Medicare-Eligible Members

DECISION GUIDE FOR OPEN ENROLLMENT

September 30-October 31, 2017

This Decision Guide will help you navigate your options for the 2018 benefit year.

READ CAREFULLY!

All Medicare retirees currently enrolled in the 70/30 Plan will be automatically enrolled into the UnitedHealthcare® (UHC) Group Medicare Advantage (PPO) Base Plan effective January 1, 2018. You will need to take action during Open Enrollment if you want to be enrolled in a different plan option.

If you are currently enrolled in a UnitedHealthcare® (UHC) Group Medicare Advantage Plan and are satisfied with that plan, you do NOT need to take any action during Open Enrollment.

2018

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

CHANGES AHEAD!

This is the perfect time to review and update your State Health Plan coverage.

Changes are coming in 2018 for State Health Plan members! The State Health Plan renegotiated the contract with UnitedHealthcare® (UHC) and Medicare Advantage Base Plan rates are **frozen** for 2018! The renegotiated contract includes savings on Plan payments per member, which contributes to the Plan's long-term financial stability. These savings are passed to you in the form of **frozen** monthly premium rates at a time of rising health-care costs.

All Medicare members currently enrolled in the 70/30 Plan will be automatically enrolled into the UnitedHealthcare® Group Medicare Advantage (PPO) Base Plan effective January 1, 2018. You will need to take action during Open Enrollment if you want to be enrolled in a different plan option.

If you are currently enrolled in a UnitedHealthcare® Group Medicare Advantage Plan and are satisfied with that plan, you do NOT need to take any action during Open Enrollment.

Any current Medicare member not enrolled in Medicare Part B as of August 1, 2017, will NOT be automatically enrolled into the Group Medicare Advantage (PPO) Base for January 1, 2018.

As a Medicare-eligible member, you have three plan options to choose from for 2018:

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

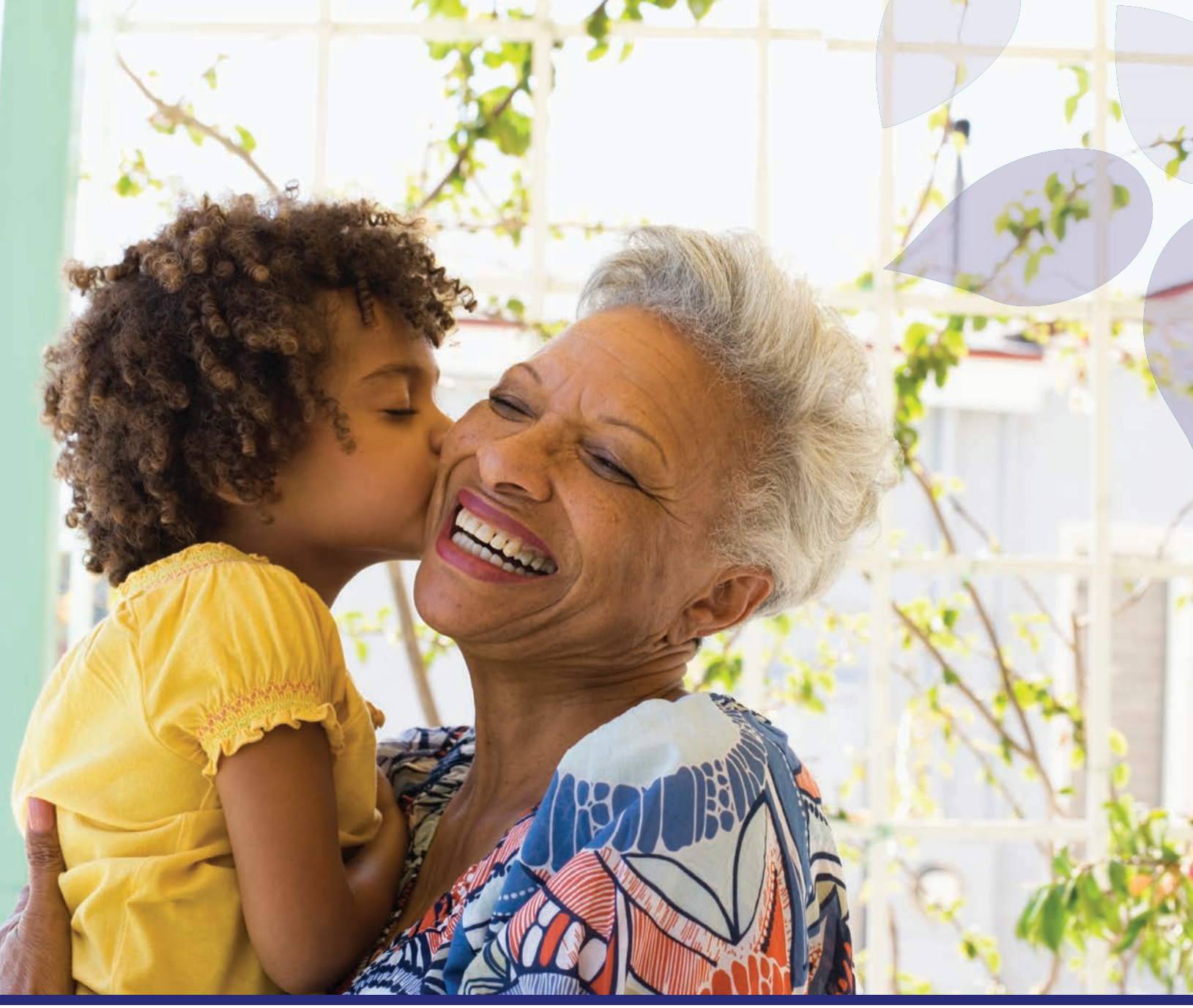
The choices you make during Open Enrollment are for benefits effective January 1, 2018, through December 31, 2018.

