

For Medicare-eligible Retirees

# DECISION GUIDE FOR OPEN ENROLLMENT

October 1–31, 2016



2017

# TIME FOR A CHANGE

This is the perfect time to take a moment and look at your State Health Plan coverage.

Circumstances and your coverage needs may change from year to year. Open Enrollment is an ideal time to review and evaluate all your options and to decide whether you want to stay in the same plan or enroll in a different option.

As a Medicare-eligible retiree, you have three plan options to choose from for 2017:

- **The UnitedHealthcare® (UHC) Group Medicare Advantage (PPO) Base Plan**
- **The UnitedHealthcare® (UHC) Group Medicare Advantage (PPO) Enhanced Plan**
- **The Traditional 70/30 Plan, administered by Blue Cross and Blue Shield of North Carolina (BCBSNC)**

Beginning January 1, 2017, the State Health Plan will no longer offer the Humana Group Medicare Advantage Plans.

In order to provide Medicare Advantage Plan coverage at the lowest cost and highest value, the State Health Plan's Board of Trustees approved moving to one Medicare Advantage provider for 2017. This is expected to reduce costs, and the State Health Plan will be taking this opportunity to pass on some of the savings to you.

In addition, certain pharmacy benefits will change. These changes will be explained later in this guide.

## What Does This Mean for You?

- If you (and any eligible dependents) are currently enrolled in a **Humana** Group Medicare Advantage plan, you will automatically be enrolled in the **UHC Group Medicare Advantage (PPO) Base Plan** for 2017 unless you choose another option during Open Enrollment. This plan is premium-free for eligible retirees (though not dependents).
- If you (and any eligible dependents) are currently enrolled in a **UHC Group Medicare Advantage (PPO) Plan—Base or Enhanced**—or the **Traditional 70/30 Plan**, you will automatically be re-enrolled in the same plan for 2017 unless you choose another option.

**Therefore, you must take action if you wish to enroll in a plan that is different from the option you will be enrolled in automatically.**

## Attention

### Current Humana Members

As a result of a federal requirement, you will receive a disenrollment letter from Humana in November or December telling you that you will no longer have coverage under your current Humana Group Medicare Advantage Plan after December 31, 2016. To clarify: Your current Humana coverage will continue through the end of 2016. Your new coverage for 2017 will become effective January 1, 2017.



## A LOOK AT YOUR OPTIONS

For 2017, your State Health Plan coverage options include:

- **The UHC Group Medicare Advantage (PPO) Base Plan**
- **The UHC Group Medicare Advantage (PPO) Enhanced Plan**
- **The Traditional 70/30 Plan (administered by BCBSNC)**

### **UHC Group Medicare Advantage (PPO) Plans**

The UHC Group Medicare Advantage (PPO) Plans are customized to combine Medicare Parts A and B along with Medicare Part D (prescription coverage) into one plan with additional benefits, services and discount programs.

Note: The premiums for Medicare Part A (if applicable) and Medicare Part B are paid out of your Social Security benefits.

## Key Facts to Know About the UHC Group Medicare Advantage (PPO) Plans

- The UHC Group Medicare Advantage (PPO) Plans offer **simplicity**:
  - When you enroll, you have one plan, with one ID card, for both medical and prescription drug coverage.
  - You deal with one Medicare Advantage provider (UnitedHealthcare Insurance Company), through which you receive both your Medicare and Medicare Advantage Plan benefits.

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- **Benefit advantages** of the UHC Group Medicare Advantage (PPO) Plans:
  - The UHC Group Medicare Advantage (PPO) Plans offer benefits in addition to the coverage offered under Medicare.
  - For some benefits offered under the UHC Group Medicare Advantage (PPO) Plans, you pay less than you would under Original Medicare.
  - Additional benefits and services offered under the UHC Group Medicare Advantage (PPO) Plans include:
    - Nurse help line
    - SilverSneakers® Fitness Program
    - Routine eye exams
    - Routine hearing exams
    - Hearing aids
    - Routine foot care

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- Your UHC Group Medicare Advantage (PPO) Plan coverage includes **Medicare Prescription Drug coverage (Medicare Part D) with no coverage gap** (meaning there is no donut hole). Therefore, you do not need a stand-alone Medicare Part D Plan.
  - If you currently have a Medicare Part D or another Medicare Advantage Plan, and choose one of the State Health Plan’s UHC Group Medicare Advantage (PPO) Plan options:
    - The Centers for Medicare and Medicaid Services (CMS) will disenroll you from the other plan(s) as of January 1, 2017.

