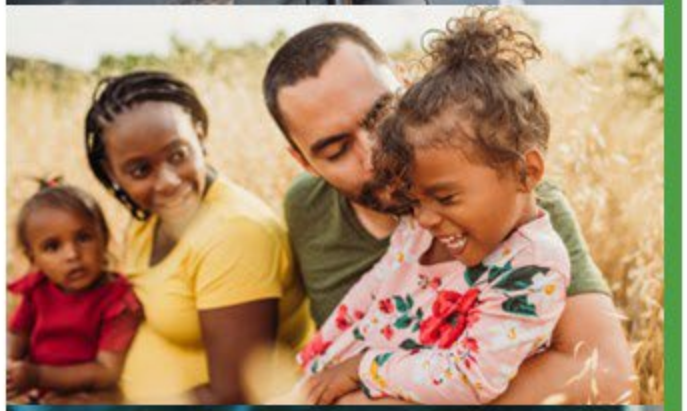

2026

Policies and Processes

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

Medicare

MEDICARE ELIGIBILITY

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

The State Health Plan sends a MEDICARE ELIGIBILITY LETTER to active employees and their dependents prior to their 65th birthday. This letter outlines their coverage options once they become Medicare eligible. If an individual chooses to drop Plan coverage when they become Medicare eligible, the change must be made within 30 DAYS of the Qualifying Life Event (QLE), which is the first of the month they become Medicare eligible.

Medicare can be primary for members in active groups in the following situations:

- During the last month that a retiree is still covered by the active group prior to enrollment in the Retirement Systems.
- Following the 30-month State Health Plan primary period for members with End Stage Renal Disease (ESRD).
- For members enrolled in the 12-month Reduction in Force (RIF) health coverage.

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When Does Coverage End For Employees?

Terminations of health coverage for employees must be processed within 30 days.
The Plan will not approve retroactive terminations past 30 days when a group continues to carry a member that is no longer eligible for coverage.

State Health Plan's GENERAL RULES under statute for when coverage ends for a non-retiree:

- The last day of the month in which an employee's employment is terminated.
- If employment is terminated on or after the 16th of the month, and the covered individual has made the required contribution for coverage in the following month, that coverage may continue to the end of the calendar month following the month in which employment was terminated. (FIORI AGENCIES follow this rule.)

Public schools, community colleges, local government units, charter schools, and other non-FIORI groups can choose which rule they wish to follow, but the decision must be made before the beginning of the upcoming Plan year.

Visit the Enrollment Information section of the Plan's website under the Health Benefits Representative (HBRs) tab, for more information.

Eligibility While on Disability

If an employee does not return to work at the end of their short-term disability period, HBRs should cancel the employee's coverage within 30 days of the date that short-term disability ends. 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 for employees on disability, even though they are no longer eligible, WILL BE RESPONSIBLE for the associated premiums. These premiums will not be refunded.

To generate a COBRA NOTICE, terminate employment as involuntary since the employee is no longer eligible for coverage under the active group.

COBRA coverage will be needed to close the gap in coverage between the Active and Retirement Systems health benefits if the extended short-term or long-term disability is not approved when short-term disability ends.

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Leave of Absence: Eligibility

The Leave of Absence Categories should be used when employees are on leave and are still ELIGIBLE for State Health Plan coverage.

Direct Bill: Leave of Absence – Partially Paid category can be used for any eligible member who is on leave of absence with pay and/or receiving workers compensation.

- EXAMPLES: FMLA, Approved Leave of Absence

Direct Bill: Leave of Absence – Fully Paid category should be used for any eligible member who is on leave of absence without pay.

- EXAMPLES: Short-Term Disability

When their status changes, the member will be able to log into eBenefits and change their benefits using the LEAVE OF ABSENCE life event.

Leave of Absence: Billing

If a member on Leave of Absence has sufficient funds on their paycheck to pay their State Health Plan premium, you can leave them in PAYROLL DEDUCT: FULL TIME status.

Some members on Leave of Absence are not receiving pay and cannot pay their State Health Plan premium, but they are still eligible for coverage.

There are two Leave of Absence employment status categories that REMOVE THE BURDEN OF BILLING the member for their State Health Plan premium from the group. All members in either of these LOA statuses will be sent an invoice from iTedium for their coverage instead.

Direct Bill: Leave of Absence – Partially Paid

Group pays employer contribution, and the member pays employee contribution.
The employee portion is removed from the group's invoice for these members.

Direct Bill: Leave of Absence – Fully Paid

Group pays nothing and the member pays both employee and employer contributions.
These members remain on the group invoice but with $0 premiums.

COBRA

An acronym for the Consolidated Omnibus Budget Reconciliation Act of 1985.

COBRA allows certain employees and their dependents that would otherwise lose group coverage to temporarily continue coverage with the same plan.

Initial COBRA notices are sent to all new hires and dependents. This notice is intended to inform the members of their potential future options and obligations under COBRA.

