



Insurance Benefits Guide

2017



RALLY®

Getting healthier just got easier



Rally® can help you get healthier, one small step at a time.

At the South Carolina Public Employee Benefit Authority (PEBA), we're committed to providing State Health Plan members with a convenient way to get engaged in managing their health. We are excited to announce the introduction of Rally®, a digital health platform brought to you by PEBA in partnership with BlueCross BlueShield of South Carolina, in April 2017.

Rally will show you how to make simple changes to your daily routine, set smart goals for yourself and stay on target. You'll get personalized recommendations to get you moving more, eating better, feeling great — and you'll have fun doing it.

Start with a quick Health Survey. Rally will tell you your Rally AgeSM, a measure of your overall health, and recommend Missions for you — simple activities designed to immediately improve your diet, fitness and mood. Start easy, and level up when you're ready.

Plus, there are lots of ways to earn Rally Coins, which you can use for a chance to win awesome rewards. Rack up coins for participating in Missions, pushing yourself in a Challenge — even just for logging in every day!



Get your Rally Age



Build better habits



Win cool stuff

Get ready to Rally! Coming April 1, 2017



South Carolina



Rally is a product of Rally Health Inc., an independent company that offers a health management program on behalf of the South Carolina Public Employee Benefit Authority. BlueCross BlueShield of South Carolina is an independent licensee of the Blue Cross and Blue Shield Association.

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Disclaimer

Benefits administrators and others chosen by your employer who may assist with insurance enrollment, changes, retirement or termination and related activities are not agents of the South Carolina Public Employee Benefit Authority (PEBA) and are not authorized to bind the South Carolina Public Employee Benefit Authority.

The *Insurance Benefits Guide* contains an abbreviated description of insurance benefits provided by or through the South Carolina Public Employee Benefit Authority. The Plan of Benefits documents and benefits contracts contain complete descriptions of the health and dental plans and all other insurance benefits. Their terms and conditions govern all benefits offered by or through the South Carolina Public Employee Benefit Authority. If you would like to review these documents, contact your benefits administrator or the South Carolina Public Employee Benefit Authority.

The language in this document does not create an employment contract between the employee and the South Carolina Public Employee Benefit Authority. This document does not create any contractual rights or entitlements. The South Carolina Public Employee Benefit Authority reserves the right to revise the content of this document, in whole or in part. No promises or assurances, whether written or oral, which are contrary to or inconsistent with the terms of this paragraph create any contract of employment.

State Health Plan's grandfathered status allows premiums to remain stable

PEBA considers the State Health Plan to be a "grandfathered health plan" under the Affordable Care Act (ACA). As a grandfathered plan, PEBA will be able to minimize the increase in State Health Plan premiums while it assesses the future financial impact of the act. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when the law was enacted. Being a grandfathered health plan means that the plan may not include certain consumer protections of the ACA that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the ACA, such as the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to PEBA at 803.737.6800 , 888.260.9430 or online at www.peba.sc.gov/contactus.html.

You may also contact the U.S. Department of Health and Human Services at www.healthcare.gov.

Notice of non-discrimination

The South Carolina Public Employee Benefit Authority (PEBA) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. PEBA does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

PEBA:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact PEBA's Privacy Officer.

If you believe that PEBA has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: PEBA Privacy Officer, 202 Arbor Lake Dr., Columbia, SC 29223, 803.734.0119 (phone), 803.570.8110 (fax), or at privacyofficer@peba.sc.gov. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, PEBA's Privacy Officer is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1.800.368.1019, 800.537.7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

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ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.803.734.0119.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1.803.734.0119

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કરો 1.803.734.0119.

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مقرب لصتا

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мовою, ви можете звернутися до
безкоштовної служби мовної підтримки.
Телефонуйте за номером 1.803.734.0119.

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में
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គឺអាចមានសំរាប់អ្នក។ ចូរ ទូរស័ព្ទ
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General information

This guide provides an overview of the insurance programs the South Carolina Public Employee Benefit Authority (PEBA) offers plus premiums and contact information. While the guide provides a general description of many of these benefits, the Plan of Benefits, found at www.peba.sc.gov/assets/planofbenefits.pdf, contains a complete description of all benefits. Its terms and conditions govern all health benefits offered by PEBA.

The What's new for 2017? section highlights major changes in insurance benefits offered for 2017.

Here are some other changes to this guide for 2017:

- Prescription drug benefits information is now found in its own chapter, titled **Prescription drugs**, which follows the **Health insurance** chapter.
- The **Retirement and disability** chapter is now titled **Retiree group insurance**.
- Portions of this guide have been rewritten to make it easier to understand. If you can't find what you're looking for, use the index, as well as the search function within the electronic PDF version.

PEBA serves as your insurance plan sponsor

The State Health Plan, which includes the Savings Plan, the Standard Plan and the Medicare Supplemental Plan, is a self-funded health plan. This means that the State Health Plan does not pay premiums to an insurance company, but rather collects subscriber premiums and employer contributions, and then holds the funds in trust to be used to pay claims and administrative costs. Any interest earned from this account is used to help

fund the plan. Administrative costs account for about 4 percent of the funds collected as premiums.

