Medicare and the State Health Plan for Teachers and State Employees in North Carolina - 2022

How does Medicare work with the State Health Plan when YOU ARE NO LONGER EMPLOYED?

- You **must enroll** in Original Medicare Part A and Part B upon eligibility.
- The State Health Plan offers several health plan options for Medicare eligible retirees. **Your type of coverage depends on the health plan you choose**. The plan options are the 70/30 PPO Plan or a Group Medicare Advantage Base Plan or a Group Medicare Advantage Enhanced Plan.
  - The 70/30 PPO Plan is administered by Blue Cross and Blue Shield of North Carolina (Blue Cross NC).
  - The Group Medicare Advantage Plans are offered through Humana.
- **If you select the 70/30 PPO Plan option, Medicare will be your primary health coverage**, **and the 70/30 PPO Plan** will become your **secondary** health plan.
- **If you select a Humana Group Medicare Advantage plan option**, the Group Medicare Advantage plan will be your complete coverage and manage/administer your Medicare Part A and Part B benefits plus provide Medicare Part D prescription drug coverage with additional benefits/services/discount programs not found in Original Medicare or the 70/30 PPO Plan.
- **Under the 70/30 PPO Plan**: Starting January 1, 2022, **this plan has a combined (medical and pharmacy) annual deductible of $1,500 and a combined out-of-pocket limit of $5,900.** In-network physician[1] office services require only a copayment (no deductible or coinsurance). Most other services are subject to the combined annual deductible and 30% coinsurance. Out-of-network services are subject to a higher combined deductible and 50% coinsurance and you may also be held responsible for the difference between the allowed amount and the actual charge.
  - You must meet the 70/30 PPO Plan's combined annual deductible for those services that are subject to the deductible, even though you are on Medicare. The 70/30 PPO Plan combined annual deductible period is based on calendar year.
  - The **70/30 PPO** Plan benefits are applied to the remaining covered charges after Medicare has paid. There is a **combined out-of-pocket limit** under the 70/30 PPO Plan. After the combined out-of-pocket limit has been reached, the 70/30 PPO Plan will cover the remaining Medicare approved charges at 100%.
  - **Copayments do not count** toward the combined annual deductible. However, they will be applied to the combined out-of-pocket maximum. Please note the combined annual deductible is also applied to the combined out-of-pocket maximum.
  - For questions regarding the 70/30 Plan call Blue Cross NC at **888-234-2416** for questions.
- **Under the Humana Group Medicare Advantage Base or Enhanced plans:** Most services require only a copayment (copayment can be the same whether seeing an in or out-of-network provider). Copayment amount may depend upon plan option selected (Base or Enhanced).
  - There are **no deductibles** under the Group Medicare Advantage Base or Enhanced plans.
  - Provider **must participate in Medicare and be willing to accept your plan of coverage**.

[1]PPO Options: In-network hospital owned or operated practices may be subject to deductible and coinsurance. Please call your physician or see the Provider Directory to see if your physician's practice is hospital owned or operated.

- Predictable copays for all covered services.
- Added benefits/services such as Silver Sneakers; disease and case management, hearing aid benefit, etc.
- There is a **maximum out-of-pocket amount for medical services** and **both medical copayments and coinsurance do count** toward reaching this amount. After the medical maximum out-of-pocket amount is met, the Group Medicare Advantage plan is responsible for 100% of covered medical services for remainder of plan year.

Will you have prescription drug coverage when YOU ARE ON MEDICARE AND NO LONGER EMPLOYED?

Yes, Medicare-eligible members who elect the 70/30 PPO Plan will have the same prescription coverage as you did while actively employed, the Traditional State Health Plan Prescription benefits, administered through CVS Caremark.

If you choose to enroll into one of the Humana Group Medicare Advantage Plans, they include **Medicare Part D** prescription drug coverage. **It is important to note there is no donut hole or coverage gap as found under an individual/stand-alone Medicare Part D plans.** Medicare Part D coverage is built into the State Health Plan's Humana Group Medicare Advantage Plans and includes coverage of medications not typically found in standard individual Medicare Part D plans plus the ability to obtain 90 day fills at many local retail pharmacies for the same low mail order copay amount.

The Humana Group Medicare Advantage plan options under the State Health Plan have a **prescription out-of-pocket maximum of $2,500**. Once the out-of-pocket maximum is met, your covered prescriptions will be covered at 100%.

The 70/30 has a combined (medical and pharmacy) annual deductible of $1,500 and a combined out-of-pocket maximum of $5,900. Not all medications require meeting the combined annual deductible. Your prescription copays do not apply toward the combined annual deductible but will apply toward meeting the combined out-of-pocket maximum. Once the combined out-of-pocket limit is met, your covered prescriptions will be covered at 100%.

Will I need additional health insurance?

Many Medicare beneficiaries purchase a **Medigap** (Medicare Supplement) plan, because they **do not** have access to a Retiree Employer Group Health Plan such as the North Carolina State Health Plan. An additional Medigap plan is generally not needed when you have the State Health Plan 70/30 Plan as secondary coverage to Medicare. If you have high medical expenses with high out-of-pocket costs, a Medigap plan may be an option to consider.

