STATE HEALTH PLAN

Health Benefits Representative Quick Guide

2026

This guide features information for Health Benefits Representatives (HBRs) who work with the State Health Plan. This guide is updated as needed, so check back often.







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

September 2025

STATE HEALTH PLAN ACRONYMS

HBR	Health Benefits Representative
COBRA	Consolidated Omnibus Budget Reconciliation Act
QLE	Qualifying Life Event
PCP	Primary Care Provider
ESRD	End Stage Renal Disease
OE	Open Enrollment
NCGS	North Carolina General Statutes
RIF	Reduction In Force
SSO	Single Sign-On
SSN	Social Security Number

ROLES & RESPONSIBILITIES

The Health Benefits Representative (HBR) plays a vital role in administering the State Health Plan (Plan).

YOU ARE THE MAIN AVENUE THROUGH WHICH MEMBERS RECEIVE THEIR BENEFIT INFORMATION.

The employee also plays an essential role in following State Health Plan guidelines to ensure an understanding of their health plan benefit, its accuracy, and the timeliness of enrollment.

Please note: If you are an HBR for a state agency, your role is slightly different. State "designated Central Agency HBRs" have view-only access to eBenefits, the Plan's enrollment system. BEST Shared Services has administrative access. Please contact BEST Shared Services for more information regarding your role.

HBR ROLE

ATTEND training to obtain an understanding of State Health Plan rules and benefits.

USE the tools and resources provided by the State Health Plan.

COMMUNICATE benefits and eligibility information to employees.

SUBSCRIBE to the State Health Plan monthly e-newsletter, HBR Update.

EDUCATE employees on how to use the online enrollment system, eBenefits. **eBenefits is a self-service system** and HBRs should NOT process enrollments or life event changes for employees. New HBRs must complete the **required training** before receiving access to eBenefits. Failure to follow policy rules may result in removal of eBenefits access.

PERFORM employee benefits data management, including processing new hires, employee terminations, managing tasks in the eBenefits system, and Open Enrollment.

OBTAIN documentation to verify the eligibility of dependents being added to health coverage and to confirm that a status change meets the definition of a qualifying life event as defined by Section 125.

RECONCILE group premium statements and remit group fees.

COLLECT the member premium for active employees, including while an employee is on a leave of absence (LOA), family and medical leave (FMLA) or Workers' Compensation (WC) for those groups that do not use iTEDIUM for their direct bill population.

NOTIFY the State Health Plan of any HBR personnel changes by emailing HBRInquiries@nctreasurer.com or by filling out the Contact and Access Request Form.

STATE HEALTH PLAN VENDORS

The State Health Plan works closely with a large network of vendor partners to administer benefits and services. For a complete list, visit the Plan's contracted vendors page on the Plan's website. Below are the Plan's main member-facing vendor partners.

ELIGIBILITY AND ENROLLMENT SERVICES (EES)

Benefitfocus, the Plan's EES vendor, is responsible for managing the Plan's eligibility rules, accurately transmitting and receiving enrollment with the Plan's other service vendors and providing telephonic member enrollment. The Eligibility and Enrollment Support Center is also managed by Benefitfocus. The call center is available each state business day between 8 a.m. and 5 p.m. to assist Plan members as well as HBRs through the account management team.

THIRD PARTY ADMINISTRATOR (TPA)

Aetna, the Plan's TPA, provides a statewide network for members, administers the Plan's network, provides medical management, processes claims and claim appeals, and provides customer service for claims issues. The Plan is self-funded, which means taxpayers and Plan members, not Aetna, fund the claims.

MEDICARE ADVANTAGE PRESCRIPTION DRUG PLAN (MAPDP)

Humana is the Plan's MAPDP. This is a fully insured product, which means Humana is at full risk for these claims. The claims are funded by Humana, which means the checks are written on Humana paper.

PHARMACY BENEFITS MANAGER (PBM)

CVS is the Plan's PBM that processes pharmacy claims. While the PBM is also self-funded, the reimbursement model for the PBM is different because the member pays for the pharmacy claim at point of sale (at the pharmacy). The PBM pays the pharmacy, and the Plan reimburses the PBM.

COBRA ADMINISTRATION AND BILLING SERVICES (CABS)

iTEDIUM is the Plan's CABS vendor. Like the TPA, the CABS services are self-funded. Checks are written off the Plan's bank accounts and are on Plan paper.