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

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

## What's New Under the Group Medicare Advantage Plans for 2017?

Pharmacy benefits under the UHC Group Medicare Advantage (PPO) Plans are changing:

- Coverage of preferred brands of insulin will be limited to Lilly products, and Novo products will not be covered. Both products are considered to be equally medically effective, but this change will enable further cost savings.
- Some high-cost generic drugs will be covered in a different tier than in 2016. For questions about the coverage of a specific drug, call UHC at **866-747-1014**.

## Important Features That Are NOT Changing for 2017

The non-pharmacy medical benefits provided by the UHC Group Medicare Advantage (PPO) Plans in 2017 are the same as those provided by the plans in 2016.

If you choose to enroll in a UHC Group Medicare Advantage (PPO) Plan for 2017, 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.



# THE TRADITIONAL 70/30 PLAN

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

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



## **The Traditional 70/30 Plan and Medicare**

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

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

## What's New Under the Traditional 70/30 Plan for 2017?

Below are the benefit changes to the Traditional 70/30 Plan:

- Increased deductible
- Increased medical coinsurance maximum
- Increased pharmacy out-of-pocket maximum
- Increased copays for:
  - Office visits
  - Urgent care
  - Emergency room visit (waived with hospital admission or observation stay)
  - Hospital admissions
  - Prescriptions
- Pharmacy copays and the maximum amount you can be required to pay for a supply of prescription drugs are increasing, in most cases slightly.
- The formulary, or drug list for prescription drugs, is moving from an open formulary to a closed formulary. Under a closed formulary, certain drugs are not covered. Members who are currently taking a drug that will not be covered in 2017 will receive information regarding their prescription.  
  
Please note that there will be an exception process available to providers who believe that, based on medical necessity, it is in the member's best interest to remain on the non-covered drug(s).
- There is a new Diabetic Testing Supplies pharmacy tier that includes a copay for test strips, lancets, syringes and needles.

## NEW PHARMACY BENEFIT MANAGER FOR THE TRADITIONAL 70/30 PLAN

As of January 1, 2017, CVS Caremark will become the State Health Plan's new Pharmacy Benefit Manager for the Traditional 70/30 Plan. If you are enrolled in this plan:

- During Open Enrollment, you will have access to an online drug lookup tool which allows you to compare costs for various drugs covered under the plan. This tool can help you save money on medications for which you pay coinsurance. For more information, visit the State Health Plan's website at [www.shpnc.org](http://www.shpnc.org) or, beginning October 1, call CVS Caremark at **888-321-3124**.
- In December, you will receive more information from CVS Caremark regarding your new prescription drug coverage and the new programs and tools available. You will also receive a new member ID card from BCBSNC. This is the card that you **MUST** start using as of January 1, 2017—the old card will not work at the pharmacy or provider's office.



# SUMMARY OF KEY CHANGES TO THE TRADITIONAL 70/30 PLAN



The chart below shows changes to some key plan features under the Traditional 70/30 Plan for 2017, comparing **in-network** benefits.

PLAN FEATURE	2016 TRADITIONAL 70/30 PLAN	2017 TRADITIONAL 70/30 PLAN
Deductible	\$1,054 Individual \$3,162 Family	\$1,080 Individual \$3,240 Family
Medical Coinsurance Maximum	\$4,282 Individual \$12,846 Family	\$4,388 Individual \$13,164 Family
ACA Preventive Services	\$39 for primary care, \$92 for specialist	\$40 for primary care, \$94 for specialist
Doctor's Office Visit—Primary Care Provider	\$39 copay	\$40 copay
Doctor's Office Visit—Specialist	\$92 copay	\$94 copay
Inpatient Hospital	\$329 copay, then 30% after deductible	\$337 copay, then 30% after deductible
Urgent Care	\$98 copay	\$100 copay
Emergency Room (Copay Waived with Admission or Observation Stay)	\$329 copay, then 30% after deductible	\$337 copay, then 30% after deductible
PRESCRIPTION DRUGS: RETAIL PURCHASE FROM IN-NETWORK PROVIDER, PER 30-DAY SUPPLY		
Pharmacy Maximum	\$3,294	\$3,360
Tier 1 (Generic)	\$15 copay	\$16 copay
Tier 2 (Preferred Brand and High-Cost Generic)	\$46 copay	\$47 copay
Tier 3 (Non-preferred Brand)	\$72 copay	\$74 copay
Tier 4 (Low-Cost Generic Specialty)	N/A	10% up to \$100
Tier 5 (Preferred Specialty)	25% up to \$100	25% up to \$103
Tier 6 (Non-preferred Specialty)	25% up to \$132	25% up to \$133
Preferred Diabetic Supplies (e.g., Test Strips, Lancets, Syringes, Needles)*	N/A	\$10 copay