A COBRA notice is sent when a qualifying event occurs, such as a termination.

Visit the Individual Members section of the Plan's website, then select COBRA Plan Overview, for more information and COBRA rates.

Reduction in Force (RIF)

Employees who lose their jobs as a result of a reduction in force (RIF) WILL CONTINUE to have coverage under the State Health Plan for up to 12 MONTHS, as long as the employee:

Has 12 or more months of service and the employee was covered by the Plan at the time of separation from service.

OR

Completed a contract term of employment of 10 or 11 months as an employee of a local school administrative unit.

Visit the Reduction in Force Information for HBRs section of the Plan's website under the Health Benefits Representative (HBRs) tab, for more information.

Enrollment Exceptions and Appeals Policy

To ensure consistency and adherence with both state and federal legislation, it is important that all transactions — including new hire enrollments, dependent additions or removals due to a qualifying life event (QLE), and the processing of terminations, are completed in a timely manner.

Retroactive changes outside the State Health Plan's enrollment or termination rules may be requested by HBRs through the exception process and may be approved under CERTAIN CRITERIA ONLY.

Please take time to review the Exceptions Process section on the Plan's website under the HBRs tab and also review the SHP Enrollment Exceptions and Appeals and SHP Termination and Reinstatements Rules.

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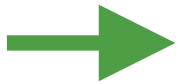
How to Submit an Exception Request

VISIT the Exceptions Process section on the Plan's website and SELECT Exception Request Form.

Next, COMPLETE each field in the form and SELECT Submit Exception Request Form.



Exceptions Process

To ensure consistency and adherence to both state and federal legislation, it is important that all transactions for new hire enrollments, adding or dropping dependents due to a qualifying life event, and the processing of terminations are completed in a timely manner. For more information, visit the Enrollment Information page.

The exceptions process allows HBRs to submit requests to make changes that are outside of the State Health Plan's rules and regulations.

The exceptions request process is not intended for arbitrary requests and will be handled on a case-by-case basis. The Plan will take into consideration the reason for the request, if the request is submitted within a reasonable amount of time, and whether or not granting an approval will be in conflict with state and federal laws.

How to Submit an Exception Request

Please click the link below to submit an exception. If you have any questions regarding this form, please email HBRInquiries@nctreasurer.com.

Exception Request Form

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Exceptions: Important Reminders

- Exceptions need to DOCUMENT the extenuating circumstances that prevented the action from taking place within the existing rules and regulations. **Exceptions are for enrollment issues ONLY.** Once an exception is submitted, it cannot be amended to add additional information – a new exception with the new information must be submitted.
- You will receive an email CONFIRMATION that the exception has been submitted. If you do not receive this, the exception was not submitted, or the email address was entered incorrectly while completing the form.
- All appropriate **documentation must be uploaded to eBenefits for the exception to be reviewed**. If required documentation is missing, the exception will be denied with instructions to submit a new exception after the documents have been uploaded.
- When an exception is **APPROVED**, the affected vendor(s) are NOTIFIED TO UPDATE their system with the exception information. The HBR is also notified that the exception has been reviewed.
- If the member does not want the exception after it has been approved, a new exception with the new information must be submitted.
- In the event the exception is **DENIED**, the bottom of the form will outline the NEXT STEPS available to the member. The Plan cannot provide any information beyond what was included in the exception form response.

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Policy and Procedure on Arrears

- The EMPLOYING UNIT is RESPONSIBLE for ensuring the member's premium is paid by the first of each month.
- Employing Units are expected to pay the premiums for these members along with the premiums for other active members by the invoice due date.
- Premium payments are due by the first day of the effective month. The premium payment grace period ends thirty (30) days after the due date. Members who do not pay their premiums in full by the final day of the grace period will have their coverage canceled.
- If the employee does not pay the premium by the last day of the grace period, the employing unit should complete the cancellation by end of the effective month using the LOSS OF COVERAGE DUE TO NON-PAYMENT reason code in eBenefits.
- Such members and/or their dependents who are terminated for non-payment 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.
- For detailed information, review the Policy and Procedure on Arrears.

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Retirement Termination Process

HBRs should terminate employees as soon as the employee notifies them of the date of their retirement into the State Retirement Systems. 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.

Refer to the detailed instructions on **How to Retire a Member in eBenefits** under Resources in eBenefits.

The FIRST MONTH of retirement, the retiree remains covered under their active agency. Their coverage under the State Retirement Systems (SRS) is effective the first of the month following their retirement date.

- FOR EXAMPLE: If the retirement date is January 1, then the SRS benefit effective date is February 1. The employer will cover the member until January 31.

The retiree will be automatically enrolled into a health plan after the member has submitted and the Retirement Systems has processed, Form 6E, Choosing Your Retirement Payment Option.

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Employees Hired on or after Jan. 1, 2021

State law now dictates that employees hired on or after January 1, 2021, are not eligible for retiree medical benefits. The change was included in the 2017 Appropriations Act.