Here are a few items to consider when thinking about purchasing a Medigap plan:

- Evaluate Cost – Will the additional premium cost outweigh the State Health Plan coverage and out-of-pocket expenses?
- Pre-existing Conditions – Will the company impose a pre-existing condition waiting period or increase premium due to past health history?
- Guarantee Issue Right – Are you eligible for a Medigap plan under a Guarantee Issue basis?
- Networks – There are no networks involved under a Medigap plan.
- **IMPORTANT:** Medigap plans **ONLY** work with **Original Medicare**. **They will not work with Medicare Advantage plans.**

What does Medicare pay? What does the State Health Plan 70/30 PPO Plan pay?

It is important to remember that the State Health Plan's 70/30 PPO Plan is a secondary plan of coverage to Medicare and **NOT** supplemental coverage. North Carolina law requires State Health Plan benefits to coordinate with Medicare benefits. This means that charges left unpaid by Medicare are paid by the State Health Plan after the combined annual deductible or coinsurance are applied, up to the total allowed charge for the procedure or after the copayment is paid for those services on the 70/30 PPO Plan that require only a copayment.

What about a Medicare-eligible spouse of a State retiree?

You will want to evaluate all potential options for the **Medicare-eligible spouse**. What is the cost of the monthly premium for a Medicare-eligible spouse to be covered under the State Health Plan 70/30 PPO Plan versus the Humana Group Medicare Advantage Plan options versus having the Medicare-eligible spouse dropped from the State Health Plan and obtaining a Medigap (Medicare Supplement) plan along with a Medicare Prescription Drug plan or an Individual Medicare Advantage Plan? **Please note the Humana Group Medicare Advantage Plan options offer an affordable option for covering a Medicare-eligible spouse under the State Health Plan**.

Currently the State Health Plan policy is that if a retiree's Medicare-eligible spouse is dropped, they can be added back to the State Health Plan during any State Health Plan's Open Enrollment Period as long as the State retiree is living and still covered by the State Health Plan. However, there may be an exception to add a spouse if a qualifying life event occurs outside of the open enrollment period.

How does Medicare work with the State Health Plan when you are STILL ACTIVELY WORKING AND EMPLOYED BY THE STATE?

- Upon eligibility for Medicare, **it is recommend you enroll in Medicare Part A** as it is typically premium-free.
- You can **delay enrollment in Medicare Part B** as the State Health Plan **will remain primary for actively employed workers**.
- **You must remember to enroll in Medicare Part B when you decide to retire/stop actively working**. **Medicare Part B should become effective as of your retirement date. To enroll in Medicare Part B, you and your employer will need to each fill out a form that should be obtained from Social Security Administration (CMS 40B and CMS L564E) or you may enroll online through Social Security.**
- **If you are actively working for the state and covering a dependent who is becoming Medicare eligible, they may not be enrolled into the Humana Group Medicare Advantage plans until you have retired from state employment. You may want to consider removing them from your coverage and move them into Individual Medicare Advantage, Medicare Prescription or Medigap. Their becoming Medicare eligible is a qualifying life event (QLE) to allow you to drop them from your State Health Plan coverage.**

Still actively working but considering retirement?

- First and foremost, speak with your Health Benefit Representative/Human Resources Office for your agency. Your State Health Plan options when you retire can be affected based on retirement processing date.
- **Eligible retiring employees who are under 65 and not Medicare eligible** will be automatically enrolled in the health plan they were enrolled in as an active employee along with any covered dependents.
- **Eligible retiring employees and/or dependents that are Medicare-eligible whose retirement is submitted and approved 60 days or greater from the retirement health benefit effective date** will be automatically enrolled into the Humana Group Medicare Advantage Base Plan, which is premium-free for

a qualified retiree-only coverage. Retirees will have up to 30 days **BEFORE** their benefit effective date to change plans. Will need to be sure Medicare Part A and Part B are in place as of their retirement date.

- If no action is taken, retirees will remain in the Humana Group Medicare Advantage Base Plan they were assigned. Changes to plan elections can be made during the next State Health Plan's Open Enrollment period. If the retiree has dependents that are non-Medicare Primary, they will be automatically enrolled into the health plan they were enrolled in as an active dependent.

- **Eligible retiring employees that ARE Medicare-eligible and whose retirement is submitted and approved less than 60 days prior to the retirement health benefit effective date** will be automatically enrolled in the Traditional 70/30 Plan. Changes to plan elections can be made up until the day before the benefit effective date. Again, member will need to be sure Medicare Part A and Part B are in place as of their retirement date. If retirees have dependents that are non-Medicare Primary, they will be automatically enrolled into the health plan they were enrolled in as an active dependent.
- **It is important to note that if an upcoming retiree had opted out State Health plan coverage as an active employee it does not carry forward into retirement**. If they are eligible for State Health Plan coverage as a retiree based on years of service, they will be auto-enrolled into a plan. If they do not want coverage as a retiree, they will have to opt out as a retiree during the retirement process (online through ORBIT or by calling the Eligibility & Enrollment Support Center at 855-859-0966).