\* **Non-preferred** diabetic supplies will be included in Tier 3.

See the plan comparison chart on pages 9-10 for a detailed comparison of 2017 benefits under all three of your plan options.

# 2017 STATE HEALTH PLAN COMPARISON

## Medical and Hospital Benefits

PLAN DESIGN FEATURES	UNITEDHEALTHCARE® (UHC) GROUP MEDICARE ADVANTAGE BASE PLAN	UNITEDHEALTHCARE® (UHC) GROUP MEDICARE ADVANTAGE ENHANCED PLAN	TRADITIONAL 70/30 PLAN*
Use of Network Providers	You can see any provider (in-network or out-of-network) that participates in Medicare and accepts Medicare assignment. Your copays or coinsurance stay the same.		You pay less when you use Blue Cross Blue Shield of North Carolina (BCBSNC) network providers.
Annual Deductible	\$0		<b>Individual:</b> \$1,080 in-network \$2,160 out-of-network <b>Family:</b> \$3,240 in-network \$6,480 out-of-network
Coinsurance	Most covered services require only a copay; however, some services require coinsurance (usually 20%).		<b>In-network:</b> 30% of eligible expenses after deductible <b>Out-of-network:</b> 50% of eligible expenses after deductible and the difference between the allowed amount and the charge
Annual Out-of-Pocket Maximum or Coinsurance Maximum	\$4,000 Individual No Family Maximum (An out-of-pocket maximum applies for this plan; it includes copays and coinsurance).	\$3,300 Individual No Family Maximum (An out-of-pocket maximum applies for this plan; it includes copays and coinsurance).	<b>Individual:</b> \$4,388 in-network \$8,776 out-of-network <b>Family:</b> \$13,164 in-network \$26,328 out-of-network (A coinsurance maximum applies for this plan; it does not include your payments toward your deductible or your copays).
Affordable Care Act (ACA) Preventive Services	See plan materials for information about ACA covered services, as some require a copay.		<b>In-network:</b> \$40 for primary doctor; \$94 for specialist
Office Visits	\$20 for primary doctor; \$40 for specialist	\$15 for primary doctor; \$35 for specialist	<b>In-network:</b> \$40 for primary doctor; \$94 for specialist
Urgent Care	\$50	\$40	\$100
Emergency Room (Copay waived w/admission or observation stay)	\$65		<b>In-network:</b> \$337 copay plus 30% coinsurance after deductible
Inpatient Hospital	Days 1-10: \$160/day Days 11+: \$0	Days 1-10: \$150/day Days 11+: \$0	<b>In-network:</b> \$337 copay plus 30% coinsurance after deductible
Outpatient Hospital	\$125	\$100	<b>In-network:</b> 30% coinsurance after deductible

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

PLAN DESIGN FEATURES	UNITEDHEALTHCARE® (UHC) GROUP MEDICARE ADVANTAGE BASE PLAN	UNITEDHEALTHCARE® (UHC) GROUP MEDICARE ADVANTAGE ENHANCED PLAN	TRADITIONAL 70/30 PLAN*
Diagnostic (e.g., CT, MRI)	\$100		<b>In-network:</b> 30% coinsurance after deductible
Skilled Nursing Facility	Days 1-20: \$0 Days 21-100: \$50/day		<b>In-network:</b> 30% coinsurance after deductible
Chiropractic Visits	\$20		<b>In-network:</b> \$72
Durable Medical Equipment	20% coinsurance		<b>In-network:</b> 30% coinsurance after deductible
SilverSneakers® Fitness Program	Included		Not covered