HBR TRAINING

New HBRs and other individuals requiring access to the enrollment system, eBenefits, or eBilling, must follow this process:

1. Complete the Health Benefits Representative Contact and Access Request Form on the Plan's website.
2. A member of the HBR Support team will grant access and notify the HBR via email with their login information. eBilling login, if applicable, will be provided as well.
   Note: If you already have access to eBilling, but have forgotten your login information, please contact iTEDIUM directly at 855-552-6272 or GroupBilling@iTEDIUM.com.

All training opportunities are located on the Plan's website in the HBR section, under Training and Development, along with other training documents to help with your HBR duties. Webinars are offered periodically throughout the year on a variety of topics.

HBR RESOURCES

THE PLAN AND ITS PARTNERS OFFER SUPPORT AND SEVERAL RESOURCES FOR HBRs.

For **A COMPLETE LIST OF WHO TO CALL**, view the Contact Information for HBRs.

The **STATE HEALTH PLAN WEBSITE** at **www.shpnc.gov** has a wealth of information that is critical in understanding benefits, rules and processes.

BENEFITS BOOKLETS are available on the Plan's website at **www.shpnc.gov** under Employee Benefits. This is a great tool to assist you in understanding Plan benefits.

HBR SUPPORT Benefitfocus, the Plan's Eligibility and Enrollment vendor, is committed to providing HBRs immediate access to support. To ensure you are able to receive prompt assistance, Benefitfocus uses One Place 365. This platform provides a secure avenue for issues or questions.

For eBilling support, please contact iTEDIUM directly at 855-552-6272 or GroupBilling@iTEDIUM.com. You may also contact the HBR Support Line at 800-422-5249. Groups with dedicated account managers may contact their account manager.

For issues that are not resolved in a timely manner and need to be escalated, please contact the Plan office at 919-814-4400 or HBRInquiries@nctreasurer.com. **Please do not email Plan staff directly.**

GOVERNANCE OF PLAN RULES

THE STATE HEALTH PLAN IS GOVERNED BY NORTH CAROLINA GENERAL STATUTE (NCGS) 135 ARTICLE B.
GROUPS MUST ADHERE TO THE RULES ESTABLISHED FOR THE PLAN.
To view the legal statute, visit **www.shpnc.gov**, click About the State Health Plan, and scroll down to Legal Statutes.

INVOICE AND PAYMENT

iTEDIUM is the State Health Plan's billing vendor. You will receive your invoice through the eBilling System.

The eBilling Guide and eBilling HBR Training are available under the HBR tab, Payroll and Billing.

Monthly invoices are mailed in advance of the due date and break down the total monthly charges for your group.

For questions about group premiums, contact the billing administrator at GroupBilling@iTEDIUM.com or by phone at 1-855-552-6272.

PAYING YOUR MONTHLY INVOICE

All groups must pay as billed; your billed amount is firm. Deviating from the total amount will result in a balance forward on your next statement and may result in claims suspension and group delinquency.

The Plan operates on a pre-pay basis. All premiums are due by the first of each effective month. Claims for services incurred for a group after the current effective month may not be paid until the past due payment has been received.

HEALTH PLAN OPTIONS

The State Health Plan offers two Preferred Provider Organization (PPO) plans for permanent employees.

These plans are administered by Aetna.

- The Standard PPO Plan
  (formerly known as the Base PPO 70/30 Plan)
- The Plus PPO Plan
  (formerly known as the Enhanced PPO 80/20 Plan)

For detailed plan information, visit the Plan's website at **www.shpnc.gov** and select Plans for Active Employees.

The Plan also offers a High Deductible Health Plan (HDHP) for eligible full-time non-permanent employees. Information regarding this plan can be located on the Plan's website.

ELIGIBILITY AND ENROLLMENT FOR PERMANENT EMPLOYEES

For complete eligibility information, review the Eligibility section in the benefits booklets. Visit the Plan's website at **www.shpnc.gov**, click Employee Benefits, and select the appropriate plan and booklet.

Employees with permanent employment are those working at least 30 hours per week for nine or more months per calendar year. Employees are eligible for the employer shared amount.

For permanent state employees working 20 or more hours but less than 30 hours per week, these employees may enroll, but they must pay the full cost of coverage.