If you have non-Medicare Primary dependents on your plan, they have different options which include the 80/20 Plan and the 70/30 Plan. More information regarding these plan options is available at **www.shpnc.org**.

Questions?

We're here to help. See the back cover for the Eligibility and Enrollment Support Center and other important numbers.

If you are a retiree and wish to change your plan, you must do so during Open Enrollment. You may also elect to drop State Health Plan coverage. You no longer have to experience a qualifying life event to drop coverage outside of Open Enrollment.



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. You must have both Medicare Parts A and B in effect to be enrolled in one of the UHC Group Medicare Advantage (PPO) Plans.

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

UHC Group Medicare Advantage (PPO) Plans Key Facts

- The UHC Group Medicare Advantage (PPO) Plans offer **simplicity**:
  - When you enroll, you have one plan, with one ID card, for both medical and prescription drug coverage.
  - Although you remain in the Medicare program, UnitedHealthcare administers the Medicare Advantage plan, which includes all of the benefits of Original Medicare, along with additional features and programs.

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

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

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

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

- Your UHC Group Medicare Advantage (PPO) Plan coverage includes **Medicare Prescription Drug coverage (Medicare Part D) with no coverage gap** (meaning there is no donut hole). Therefore, you do not need a stand-alone Medicare Part D Plan.
  - If you currently have a Medicare Part D or another Medicare Advantage Plan, and choose one of the State Health Plan's UHC Group Medicare Advantage (PPO) Plan options the Centers for Medicare and Medicaid Services (CMS) will disenroll you from the other plan(s) as of January 1, 2018.
- **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.
- **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.

Important Features That Are NOT Changing for 2018

The medical benefits provided by the UHC Group Medicare Advantage (PPO) Plans in 2018 are the same as those provided by the plans in 2017.

If you choose to enroll in a UHC Group Medicare Advantage (PPO) Plan for 2018, you can see any provider (in-network or out-of-network) that participates in Medicare and accepts Medicare assignment. Your copays or coinsurance stay the same.

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

THE 70/30 PLAN

The 70/30 Plan is a PPO Plan where you pay 30% coinsurance for eligible in-network services. 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 70/30 Plan will be secondary. After you meet the 70/30 annual deductible (if applicable), the plan pays its share toward your eligible expenses, up to the amount that would have been paid if the plan provided your primary coverage. You pay any copays or coinsurance, as applicable. The 70/30 Plan includes prescription drug coverage as well.

The 70/30 Plan and Medicare

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

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

The medical benefits provided by BCBSBC in 2018 are the same as those provided by the plans in 2017.

