Plan (70/30), which will be administered by Aetna as of Jan. 1, 2025. It is currently administered by Blue Cross NC.**

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

ID CARD UPDATE:

No matter what action members take during Open Enrollment, all members will receive a new State Health Plan ID card for 2025, from either Humana or Aetna, depending on the plan in which you enroll. Your current card will not work after Dec. 31, 2024.

IMPORTANT NOTES FOR 2025

Humana Group Medicare Advantage (PPO) Plans

- Eligible subscriber premiums for the Humana Group Base Medicare Advantage (PPO) Plan will be $37. The dependent premiums have changed. Adding a dependent will be $74 for the Base Plan and $200 for the Enhanced Plan (includes subscriber + spouse).
- There are **NO major** benefit changes with the Humana Medicare Advantage Plans. Member copay of the plan's insulin products covered under Part B and Part D is **no more than $35 for every** one-month (up to a 30-day) supply.
- Pharmacy out-of-pocket maximum will be **lowered** from $2,500 to $2,000.
- Members who reach the Catastrophic Coverage Stage for prescriptions will pay nothing for covered Part D drugs.
- There may be changes to the Humana Medicare Advantage Plan formulary (drug list), so members are encouraged to review that information when it becomes available.

Base PPO Plan (70/30) Administered by Aetna

- Aetna will become the Plan's new Third-Party Administrator (TPA) on Jan. 1, 2025. **This transition does not affect members on the Humana Medicare Advantage Plans.**
- Members will be able to enjoy Aetna's broad national network which includes 99.5% of North Carolina providers including all major hospitals in North Carolina. To locate a provider, visit the State Health Plan's website at **www.shpnc.org**, click "Find a Doctor" and select "Aetna 2025."
- There are **NO major** benefit or premium changes with the Base PPO Plan (70/30).
- The formulary (drug list) for the Base PPO Plan (70/30) 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.
- Members who select a Clear Pricing Project Provider as their Primary Care Provider will continue to enjoy a $0 copay on the Base PPO Plan (70/30).
- Preferred and non-preferred insulin continues to have a $0 copay for a 30-day supply on the Base PPO Plan (70/30).
- International benefits include emergency or urgent care visits only.
- **Members will need to re-select a Primary Care Provider during Open Enrollment to continue to enjoy the lower copays when seeing that provider in 2025.**

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 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 2025 benefit year. So, it is important to verify your medications are still covered and if there are any formulary changes for 2025.
- 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** deductibles
- **NO** referral needed to see a specialist
- **Lower premiums** for Medicare-eligible dependent coverage 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 most Part D vaccines (e.g., Shingrix)
- **Free** enrollment in the SilverSneakers® fitness program
- **$0 copay** for post-discharge benefits including transportation and personal home care
- **Well Dine Program** 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 podiatry, routine hearing exam, a hearing aid allowance, and private duty nursing

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.**

How Humana Group Medicare Advantage (PPO) (90/10)* Plans Coordinate With Other Medicare 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 Jan. 1, 2025.

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 plan, it will not work with Medicare Advantage plans. Should you choose to enroll in a Medicare Advantage plan, you may want to consider canceling your Medigap plan.

If you have other retirement group health coverage (i.e., from another state, company or the federal government):

- It's important to READ any Open Enrollment materials from each plan as they may have different enrollment dates and offer Medicare Advantage/Medicare Part D plan.
- Contact the administrator of that other plan to determine how it will or will not coordinate with the Humana Group Medicare Advantage (PPO) Plans.

**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, which will be administered by Aetna, 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.**

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 will continue to have access to the North Carolina State Health Plan Network, which is made up of North Carolina providers who signed up for the Plan's Clear Pricing Project (CPP), and Aetna's 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 2025. 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." You will then select "Aetna 2025." Then look for "Clear Pricing Project Provider" next to a provider's name.

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

- For the formulary (drug list), which determines what medications are covered and what tier they fall under, **changes may occur on a quarterly basis**, so there is a possibility that you will have changes in your prescription coverage in 2025.
- 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 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 2025 health plan choice.
- Remember to always discuss your prescription options with your provider.