DEPENDENTS

Eligible dependents include the following:

- Legal Spouse
- A child under age 26 including biological, legally adopted, foster, and children for whom the employee is a court-appointed guardian and stepchildren of the employee.
- A dependent child over the age of 26 if he or she is disabled to the extent that he or she is incapable of earning a living. The handicap must have developed or begun to develop before the dependent's 26th birthday if the dependent was covered by the State Health Plan.

  When requesting an extension of coverage, employees should complete the Coverage Request for a Dependent Child with a Disability available on the Plan's website and contact the Eligibility and Enrollment Support Line if they have questions. The form must be approved prior to the termination date.

MEMBERS ARE REQUIRED TO PROVIDE THEIR HBR WITH DOCUMENTATION TO VERIFY THE ELIGIBILITY OF ALL DEPENDENTS ADDED TO HEALTH COVERAGE.

View the list of acceptable documents on the Plan's website in the HBR tab by clicking Enrollment Information and then Required Documentation for Qualifying Life Events & Dependent Eligibility.

ENROLLMENT

New employees must enroll themselves and dependents within 30 days of their date of hire. The new permanent employee has the choice to enroll:

- the first of the month following their hire date or
- the first of the second month following their hire date

For more information, see the Health Benefits Representative's Enrollment Information section of the Plan's website at **www.shpnc.gov**.

OPEN ENROLLMENT

During Open Enrollment, which typically takes place in October, employees can re-evaluate their health care needs for the upcoming benefit year that runs January 1 – December 31. They may enroll in the State Health Plan, switch between plans, and add or remove dependents without a qualifying life event.

The Plan mails materials to enrolled members only. HBRs are responsible for sending OE information to all employees.

QUALIFYING LIFE EVENTS

The State Health Plan must adhere to rules for making midyear changes under Section 125 of the Internal Revenue Code and NCGS 135 Article B. These events, called Qualifying Life Events (QLE), allow members to make certain coverage changes, such as adding/dropping dependents, canceling coverage, or enrolling in coverage.

Under the "general consistency rule," an election change must satisfy the consistency requirement: "If the election change is on account of and corresponds with a change in status that affects eligibility for coverage under an employer's plan." Regulations do not permit midyear election changes for family members who are not affected by the change in status, such as unaffected children in a case of loss of dependent child status.

The benefits booklets provide a list of QLEs. If you have questions about what changes can be made, please call the HBR Support line at 800-422-5249, create a case via One Place 365, or reach out to your Account Manager.

Employees must provide supporting documentation to their HBR to verify the qualifying life event in accordance with State Health Plan policy within 30 days of the QLE or 60 days of becoming entitled to or losing eligibility for Medicaid or the Children's Health Insurance Program (CHIP). See the State Health Plan Required Documentation for Qualifying Life Events & Dependent Eligibility for a list of acceptable documentation.

HOW DO EMPLOYEES ENROLL IN PLAN BENEFITS?

Permanent employees enroll through eBenefits, managed by the Plan's Eligibility and Enrollment vendor Benefitfocus. To access eBenefits, go to the State Health Plan's website at **www.shpnc.gov** and click **eBenefits**. Call the Eligibility and Enrollment Support Center at 855-859-0966 for assistance.

IMPORTANT NOTES:

- HBRs are provided with access to the eBenefits system once they have completed the required training. Review the process outlined on the Plan's website in the Training and Development section.
- Dependents over 6 months of age must have a valid, unique Social Security number (SSN). In the event a dependent doesn't have an SSN, Benefitfocus can generate a dummy SSN. This is ONLY an option for dependents that are not eligible for an SSN or a Tax Identification Number (TIN), such as foreign nationals. This does NOT apply to members that are adding dependents and just don't have the SSN with them at the time the dependent is being added. In this case, members must wait until they have the SSN before adding the dependent. Newborn dependents can be added without a SSN and the SSN can be added as soon as it has been issued. The HBR may also reach out to HBR Support to have a dummy SSN created.
- Premiums are taken out pre-tax. If the employee wishes to have premiums paid on an "after-tax" basis, he/she must complete the Enrollment for Flexible Benefit Plan (IRS Section 125) for the State Health Plan form and return it to their HBR within their enrollment period. The next opportunity for them to change this election is Open Enrollment. A member who changes to an after-tax basis is still subject to the same rules for when health plan changes can be made. Refer to the Qualifying Life Events section.
- Enrollments are not sent to vendors until the HBR approves the enrollment task.

