

North Carolina
State Health Plan

for Teachers and State Employees

www.shpn.org

-MEMORANDUM-

TO: All Active Employees

FROM: The North Carolina State Health Plan

SUBJECT: Enrollment for Flexible Benefit Plan (IRS Section 125)
for the North Carolina State Health Plan

If you are an **active** employee, you are eligible for participation in the Flexible Benefit Plan to have your health insurance premium payments deducted on a pre-tax basis. **Retirees** and members with **COBRA** continuation coverage are **not eligible** for participation since they must have current earnings from which the premium payments can be deducted.

The Flexible Benefit Plan allows any premiums you pay for health benefit coverage to be deducted from your paycheck before Federal, State and FICA taxes are withheld. By participating, you will be able to lower your taxable income and lower your tax liability, thereby in effect, lowering the net cost of your health plan coverage.

The Flexible Benefit Plan is designed so that your participation will be automatic unless you decline. If you wish to **decline participation** and have your contributions paid on an "after tax" basis, you must complete the **attached Rejection Form** and return it to your Health Benefits Representative. You will have the opportunity to change your participation election during each annual enrollment period.

The Flexible Benefit Plan administered by the North Carolina State Health Plan is for the payment of health insurance premiums on a before tax basis only and is separate and distinct from NC Flex, which is administered by the Office of State Personnel.

If you elect to have your premiums paid on a before tax basis, your health benefit coverage can only be changed (dependents added or dropped) during the annual enrollment period or when one of the following events occurs:

- You change your legal marital status, which includes marriage, death of spouse, divorce, legal separation, or annulment.
- Your dependents change due to birth, adoption, placement for adoption, or death of the dependent.
- You, your spouse, or your dependents terminate or commence employment.
- You, your spouse, or your dependents reduce or increase their hours of employment.
- Your dependents cease or commence to satisfy the requirements for coverage due to attainment of age or student status.
- You, your spouse, or your dependents are entitled to coverage under Part A or Part B of Medicare, or Medicaid.
- You, your spouse, or your dependents commence or return from an unpaid leave of absence such as Family and Medical Leave or military leave.
- You receive a court order to provide coverage for your child(ren).
- There is a substantial change (at least \$50 per month) in the premiums and/or benefits in the plan covering dependents. **Example:** Spouse covers dependent child(ren) and the cost of spouse's coverage increases at least \$50 per month, dependents can be added to the State Health Plan.
- The employee stops the withholding of premiums from their pay.

When one of these events occurs, you must complete a Change Form and forward it to your Health Benefits Representative within 30 days of the event. If however, you do not inform your Health Benefits Representative within 30 days, you must wait until the next annual enrollment to make the coverage change. Whenever you report a change due to a qualifying event, your premium deduction will be on a pre-tax basis.

Employees who stop the withholding of premiums and terminate coverage on their dependents may **only** re-enroll their dependents if one of the above status changes occur **or** at the next annual enrollment.

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Flexible Benefit Plan
REJECTION FORM
For Active Employees Only

Employing Unit: _____

Name: _____
Last First Middle

Social Security Number: _____

Address: _____
Street

_____ City State Zip Code

Election for current benefit year:

Effective Date: _____

I do **not** want the health insurance premiums I am currently paying to the North Carolina State Health Plan withheld from my earnings on a "before tax" basis.

Employee's Signature Date

Please return this form to your Health Benefits Representative.