2025 MONTHLY PREMIUMS

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 members who are 100% contributory. The premium owed will billed to you.

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

HUMANA GROUP MEDICARE ADVANTAGE (PPO) (90/10)* BASE PLAN	
COVERAGE TYPE	**2025 MONTHLY PREMIUM**
Subscriber Only	$37.00
Subscriber + Child(ren)	$74.00
Subscriber + Spouse	$74.00
Subscriber + Family	$111.00

HUMANA GROUP MEDICARE ADVANTAGE (PPO) (90/10)* ENHANCED PLAN	
COVERAGE TYPE	**2025 MONTHLY PREMIUM**
Subscriber Only	$100.00
Subscriber + Child(ren)	$200.00
Subscriber + Spouse	$200.00
Subscriber + Family	$300.00

BASE PPO PLAN (70/30)	
COVERAGE TYPE	**2025 MONTHLY PREMIUM****
Subscriber Only	$452.08
Subscriber + Child(ren)	$607.08
Subscriber + Spouse	$877.08
Subscriber + Family	$896.08

**The Humana Group Medicare Advantage Plans have a benefit value equivalent to a 90/10 plan.*
***Assumes completion of tobacco attestation.*

TOBACCO ATTESTATION PREMIUM REDUCTION
(FOR BASE PPO PLAN 70/30 ONLY)

- If you either attest to being a non-tobacco user or agree to a tobacco cessation counseling session and upload the required documentation by the deadline, you will reduce your premium by $60 per month in 2025 (the premium credit only applies to the subscriber-only premium).
- If you are NOT a tobacco user, you will simply need to complete an attestation online during Open Enrollment to receive the premium credit.
- Even if you completed the tobacco attestation during last year's Open Enrollment, you must make a new attestation during this year's Open Enrollment period to receive the $60 premium credit for the 2025 Plan benefit year.
- Tobacco users can attend a tobacco cessation counseling session at a provider's office for FREE to receive a lower premium for 2025! **You have until Nov. 30, 2024, to complete a counseling session and upload the required documentation from your visit**.
- If you combine your tobacco cessation visit with another service, there may be a copay.
- After you visit a provider for your tobacco cessation session, the provider will submit a claim on your behalf. To ensure you receive credit for your visit, you must upload your office visit summary to the "Document Center" located in eBenefits, the Plan's enrollment system. Make sure to request a copy of your visit summary during your counseling session.

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.

Members affected by IRMAA and enrolled in either Humana Group Medicare Advantage Plans, which include a Part D prescription drug plan, are responsible for IRMAA charges.

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.

2025 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

PLAN DESIGN FEATURES	HUMANA GROUP MEDICARE ADVANTAGE BASE PLAN	HUMANA GROUP MEDICARE ADVANTAGE ENHANCED PLAN	BASE PPO PLAN (70/30)*
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
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	$2,000 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.

Open Enrollment To Do List

You can enroll in or change your plan any time from Sept. 30 through Oct. 25, 2024, 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 2025 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 Sept. 30, 2024, members should visit the Plan's website at **www.shpnc.org**, click eBenefits and select Log into eBenefits.
- In eBenefits, confirm that you have a physical address and not just a P.O. Box to ensure you receive all mailings.
- If applicable, complete the tobacco attestation to reduce your monthly premium.
- 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.**

ID CARD UPDATE: No matter what action members take during Open Enrollment, all members will receive a new State Health Plan ID card for 2025, from either Humana or Aetna, depending on the plan in which you enroll. Your current card will not work after Dec. 31, 2024.

For assistance during Open Enrollment call the Plan's Eligibility and Enrollment Support Center at 855-859-0966. The Support Center will offer extended hours during Open Enrollment. Monday-Friday, 8 a.m.-10 p.m., and Saturday, 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.

ENROLLMENT TIPS

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 at **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.