The 70/30 Plan Pharmacy Benefit Reminders

- Remember that the 70/30 Plan utilizes a closed formulary, or drug list. This means that certain drugs are not covered. The formulary is updated on a quarterly basis so there is always a possibility that your medication could become a non-covered drug.
- If you are taking a non-preferred brand name drug, specialty medication or a non-covered medication that was approved for coverage through an exceptions process, you will be subject to a Tier 3 or Tier 6 copay. Under the 70/30 Plan, a Tier 3 copay is $74 and Tier 6 is a 25% coinsurance to a maximum of $133.
- **Medications that are subject to coinsurance in most cases will result in higher out-of-pocket costs to members.** Be sure to check the tier level of any of your maintenance medications by calling the Plan's Pharmacy Benefit Manager, CVS Caremark Customer Service at 888-321-3124, prior to making your 2018 health plan choice. Remember to always discuss your prescription options with your provider.

STRENGTHEN OPIOID MISUSE PREVENTION (STOP) ACT:

Under North Carolina's new STOP Act, effective January 1, 2018, prescribers of controlled substances are limited to issuing only a 5-day supply of an opioid or narcotic medication for the initial treatment of acute pain (or a 7-day supply after surgery). This requirement does not apply to cancer care, palliative care, hospice care, chronic pain management or medication-assisted treatment for substance use disorders. If you are suffering with acute pain, please check with your health care provider prior to the end of this year to make sure your current medication therapy isn't interrupted.

See the plan comparison chart on pages 8-9 for a detailed comparison of 2018 benefits under all three of your plan options.

2018 STATE HEALTH PLAN COMPARISON



Medical and Hospital Benefits

PLAN DESIGN FEATURES	UHC GROUP MEDICARE ADVANTAGE BASE PLAN	UHC GROUP MEDICARE ADVANTAGE ENHANCED PLAN	70/30 PLAN*
Use of Network Providers	You can see any provider (in-network or out-of-network) that participates in Medicare and accepts Medicare assignment. Your copays or coinsurance stay the same.		You pay less when you use BCBSNC network providers.
Annual Deductible	$0		**Individual:** $1,080 in-network $2,160 out-of-network **Family:** $3,240 in-network $6,480 out-of-network
Coinsurance	Most covered services require only a copay; however, some services require coinsurance (usually 20%).		**In-network:** 30% of eligible expenses after deductible **Out-of-network:** 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).	**Individual:** $4,388 in-network $8,776 out-of-network **Family:** $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).
ACA Preventive Services	See plan materials for information about ACA covered services, as some require a copay.		**In-network:** $40 for primary doctor; $94 for specialist
Office Visits	$20 for primary doctor; $40 for specialist	$15 for primary doctor; $35 for specialist	**In-network:** $40 for primary doctor; $94 for specialist

Medical and Hospital Benefits, continued

PLAN DESIGN FEATURES	UHC GROUP MEDICARE ADVANTAGE BASE PLAN	UHC GROUP MEDICARE ADVANTAGE ENHANCED PLAN	70/30 PLAN*
Lab Services	$40 copay; if lab test performed and processed in doctor's office, $0 copay	$20 copay; if lab test is performed and processed in doctor's office, $0 copay	In-network: 30% coinsurance, Out-of-network: 50% coinsurance; if performed during PCP or Specialist office visit, no additional fee if in-network lab used.
Urgent Care	$50	$40	$100
Emergency Room (Copay waived w/admission or observation stay)	$65		**In-network:** $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	**In-network:** $337 copay plus 30% coinsurance after deductible
Outpatient Hospital	$125	$100	**In-network:** 30% coinsurance after deductible
Diagnostic (e.g., CT, MRI)	$100		**In-network:** 30% coinsurance after deductible
Skilled Nursing Facility	Days 1-20: $0 Days 21-100: $50/day		**In-network:** 30% coinsurance after deductible
Chiropractic Visits	$20		**In-network:** $72
Durable Medical Equipment	20% coinsurance		**In-network:** 30% coinsurance after deductible
SilverSneakers® Fitness Program	Included		Not covered