RESOURCES FOR NEW EMPLOYEES

Refer to the resources located in the New Employee Resources section of the Plan's website. These are great resources for your employees, and also help you become knowledgeable on benefits and assist employees when they have questions about their benefits and how to enroll.

ID CARDS

If the member is enrolling on or after their effective date, they will receive their ID card in the mail within 10 days of enrollment and approval by the HBR. ID cards serve as both medical and prescription drug cards. Each member will also receive their own ID card with their own assigned Primary Care Provider (PCP), if selected, printed on the front of the ID card.

For additional cards a member can contact Aetna at 833-690-1037, or follow the instructions to request a new card.

WHEN COVERAGE ENDS

Please see the rules located on the Plan's website in the HEALTH BENEFITS REPRESENTATIVE SECTION Enrollment Information and in the BENEFITS BOOKLETS available on the website **www.shpnc.gov**.

ENROLLMENT EXCEPTIONS AND APPEALS POLICY

To ensure consistency and adherence to state and federal legislation, transactions for new hire enrollments, adding/dropping dependents for QLEs, and processing terminations must be completed in a timely manner.

Please take time to review the Exceptions Process section on the Plan's website under the Health Benefits Representative tab as well as the SHP Rule on Enrollment Exceptions and Appeals policy located on the same page.

Changes within Plan rules can be processed by contacting the HBR Support line. For example, if the HBR processed an employee termination date for effective 1/31 and it needs to be corrected to 2/28.

ELIGIBILITY FOR HEALTH COVERAGE WHILE ON A LEAVE OF ABSENCE

ELIGIBILITY FOR FULLY CONTRIBUTORY

An employee on official leave of absence without pay may elect to continue coverage provided that they pay the full employee and employer contribution to the group during the leave period. Because of this rule, a leave of absence event does not generate a COBRA offer notice.

ELIGIBILITY FOR PARTIAL CONTRIBUTORY

These include:

- Employees on official leave of absence while completing an approved full-time program in school administration as a Principal Fellow.
- Employees on approved leave of absence with pay or receiving workers' compensation. If employee is receiving workers' compensation, but separated from service (i.e., no longer an employee) then they are no longer eligible for State Health Plan benefits.
- Employees on approved leave under the Family and Medical Leave Act of 1993 (FMLA).

Please review the SHP Policy on Arrears on the website for information on the arrears rules for the State Health Plan. This is for when a member is in a category that requires the member to be responsible for paying the full premium or a portion of the premium directly to the group or the Plan's billing vendor.

It is important to let the member know as indicated on the policy that, if their coverage is canceled for nonpayment, they cannot be reinstated, even with a qualifying life event (QLE) that otherwise under Section 125 would allow for an eligible member who is not covered to enroll. Any member whose coverage is canceled for non-payment of premium will be eligible to enroll during the next Open Enrollment period.



ELIGIBILITY FOR HEALTH COVERAGE WHILE ON DISABILITY

Former employees who are receiving disability benefits are eligible for the benefit provisions of the State Health Plan. Coverage for these people will cease, however, as of the end of the month in which the former employee is no longer eligible for disability retirement benefits.

SHORT-TERM DISABILITY

An employee with five years or more of retirement membership services is eligible on a partial contributory basis under the active group.

An employee with less than five years of retirement membership services is eligible on a fully contributory basis under the active group.

EXTENDED SHORT-TERM DISABILITY

An employee with less than five years of retirement membership services is eligible on a fully contributory basis under the active group.

An employee with five years or more of retirement membership services is eligible under the Retirement Systems Division.

LONG-TERM DISABILITY

Long-Term Disability employees must have five years or more of retirement membership services to be eligible under the Retirement Systems Division.

THE RETIREMENT SYSTEMS DIVISION FOLLOW THIS RULE FOR WHEN AN EMPLOYEE IS ELIGIBLE FOR HEALTH COVERAGE UNDER THEIR GROUP:

If the disability effective date is:

1ST – 15TH OF THE MONTH
Member's benefit effective date will be first of following month. *Example:* Member with hire date 4/12 will get benefits 5/1

16TH – 31ST OF THE MONTH
Member's benefit effective date will be first of month after the following month. *Example:* Member with hire date 6/22 will get benefits 8/1

The effective date of their health coverage is dependent upon the date that is sent on the file to Benefitfocus. The terminated employee would need to obtain COBRA coverage in order to avoid any gaps in coverage.