Specifically, the action amends Article 3B of Chapter 135 of the North Carolina General Statutes to require that retirees must earn contributory retirement service in the Teachers' and State Employees' Retirement System (or in an allowed local system unit), the Consolidated Judicial Retirement System, and the Legislative Retirement System prior to January 1, 2021, and not withdraw that service, in order to be eligible for retiree medical benefits under the amended law.

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Auto-Enrollment Process for Medicare Primary

If Medicare Eligible member's retirement is **ENTERED/KEYED 60+ DAYS** from the retirement effective date, and both Medicare Parts A & B are in effect the member will be enrolled in the **Humana Group Medicare Advantage (PPO) Base Plan**.

- Retirees will have up to 30 DAYS PRIOR to their benefit effective date to change plans. If no action is taken, retirees will remain in the Humana Base Plan and may not change plans until the next Open Enrollment period.

If Medicare Eligible member's retirement is **ENTERED/KEYED LESS THAN 60 DAYS** from the retirement effective date the member will **AUTO-ENROLL** in the **Plan's 70/30 PPO Plan** (Med Prime).

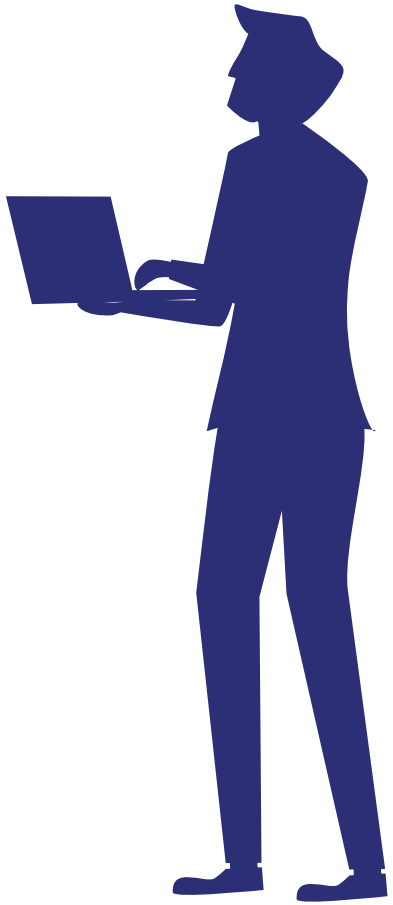
- Retirees will have up until the DAY BEFORE their benefit effective date to switch plans. If no action is taken, retirees will remain in the 70/30 Plan and may not change plans until the next Open Enrollment period.

NOTE: Auto-enrollment occurs whether or not an individual was previously enrolled as an active employee.

Visit the Planning for Retirement section of the Plan's website under the Retiree Benefits tab, for more information.

Auto-Enrollment: Non-Medicare Primary Members

- Retiring members who are under 65 will be AUTOMATICALLY ENROLLED in the health plan they were enrolled in as an active employee along with any covered dependents.
- Premium wellness credits will ROLL OVER if within the same benefit year.
- Changes must be made no later than 30 DAYS from the benefit effective date.
- Auto-enrollment occurs whether or not an individual was previously enrolled as an active employee.



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Contribution Status

Hired BEFORE October 1, 2006

- 5 Years of service
- Non-contributory Plan
- You pay 0% premium for 70/30 Plan and MA Base plan*

Hired ON or AFTER October 1, 2006

5 < 10 Years of service, you pay 100% premium

10 < 20 Years of service, you pay 50% premium

20 Years of service, you pay 0% premium*

*Partial contribution may be required for other plan options.

IMPORTANT: All retirees are AUTO-ENROLLED into a plan regardless of contribution status. To opt out, they must call 855-859-0966 or go online within the enrollment period.

Rehired Full-Time Retirees Rule

In adherence to N.C. General Statutes §135-48.40, a retiree employed full-time under an employing unit is NO LONGER ELIGIBLE for health coverage under the Retirement Systems and the employing unit is responsible for paying the employer premiums.

- Permanent rehired retirees are eligible for the traditional (Standard PPO and Plus PPO) plans.

- Effective January 1, 2016, employing units have the option to offer non-permanent full-time rehired retirees either the High-Deductible Health Plan (HDHP) or the traditional plans.

Review the Rehired Retiree Information and Rehired Retirees pages on the Plan's website, for more information.

Rehired Retirees Process

For non-permanent retirees, HBRs can follow the Retiree Termination Process outlined under the High-Deductible Health Plan section of the Plan's website under the Health Benefits Representative (HBR) tab.

Once the rehired retiree's coverage ends due to termination under the active group, the retiree can re-enroll in the Retirement Systems by using the LOSS OF COVERAGE life event online or by calling the Eligibility and Enrollment Support Center.

PERMANENT REHIRED RETIREES: Per the Retirement Systems rule, if a retiree is re-employed in a permanent TSERS position, the employing unit should contact the Retirement Systems which will terminate all benefits, including the retiree health benefit.

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