2025 Open Enrollment Outreach

You have questions? We have answers! We're ready to meet you wherever you are – in person, online or by phone!

WEBINAR EVENTS

The webinars include the same information as the in-person sessions and offer the opportunity for a question-and-answer session at the end of each webinar. Each webinar lasts approximately 2 hours.

WEBINAR DATES	WEBINAR TIMES
8/28/24	10 am
8/29/24	2 pm
9/12/24	2 pm
9/13/24	10 am
9/17/24	2 pm
9/30/24	10 am
9/30/24	2 pm
10/1/24	10 am
10/4/24	10 am
10/10/24	6 pm
10/11/24	10 am
10/21/24	10 am
10/21/24	6 pm
10/22/24	10 am

IN-PERSON EVENTS

A complete list of in-person events was mailed to members in August and are also posted on the Plan's website at **www.shpnc.org**.

TELEPHONE TOWN HALLS

Telephone town hall meetings are like listening to a radio show over the phone. You'll simply provide your phone number when you register, and we'll call you to join at the start of the event. Members who have registered and members with a valid phone number in the State Health Plan's enrollment system eBenefits will receive a call prior to an event, which will prompt you to join. If the phone number we have on file is a mobile number, you must register and agree to be contacted for the meeting via your mobile number.

TTH DATES	TTH TIMES
9/27/24	2 pm - 2:45 pm
10/4/24	2 pm - 2:45 pm

To register for an in-person event, webinar or a Telephone Town Hall visit the Plan's website at **www.shpnc.org.**

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

Instagram (@nchealthplan)

Sign up for Member Focus, the State Health Plan's monthly e-newsletter, by subscribing at www.shpnc.org

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 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, call Customer Service.

Notice of Patient Protections for Non-Grandfathered Plans

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

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

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

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance 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 in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the 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 is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12% of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[12]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution—as well as your employee contribution to employment-based coverage—is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services is **offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's 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

[1] Indexed annually; see **https://www.irs.gov/pub/irs-drop/rp-22-34.pdf** for 2023.

[2] An employer-sponsored or other employment-based 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 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

contact information for a Health Insurance Marketplace in your area.

Notice Regarding Your Rights and Protections Against Surprise Medical Bills

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

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

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

You are protected from balance billing for:

Emergency services

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

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

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

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

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

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

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

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

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

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

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, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ **Phone:** 1-855-692-5447	**The AK Health Insurance Premium Payment Program** **Website:** http://myakhipp.com/ **Phone:** 1-866-251-4861 **Email:** CustomerService@MyAKHIPP.com **Medicaid Eligibility:** https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ **Phone:** 1-855-MyARHIPP (855-692-7447)	**Health Insurance Premium Payment (HIPP) Program** **Website:** http://dhcs.ca.gov/hipp **Phone:** 916-445-8322 **Fax:** 916-440-5676 **Email:** hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ **Health First Colorado Member Contact Center:** 1-800-221-3943/ State Relay 711 **CHP+:** https://hcpf.colorado.gov/child-health-plan-plus **CHP+ Customer Service:** 1-800-359-1991/ State Relay 711 **Health Insurance Buy-In Program (HIBI):** https://www.mycohibi.com/ **HIBI Customer Service:** 1-855-692-6442	**Website:** https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html **Phone:** 1-877-357-3268
GEORGIA – Medicaid	**INDIANA – Medicaid**
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	**Health Insurance Premium Payment Program** **All other Medicaid** **Website:** https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration **Phone:** 1-800-403-0864 **Member Services Phone:** 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid **Medicaid Phone:** 1-800-338-8366 **Hawki Website:** https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki **Hawki Phone:** 1-800-257-8563 **HIPP Website:** https://hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp **HIPP Phone:** 1-888-346-9562	**Website:** https://www.kancare.ks.gov/ **Phone:** 1-800-792-4884 **HIPP Phone:** 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – 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://kynect.ky.gov **Phone:** 1-877-524-4718 **Kentucky Medicaid Website:** https://chfs.ky.gov/agencies/dms	**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	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US **Phone:** 1-800-442-6003 **TTY:** Maine relay 711 **Private Health Insurance Premium Webpage:** https://www.maine.gov/dhhs/ofi/applications-forms **Phone:** 1-800-977-6740 **TTY:** Maine relay 711	**Website:** https://www.mass.gov/masshealth/pa **Phone:** 1-800-862-4840 **TTY:** 711 **Email:** masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ **Phone:** 1-800-657-3672	**Website:** http://www.dss.mo.gov/mhd/participants/pages/hipp.htm **Phone:** 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP **Phone:** 1-800-694-3084 **Email:** HHSHIPPProgram@mt.gov	**Website:** http://www.ACCESSNebraska.ne.gov **Phone:** 1-855-632-7633 **Lincoln:** 402-473-7000 **Omaha:** 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov **Medicaid Phone:** 1-800-992-0900	**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 15218 **Email:** DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ **Phone:** 1-800-356-1561 **CHIP Premium Assistance Phone:** 609-631-2392 **CHIP Website:** http://www.njfamilycare.org/index.html **CHIP Phone:** 1-800-701-0710 (TTY: 711)	**Website:** https://www.health.ny.gov/health_care/medicaid/ **Phone:** 1-800-541-2831