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

## Pharmacy Benefits

PLAN DESIGN FEATURES	UNITEDHEALTHCARE® (UHC) GROUP MEDICARE ADVANTAGE BASE PLAN	UNITEDHEALTHCARE® (UHC) GROUP MEDICARE ADVANTAGE ENHANCED PLAN	TRADITIONAL 70/30 PLAN*
Pharmacy Out-of-Pocket Maximum	\$2,500 Individual No Family Maximum		\$3,360 Individual \$10,080 Family
<b>RETAIL PURCHASE FROM AN IN-NETWORK PROVIDER</b>			
Tier 1	\$10 copay per 31-day supply		\$16 copay per 30-day supply
Tier 2	\$40 copay per 31-day supply	\$35 copay per 31-day supply	\$47 copay per 30-day supply
Tier 3	\$64 copay per 31-day supply	\$50 copay per 31-day supply	\$74 copay per 30-day supply
Tier 4	25% coinsurance up to \$100 per 31-day supply		10% coinsurance up to \$100 per 30-day supply
Tier 5	N/A		25% coinsurance up to \$103 per 30-day supply
Tier 6			25% coinsurance up to \$133 per 30-day supply
Preferred Diabetic Testing Supplies	\$0*		\$10 copay per 30-day supply**
ACA Preventive Medications	See plan materials for information about ACA covered services, as some require a copay.		N/A
<b>MAINTENANCE DRUGS FROM AN IN-NETWORK PROVIDER—UP TO A 90-DAY SUPPLY</b>			
Tier 1	\$24 copay	\$20 copay	\$48 copay
Tier 2	\$80 copay	\$70 copay	\$141 copay
Tier 3	\$128 copay	\$100 copay	\$222 copay
Tier 4***	25% coinsurance up to \$300	25% coinsurance up to \$200	10% coinsurance up to \$300
Tier 5	N/A		25% coinsurance up to \$309
Tier 6			25% coinsurance up to \$399
ACA Preventive Medications	See plan materials for information about ACA covered services, as some require a copay.		N/A

\* Non-preferred diabetic testing supplies are not covered.

\*\* Non-preferred diabetic testing supplies are paid as Tier 3.

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

# 2017 MONTHLY PREMIUMS

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

If you are a retiree for whom the State of North Carolina pays 100% of the cost of non-contributory coverage based on your years of service, you will not pay a monthly premium for retiree-only coverage under the UHC Group Medicare Advantage (PPO) Base Plan or the Traditional 70/30 Plan. However, you must pay a monthly premium for coverage under the UHC Group Medicare Advantage (PPO) Enhanced Plan.

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

## UHC Group Medicare Advantage (PPO) Base Plan

COVERAGE TYPE	MONTHLY PREMIUM
Retiree Only	\$0
Retiree + Child(ren)	\$124.80
Retiree + Spouse	\$124.80
Retiree + Family	\$249.60

## UHC Group Medicare Advantage (PPO) Enhanced Plan

COVERAGE TYPE	MONTHLY PREMIUM
Retiree Only	\$64.00
Retiree + Child(ren)	\$252.80
Retiree + Spouse	\$252.80
Retiree + Family	\$441.60

## Traditional 70/30 Plan

COVERAGE TYPE	MONTHLY PREMIUM
Retiree Only	\$0
Retiree + Child(ren)	\$155.20
Retiree + Spouse	\$408.08
Retiree + Family	\$444.66

Some people with higher annual incomes must pay an additional amount to Social Security when they enroll in a Medicare plan that provides Medicare Part D prescription drug coverage (e.g., a Medicare Advantage Plan). If you have higher income, federal law requires an adjustment to premiums for Medicare Part B (medical insurance) and Medicare prescription drug coverage. This additional amount is called the “income-related monthly adjustment amount” or IRMAA. This extra amount, if applicable, is deducted from your Social Security check. If you have questions about this extra amount, please contact Social Security at **800-772-1213**.