Please note that retroactive coverage under the Retirement Systems Division for employees who are approved for disability at a later date is permitted. For example, if an employee is termed in June and is approved for extended short-term or long-term disability benefits in November retroactive to July, the employee will be retroactively enrolled into health coverage effective in July and the member will be responsible for all retro premiums.

It is important that you do not carry employees beyond their short-term disability benefit period while they are waiting for approval for extended short-term or long-term disability.

GROUPS THAT ELECT TO CONTINUE COVERAGE ARE RESPONSIBLE FOR PREMIUMS AND WILL NOT BE REFUNDED.

HBRs can cancel the member's coverage by terminating employment involuntarily since they are no longer eligible under the active group. Timely terminations will allow a COBRA notice to generate, which employees will need to avoid a gap in coverage while waiting for coverage to be effective under the Retirement Systems Division.

GROUP TRANSFERS

Employees of non-FIORI groups who transfer from one group to another are not automatically re-enrolled under the new group. Employees should complete enrollment within 30 days of their employment date with the group. The coverage effective date is the first day of the first month or second month following date of employment.

Health coverage for FIORI employees who transfer to another FIORI group automatically carries over.

MEDICARE FOR ACTIVE MEMBERS AND DEPENDENTS

When an Employee or Dependent becomes eligible for Medicare, this information should be updated within the Manage Medicare section under the "Manage Employee" tab in eBenefits.

A member can become eligible for Medicare due to:

- Age 65
- Disability
- End Stage Renal Disease (ESRD)

The State Health Plan mails a Medicare eligibility letter to employees and their dependents prior to their 65th birthday, detailing coverage options. If they determine they want to drop Plan coverage when they become Medicare eligible, this must be done within 30 days of the QLE, which is the first of the month that they are Medicare eligible.

Medicare is only primary for members under active groups:

- The last month that a retiree is still covered by the active group prior to being enrolled in the State Retirement Systems.
- Members with End Stage Renal Disease (ESRD) following the 30-month SHP primary period.
- Former employees who are receiving the 12-month reduction in force (RIF) health coverage.

For details, see the Benefit Coordination with Medicare section in the benefits booklets on **www.shpnc.gov**

CONTINUATION OF COVERAGE

COBRA

Federal COBRA Continuation Law applies to employer groups covering 20 or more employees. This law generally allows eligible enrollees the right to continue coverage under the employer group health plan for up to 18 months after they are no longer employed by your group. Coverage may extend up to 36 months in special circumstances.

iTEDIUM is the Plan's COBRA and billing vendor.

New hires and spouses upon enrollment into the Plan will receive the Notice of Initial COBRA Rights. This notice is intended to inform the members of their potential future options and obligations under the continuation coverage provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

A COBRA notice is sent when a qualifying event such as a termination occurs. To view COBRA rates, go to **www.shpnc.gov**, click on Plans for Active Employees, select the plan you want to view and click on 100% Contributory Non-Medicare COBRA Subscribers and Other 100% Contributory Subscribers or visit the COBRA Plan Overview for detailed information.

SURVIVING DEPENDENTS OF ACTIVE EMPLOYEES

Spouses of deceased members are eligible to continue coverage on a fully contributory basis if they were covered at the time of the member's death and enroll within 90 days. Surviving spouses are eligible for life provided their premiums are paid. Surviving dependent children who are covered by the State Health Plan at the time of employee's death are entitled to coverage as a surviving dependent.

Benefitfocus will mail the offer notice to surviving dependents of active employees instructing them to call the Plan's Eligibility and Enrollment Support Center at 855-859-0966 if they want to continue coverage. Letters are mailed monthly, the surviving dependent will receive it at the beginning of the month after the death event is processed in the system. Surviving dependents do not have to wait to receive the letter. As long as the event has been processed they may call the Eligibility and Enrollment Support Center, and Benefitfocus will set up the shell for the surviving spouse ahead of the letter being received.

