

COBRA Continuation of Coverage Invoice



Invoice Date: March 11, 2019
Total Amount Due: \$319.84
Last Payment Received: December 16, 2018
Amount Paid: \$523.68



Susan Murphey (CG5084601 MSG6378175)
5000 Montrose Blvd. Unit 8B
Houston, TX 77006-6560

IMPORTANT: This is a monthly invoice for your continuation of healthcare coverage under COBRA. On December 14, 2018, you elected to continue your healthcare coverage under COBRA. The table below shows the coverage period(s) currently due with the premium amount(s) and due date(s). **Premium payments must be postmarked on or before the corresponding grace period end date to be valid.**

COBRA Premium Payment Balance Detail

Payment Period	Premium Amount	Credit/Subsidy	Amount Due	Due Date	Grace Period End Date
04/01/2019 – 04/30/2019	\$603.64	(\$283.80)	\$319.84	04/01/2019	04/30/2019
			\$319.84	is the total amount due.	

Coverage will be canceled if valid premium payments are not postmarked on or before the Grace Period End Date as shown above. If coverage is cancelled for non-payment of premium, reinstatement of coverage is not permitted until the next Open Enrollment period. No partial payments or late payments will be accepted. Acceptance of payments by ITEDIUM, as collection agent for North Carolina State Health Plan, is without prejudice and with reservation of all rights. You may be eligible to convert your group health coverage. For more information on the Plan's Policy and Procedure on Arrears, visit www.shpnc.org.

Save Time, Postage & Ensure No Late COBRA Payments by Enrolling in Electronic COBRA Premium Payment Service!

visit www.mycobra.info to sign up today



COBRA PREMIUM PAYMENT REMITTANCE COUPON

Please Make Checks Payable To **North Carolina State Health Plan**

Upon election of COBRA, eligibility for COBRA continuation will cease upon one of the following events: (i) if you become covered under any other group health insurance plan that does not have a limitation or exclusion due to a pre-existing condition, or (ii) if you become entitled to Medicare, or (iii) the Social Security Administration determines that you are no longer disabled. By making this premium payment, I am confirming that I do not presently meet any of the three conditions listed above.

AMOUNT ENCLOSED					
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IMPORTANT: ☐ (Box A) Check here if your name or address has changed, and complete Section A on the reverse side.
☐ (BOX B) Check here if you wish to cancel your COBRA coverage and complete Section B on the reverse side.

North Carolina State Health Plan
Attention: Premium Payments Department
PO Box 505200
St. Louis, Missouri 63150

Account Details

Account Number: CG5084601
Invoice Number: 6378175



IMPORTANT INFORMATION REGARDING ELIGIBILITY, PREMIUM BILLING AND PAYMENTS

COBRA ELIGIBILITY REQUIREMENTS

Your COBRA coverage will terminate if any of the following occurs:

- You fail to make a valid payment;
- You first become covered under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition of the participant;
- You first become entitled to Medicare;
- North Carolina State Health Plan no longer provides group health coverage to any of its employees.

You or your covered spouse or dependent child or children must inform ITEDIUM in writing within 60 days of the Qualifying Event, or the date that you would lose coverage due to these Qualifying Events:

- divorce or legal separation - if the divorce of separation causes loss of coverage;
- child losing dependent status under the group health plan.

You should also notify ITEDIUM in writing before the end of the 18-month continuation coverage period when the employee (or former employee) becomes entitled to (actually covered by) Medicare to ensure that you receive the full continuation coverage period to which you are entitled.

PREMIUM BILLING AND PAYMENT

- Upon election, you are billed for the period from the loss of coverage date through the then current month. Coverage will be cancelled, with reinstatement not allowed until the next Open Enrollment period, if the first premium payment is not made within 45 days of the date of the original election of continuation coverage. Subsequent premiums are due on the 1st day of every month. However, the monthly invoice indicates a grace period, measured from the due date for each monthly premium, during which a valid payment may still be made. The grace period is defined by the group health plan (usually 30 days). If a valid payment is not postmarked on or before the Grace Period End Date, coverage will be cancelled.

- Monthly invoices are sent approximately 20 days before your premium due date, or 20 days prior to the 1st day of every month. However, you are still responsible for paying the full premium on time even if you do not get an invoice. The monthly invoice may show more than one coverage period of premiums due. The premium due for each coverage period has a corresponding Grace Period Expiration Date, which may or may not be the same for every premium shown on the invoice. You must pay these amounts in full by the corresponding Grace Period Expiration Date indicated.