NORTH CAROLINA – Medicaid	NORTH DAKOTA – Medicaid
Website: https://medicaid.ncdhhs.gov/ **Phone:** 919-855-4100	**Website:** https://www.hhs.nd.gov/healthcare **Phone:** 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org **Phone:** 1-888-365-3742	**Website:** http://healthcare.oregon.gov/Pages/index.aspx **Phone:** 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html **Phone:** 1-800-692-7462 **CHIP Website:** Children's Health Insurance Program (CHIP) (pa.gov) **CHIP Phone:** 1-800-986-KIDS (5437)	**Website:** http://www.eohhs.ri.gov/ **Phone:** 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA – Medicaid**
Website: https://www.scdhhs.gov **Phone:** 1-888-549-0820	**Website:** http://dss.sd.gov **Phone:** 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program **Phone:** 1-800-440-0493	**Website:** https://medicaid.utah.gov/upp/ **Email:** upp@utah.gov **Phone:** 1-888-222-2542 **Adult Expansion Website:** https://medicaid.utah.gov/expansion/ **Utah Medicaid Buyout Program Website:** https://medicaid.utah.gov/buyout-program/ **CHIP Website:** https://chip.utah.gov/
VERMONT – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://dvha.vermont.gov/members/medicaid/hipp-program **Phone:** 1-800-250-8427	**Website:** https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select or https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs **Medicaid/CHIP Phone:** 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ **Phone:** 1-800-562-3022	**Website:** https://dhhr.wv.gov/bms/ or http://mywvhipp.com/ **Medicaid Phone:** 304-558-1700 **CHIP Toll-free phone:** 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm **Phone:** 1-800-362-3002	**Website:** https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ **Phone:** 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

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

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

Nondiscrimination and Accessibility Notice

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

The State Health Plan:

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

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

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

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

U.S. Department of Health and Human Services
200 Independence Avenue SW Room 509F, HHH Building Washington, DC 20201
1-800-368-1019, 800-537-7697 (TDD)
File complaint electronically at: **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**
Complaint forms are available at: **http://www.hhs.gov/ocr/office/file/index.html**

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

State Health Plan
3200 Atlantic Avenue
Raleigh, NC 27604

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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.**

បុរយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សុវ៉ាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បីរអ្នក។ 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.

Aetna Health Concierge (Customer Service):
(Customer Service):
833-690-1037

Extended hours during Open Enrollment:
Monday-Friday: 8 a.m.-8 p.m.
Saturdays: 8 a.m.-2 p.m.

Humana (benefits): **888-700-2263**

CVS Caremark
((Base PPO Plan (70/30) Pharmacy Benefit questions):
888-321-3124