REDUCTION IN FORCE (RIF) EMPLOYEES

Employees who lose their jobs as a result of a reduction in force (RIF) will continue to have coverage for up to 12 months, as long as the employee was covered by the State Health Plan at the time of separation from service and has 12 or more months of service or completed a contract term of employment of 10 or 11 months as an employee of a local school administrative unit.

For detailed information on the RIF benefit and the process for termination and enrollment, please refer to the guide located in eBenefits under Resources.

RETIREMENT PROCESS

EMPLOYEES CAN SUBMIT PAPERWORK TO THE RETIREMENT SYSTEMS AS EARLY AS 120 DAYS PRIOR TO THEIR RETIREMENT DATE.

HBRs should term employees as soon as the employee notifies them of their retirement date. To prevent dual coverage, there is an enrollment rule that prevents the system from enrolling a member into a new group if their health coverage has not been termed from their previous group.

HOW TO RETIRE A MEMBER THAT IS MOVING TO THE RETIREMENT SYSTEMS

Refer to guide located in eBenefits under Resources.

RETIRING MEMBERS AND MEDICARE

Medicare becomes primary the last month that a retiring member is covered by the active group. Please notify your employees of the primacy change and the need to elect Medicare Part B to be effective the date of their retirement.

AUTO-ENROLLMENT PROCESS

All retirees who are eligible for State Health Plan coverage will be automatically enrolled into a plan once the Retirement Systems has processed their Form 6E. Retirees are auto-enrolled into a plan regardless of the contribution status or if they did not have coverage as an active employee. Please review the Planning for Retirement webpage for information on the auto-enrollment process.

For more information on retirees and their health coverage, review the Understanding Your State Health Plan Benefits at Retirement information located on the Plan's website. There are also webinars held monthly HBRs and members can attend on this topic.

REHIRED RETIREES

NC General Statute 135-48.41(j) requires employers to provide health coverage to retirees that work in a position that makes them eligible for the employer paid contribution for the State Health Plan *(works 30 hours or more)*.

While the rehired retiree is not required to enroll in a plan under the employer, the retiree is no longer eligible for the State Health Plan retiree group coverage under the Retirement Systems. They are eligible to enroll under the active group, the first of the month following their hire date.

These individuals are still receiving a retirement benefit and therefore still retired. HBRs should follow the process to complete the form and see a list of step-by-step instructions for the form.

Once they are no longer employed with the active group, the loss of coverage is a qualifying life event that allows the retiree to re-enroll under the Retirement Systems. The retiree can enroll online by using the "loss of other coverage" qualifying life event or by calling the Eligibility and Enrollment Support Line for assistance within 30 days the event.

To enroll in the Medicare Advantage plan, if eligible, they must process the re-enrollment before the effective date of health care under the Retirement Systems. The Plan cannot send retroactive enrollments for a Medicare Advantage plan. Please note that part-time rehired retirees are eligible to remain on health coverage under the Retirement Systems.

THIRD PARTY RECOVERY (SUBROGATION)

The State Health Plan has the right of subrogation upon its injured members' right to recover from liable third parties. The Plan's objective is to recover medical expenditures incurred by the Plan where a third party is liable for the care.

Members should contact Rawlings which has been contracted by the Plan to perform subrogation services, at 877-229-0872, to determine whether the Plan is claiming a right to recovery.

For more information please see the Subrogation and Recovery section on the Plan's website. You may also find additional information in the Right of Recovery/Subrogation Provision section in each of the benefits booklets available at **www.shpnc.gov**.

HIGH DEDUCTIBLE HEALTH PLAN (HDHP) FOR NON-PERMANENT EMPLOYEES

The North Carolina General Assembly approved legislation to create a health benefit to comply with the federal Affordable Care Act (ACA). The High Deductible Health Plan (HDHP) benefit option is available only to employees eligible for coverage under G.S. §135 48.40(e).

Employees are considered full-time, and thus required to be offered employer-sponsored health care if they are reasonably expected to work 30 hours per week. Groups are responsible for determining whether an employee is a full-time employee. This includes all non-permanent employees. The State Health Plan is not able to provide guidance to groups regarding eligibility for employees.

Employees can elect to enroll in coverage the first of the month that they become eligible. The same termination and qualifying life event rules apply to employees that enroll in the HDHP.

Additional information is posted under the Health Benefits Representatives tab, visit the Plan's website for more information.