- For more information on the Plan's Policy and Procedure on Arrears, visit www.shpnc.org.

VALID PAYMENTS

A valid payment consists of four criteria: proper payment, identification, receipt, and timeliness. These criteria are outlined in detail below:

1. A signed, properly dated personal check, certified check or money order payable to "North Carolina State Health Plan" payable in the total amount required to fully pay your premium(s) due. If this personal check, certified check or money order were to be returned for insufficient funds, a stop payment order or some other reason, then this requirement is not met;

2. Sending your COBRA premium to ITEDIUM at the following address:

North Carolina State Health Plan
Attention: COBRA Premiums Department
PO Box 505200
St. Louis, Missouri 63150

3. Either (i) the coupon detached from your invoice and enclosed with your payment; or (ii) your Account ID (5084601) written clearly in the Memo section of your personal check, certified check or money order;

4. Envelope containing the payment postmarked no later than the 1st of the month for the same month of coverage (example: coverage for the month of June is due June 1st);

The following languages are supported and are required to be supported in accordance with PPACA 2014.

SPANISH (Español): Para obtener asistencia en Español, llame al (877) 679-6272.

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (877) 679-6272.

CHINESE (中文): 如果需要中文的帮助, 请拨打这个号码 (877) 679-6272.

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijijigo holne' (877) 679-6272.

COVERAGE CANCELLATIONS

Cancellation requests must be made by checking the checkbox in Section C below and mailing to ITEDIUM at the address listed on the reverse side of this form. Cancellation requests must be processed 30 days prior to requested cancellation date. We cannot retroactively cancel coverage after payment has been received.

CLAIMS

Claims become payable for each period of coverage only after a premium payment for the coverage period has been made. Claims may be delayed and prescription cards not reactivated for a period of 30 to 60 days because of the time required to process your initial premium payments by ITEDIUM, your group health plan's third party administrator.

Do not send claims to ITEDIUM, as we are not your insurance carrier and we cannot pay your claims or authorize your claims to be paid. If you have any questions about claims within 30 to 60 days of your initial premium payment, please contact the Plan at the customer service number on your ID card. If premium payments are not made in a timely manner, coverage will be cancelled retroactively and claims incurred during the period for which premiums were not paid will not be paid by the Plan.

DISABILITY EXTENSION ELIGIBILITY

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify ITEDIUM at (877) 679-6272 in a timely fashion, you and your entire family may be entitled to receive an additional 11 months of COBRA continuation coverage for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. The qualified beneficiary must provide the written determination of disability from the Social Security Administration to ITEDIUM within 60 days of the latest of the date of the disability determination by the Social Security Administration, the date of the qualifying event or the benefit termination date; and prior to the end of the 18-month COBRA continuation period. You will be required to pay up to 150% of the group rate during the 11-month extension. The Qualified Beneficiary must notify ITEDIUM at (877) 679-6272, within 30 days upon the determination that the Qualified Beneficiary is no longer disabled under Title II or XVI of the Social Security Act.

COBRA PARTICIPANT ASSISTANCE

ITEDIUM offers an Internet website where COBRA participants can review invoices, pay premiums via ACH transfer, get notification of receipt of payments via electronic mail, notify ITEDIUM of a name or address change and much more! Visit <http://www.mycobra.info> to login to your COBRA Participant account. Your default login is 5084601 and your password is the last four digits of your social security number.

ITEDIUM also has Participant Specialists available to assist you in all matters. Our representatives are available Monday through Friday, 8:00 AM through 6:00 PM Eastern Standard Time. Sometimes you may encounter delays due to high call volumes. Please leave a detailed message including your question, account number, and a convenient time for our representatives to call back. You can also reach us via email at helpdesk@itedium.com.

CONVERSION OF COVERAGE TO INDIVIDUAL POLICY

You may have the right to convert your expiring group coverage to an individual health insurance policy offered by the plan's insurance carrier at the end of your COBRA continuation after completing the 18th, 29th, or 36th month. Contact the Plan at the number on your ID card for conversion coverage application forms and/or information.

** POSTMARK ALERT **

Please note that the U.S. Postal Service no longer postmarks various classes of mail. It is your responsibility to ensure that ITEDIUM receives all required notifications and payments by the due date or that you secure proper proof of mailing. A payment received after the due date without proper date verification will be denied and coverage will terminate.



SECTION A: NAME AND/OR ADDRESS CHANGE

Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone Number: (_____) _____ - _____

SECTION B: CANCELLATION OF COVERAGE

☐ Please cancel my COBRA coverage

Signed: _____