# RESOURCES TO HELP YOU UNDERSTAND YOUR PLANS AND YOUR CHOICES



## Explore [www.shpnc.org](http://www.shpnc.org)

Visit the State Health Plan website, [www.shpnc.org](http://www.shpnc.org), for news, updates and useful information about your plan choices.



## Outreach Events Coming to a Location Near You!

The State Health Plan will be holding Medicare Outreach Events at various locations this fall to tell you about your 2017 health plan options and review changes to help you make the best choice for 2017. The meeting schedule was included in the *Health Plan Options & Outreach Events Schedule* booklet, which was sent to your home mailbox in August. You can also find the list of meeting dates, locations and times on the State Health Plan website, [www.shpnc.org](http://www.shpnc.org).

**Register online** at [www.shpnc.org](http://www.shpnc.org) to reserve your spot at one of the outreach events. If you do not have access to a computer, you can register by calling **866-720-0114**, Monday through Friday, between 8 a.m. and 5 p.m. ET.



## Learn More by Phone

You can also participate in a Telephone Town Hall meeting.

DATE	TIME
September 22, 2016	7 p.m.
September 28, 2016	3:30 p.m.

Reserve your spot now by visiting [www.shpnc.org](http://www.shpnc.org) and clicking the Telephone Town Hall button at the bottom of the home page.

## Eligibility and Enrollment Support Center: 855-859-0966

During Open Enrollment, October 1-31, the Eligibility and Enrollment Support Center will offer extended hours to help you with any enrollment questions you may have.

Monday-Friday: 8 a.m.-10 p.m. ET and Saturday: 8 a.m.-3 p.m. ET.

See the back cover for more helpful phone numbers.



## HOW TO ENROLL

You can enroll in or change your plan any time from **October 1 through October 31, 2016**—either online or by phone. The choices you make during Open Enrollment are for benefits effective January 1, 2017, through December 31, 2017.



### To enroll online:

- Visit the State Health Plan's website ([www.shpnc.org](http://www.shpnc.org)), click **Enroll Now**, and select **Log into eEnroll through ORBIT**.
- Once you are logged into ORBIT, locate the eEnroll button.



### To enroll by phone:

- During Open Enrollment, call **855-859-0966**, Monday–Friday, 8 a.m.–10 p.m. ET, or Saturday, 8 a.m.–3 p.m. ET.

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

### As you enroll, be sure to:

- Review your dependent information and make changes, if needed.
- Review the benefits you've selected.
- Print your confirmation statement for your records, or ask your phone representative for your reference case number.



### Important: Make Sure Your Information Is Saved

After you have made your choices online in eEnroll 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!**

Remember, you may also elect to drop State Health Plan coverage. As a reminder, you no longer have to experience a qualifying life event to drop coverage outside of Open Enrollment.

# LEGAL NOTICES

## Notice of Grandfather Status

The State Health Plan believes the Traditional 70/30 Plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Customer Service at **888-234-2416**. You may also contact the U.S. Department of Health and Human Services at **www.healthcare.gov**. As a plan “grandfathered” under the Affordable Care Act, cost sharing for preventive benefits may continue as it does currently and be based on the location where the service is provided.

## Notice Regarding Mastectomy-Related Services

As required by the Women’s Health and Cancer Rights Act of 1998, benefits are provided for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. For more information, contact Customer Service at **888-234-2416**.

## 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)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator identified below (the “Coordinator”):

State Health Plan Compliance Officer  
**919-814-4400**

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

U.S. Department of Health and Human Services  
200 Independence Avenue SW.  
Room 509F, HHH Building  
Washington, DC 20201  
**800-868-1019, 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>.

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**.

قدع اسم ال تا ادخ نإف. ةغلل ركذا شدحتت تنك اذا: ةظوح لم  
مقرب لصتا. ن اجم اب 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 નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો **919-814-4400**.