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

Pharmacy Benefits

PLAN DESIGN FEATURES	UHC GROUP MEDICARE ADVANTAGE BASE PLAN	UHC GROUP MEDICARE ADVANTAGE ENHANCED PLAN	70/30 PLAN*
Pharmacy Out-of-Pocket Maximum	$2,500 Individual No Family Maximum		$3,360 Individual $10,080 Family
RETAIL PURCHASE FROM AN IN-NETWORK PROVIDER			
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*	N/A		$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
MAINTENANCE DRUGS FROM AN IN-NETWORK PROVIDER—UP TO A 90-DAY SUPPLY			
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 paid as Tier 3.*

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

Some high-cost generic drugs will be covered in a different tier than in 2017. For questions about the coverage of a specific drug, call UHC at **866-747-1014**, TTY 711 8 a.m. - 8.p.m. local time, 7 days a week.

2018 MONTHLY PREMIUMS

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

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

UHC Group Medicare Advantage (PPO) Base Plan

COVERAGE TYPE	MONTHLY PREMIUM
Subscriber Only	$0
Subscriber + Child(ren)	$124.00
Subscriber + Spouse	$124.00
Subscriber + Family	$248.00

UHC Group Medicare Advantage (PPO) Enhanced Plan

COVERAGE TYPE	MONTHLY PREMIUM
Subscriber Only	$66.00
Subscriber + Child(ren)	$256.00
Subscriber + Spouse	$256.00
Subscriber + Family	$446.00

70/30 Plan

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

Some people with higher annual incomes must pay an additional amount to Social Security when they enroll in a Medicare plan that provides Medicare Part D prescription drug coverage (e.g., a Medicare Advantage Plan). If you have higher income, federal law requires an adjustment to premiums for Medicare Part B (medical insurance) and Medicare prescription drug coverage. This additional amount is called the "income-related monthly adjustment amount" or IRMAA. This extra amount, if applicable, is deducted from your Social Security check or direct billed to you by the federal government if you are not collecting Social Security benefits.. If you have questions about this extra amount, please contact Social Security at **800-772-1213**.

RESOURCES TO HELP YOU UNDERSTAND YOUR PLANS AND YOUR CHOICES

Explore www.shpnc.org

Visit the State Health Plan website, **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 2018 health plan options and review changes to help you make the best choice for 2018. The meeting schedule was included in the *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**.

Learn More by Phone

You can also participate in a Telephone Town Hall meeting.

DATE	TIME
Medicare Retirees – Sept. 25	7 p.m.
Medicare Retirees – Sept. 29	2 p.m.
Non-Medicare Retirees – Oct. 4	7 p.m.

Reserve your spot now by visiting **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, September 30-October 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.–noon. ET.

See the back cover for more helpful phone numbers.

HOW TO ENROLL

You can enroll in or change your plan any time from September 30 through October 31, 2017—either online or by phone. The choices you make during Open Enrollment are for benefits effective January 1, 2018, through December 31, 2018.

To enroll online:

- Visit the State Health Plan's website (**www.shpnc.org**), click **Enroll Now/Access Benefits**, 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.– noon ET.

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

As you enroll, be sure to:

- Review your dependent information and make changes, if needed. Remember, if you are adding a new dependent you will need to provide a Social Security number and will be prompted to upload required documentation.
- Confirm that you have a physical address and not just a PO Box to ensure you receive all mailings.
- Review the benefits you've selected.
- Print your confirmation statement for your records, or ask your phone representative for your reference case number.

Important: Make Sure Your Information Is Saved

After you have made your choices online in 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! You will see a green congratulations notice when you have successfully completed your enrollment election.**

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

This booklet provides a brief summary of plan benefits. Refer to the applicable benefit plan summary for more detail, which will be mailed by the applicable provider this fall. In the event of a discrepancy between the information in this booklet and the plan benefits booklet, the information provided in the plan benefits booklet will govern.

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**.

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**.

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ **919-814 4400**.

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

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

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັ ຽຄ່າ, 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**.

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State Health Plan
3200 Atlantic Avenue
Raleigh, NC 27604

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If you are currently enrolled in a UnitedHealthcare® (UHC) Group Medicare Advantage Plan and are satisfied with that plan, you do NOT need to take any action during Open Enrollment.

SHP309

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.– noon ET)

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

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

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

CVS Caremark (pharmacy benefit questions under the 70/30 Plan): **888-321-3124**