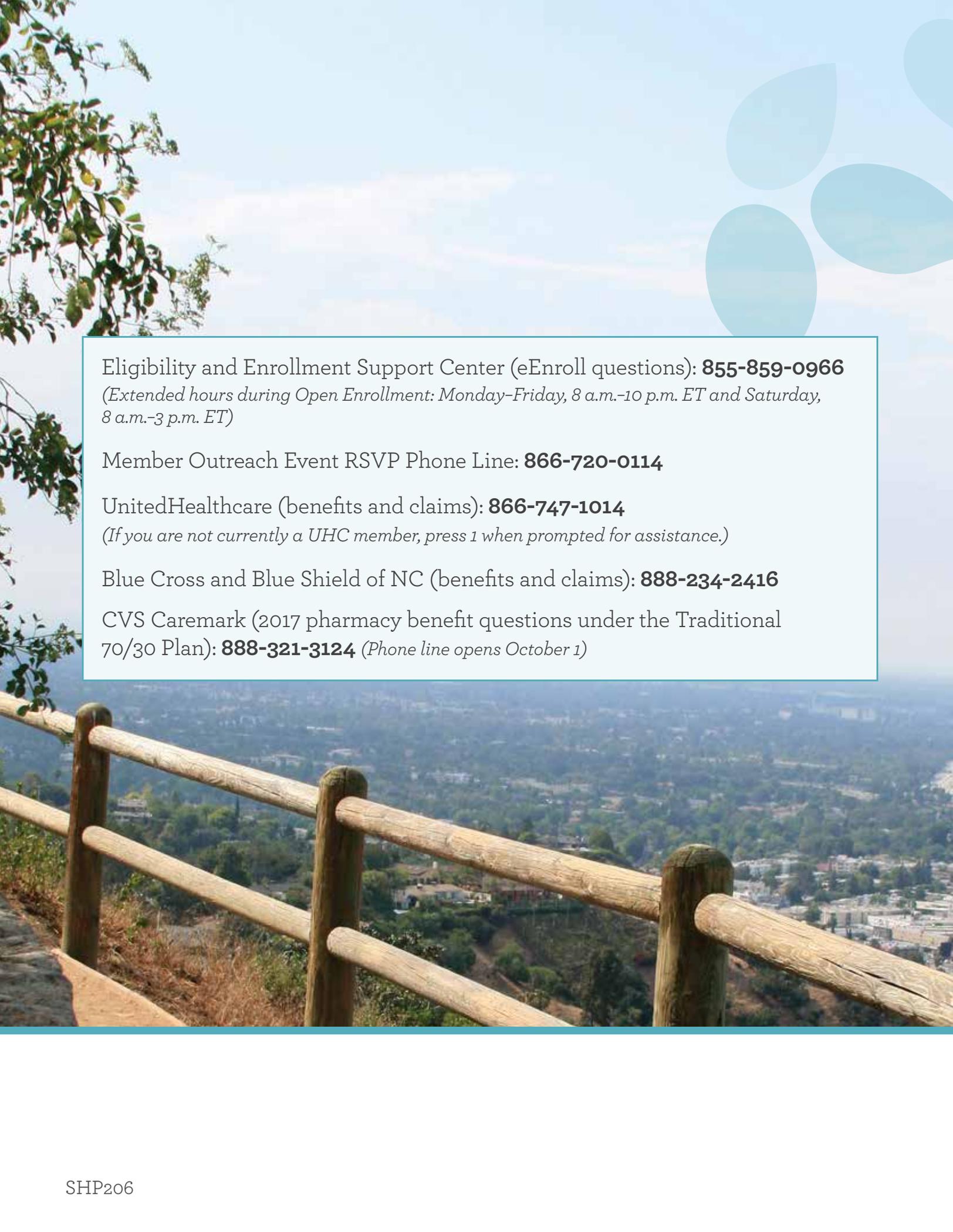
ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសាដោយមិនគិតល្បួលគឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ **919-814-4400**។

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, ໂດຍບໍ່ເສັຽຄ່າ, ດ້ານມີພ້ອມໃຫ້ທ່ານ. ໂທສ **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**。



Eligibility and Enrollment Support Center (eEnroll questions): **855-859-0966**  
*(Extended hours during Open Enrollment: Monday-Friday, 8 a.m.-10 p.m. ET and Saturday, 8 a.m.-3 p.m. ET)*

Member Outreach Event RSVP Phone Line: **866-720-0114**

UnitedHealthcare (benefits and claims): **866-747-1014**  
*(If you are not currently a UHC member, press 1 when prompted for assistance.)*

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

CVS Caremark (2017 pharmacy benefit questions under the Traditional 70/30 Plan): **888-321-3124** *(Phone line opens October 1)*