Because of this structure, using your health insurance carefully helps to keep costs low for yourself, for other people insured by the plan and for your employer, who may pay a portion of your premium.

While PEBA manages the plan, determining the benefits you receive and holding the financial responsibility for their cost, it also contracts with BlueCross BlueShield of South Carolina (BlueCross), Express Scripts and Companion Benefit Alternatives (CBA) to process State Health Plan claims and administer some parts of the plan.

What's new for 2017?

Changes listed below are effective January 1, 2017

Health insurance

- State Health Plan members enrolled in the Standard Plan or Savings Plan now have access to a new telehealth option, also known as a virtual visit option. Blue CareOnDemandSM is being offered through BlueCross. This platform, operated by BlueCross' telehealth partner American Well, focuses on live virtual visits and uses on-demand technology in which you can request a visit and connect with a provider in less than two minutes. Participating doctors are trained to treat patients through virtual technology, following strict protocols specific to telehealth and using best practices for "website manner." See Page 39 for details about this convenient and affordable service.

- Female State Health Plan subscribers and female covered spouses, are eligible to receive a covered breast pump at no cost to the member when the device is obtained through a BlueCross-contracted provider. See Page 72 for more information about how to qualify and obtain a covered breast pump.
- The State Health Plan's lifetime limit for hospice services increased to \$7,500.
- PEBA Perks are value-based benefits that are promoted and offered at no cost to members at network providers whose primary coverage is the SHP. The benefits available through PEBA Perks include colorectal cancer screenings, flu vaccine, and maternity management, stress management, and tobacco cessation programs. We will also continue to offer the benefits at no cost to members included in the Free in '15 and 2016 PEBA Perks initiatives as part of our value-based benefits in 2017. Those benefits include adult vaccinations, preventive screenings, No-Pay Copay, shingles vaccines, and diabetes education. Learn more about PEBA Perks on Page 54.

Prescription drugs

- The State Health Plan is using the Express Scripts National Preferred Formulary, which is a standard formulary offered by the Plan's pharmacy benefits manager. A formulary is a list of covered drugs and preferred drugs. PEBA's adoption of the National Preferred Formulary resulted in the exclusion of about 80 pharmacy products from coverage. As a State Health Plan member, you still have access to comparable medications that are covered by your plan. Members using any of these pharmacy products received

communications from Express Scripts beginning in October 2016 to notify them of the upcoming change and to offer covered alternatives. If you use a glucose monitor and your test strips are no longer covered, you received information on how to receive a new meter at no cost to you. If you use an insulin pump with an integrated glucose meter, call Express Scripts at 855.612.3128 for assistance.

Eligibility for insurance benefits

Eligible employees:

- Work for the state, a higher education institution, a public school district, or a participating local subdivision; and
- Receive compensation from the state, a higher education institution, a public school district, or a participating local subdivision.

Eligible employees also include clerical and administrative employees of the South Carolina General Assembly, judges in the state courts, and General Assembly members. Permanent part-time teachers working between 15 and 30 hours a week qualify for state health, vision, and dental insurance, but are not eligible for other PEBA benefits, such as life and disability insurance. Elected members of participating county and city councils whose members are eligible to participate in one of the retirement systems PEBA administers are considered full-time employees. Generally, members of other governing boards are not eligible for coverage. If you work for more than one participating group, contact your benefits administrator for further information.

Types of employees

Employees fall into these categories:

- New full-time employees whom the employer expects to work at least 30 hours a week. They are eligible for coverage within 31 days of their hire date.
- New variable-hour, part-time, or seasonal employees whom the employer does not expect to average 30 hours a week during the first 12 months they are employed. Because their employer cannot determine their eligibility, they may not enroll in benefits immediately. Their employer must measure their hours to determine whether these employees work an average of 30 hours a week during the 12 months beginning the first of the month after the employee is hired. If an employee works an average of 30 hours a week during this period, the employee is eligible for coverage during the 12-month period that follows.
- Ongoing employees who have worked for their employer from October 4, 2015, through October 3, 2016, which is the employer's work measurement period. If an ongoing employee worked an average of 30 hours a week during this 12-month period, the employee is eligible for coverage during 2017 even if the employee's hours decrease during 2017. If an ongoing employee worked an average of less than 30 hours a week during this period, the employee is not eligible for coverage during 2017 unless the employee gains coverage through some other provision of the plan.

Benefits in which eligible employees may enroll

- Health insurance – the State Health

Plan Savings Plan, the Standard Plan, and, for eligible members of the military community, the TRICARE Supplement Plan

- Members enrolled in the Savings Plan are eligible for a Health Savings Account. See Page 155 for more information.
- State Dental Plan and Dental Plus
- State Vision Plan
- Basic, Optional, and Dependent Life insurance
- Basic and Supplemental Long Term Disability insurance
- Dependent Care Spending Account
- Medical Spending Account or a Limited-use Medical Spending Account

An eligible retiree

An individual may be eligible for health, dental, and vision coverage in retirement if:

1. He retires from an employer that participates in the state insurance program.
2. He is eligible to retire when he leaves employment.
3. His last five years of employment were served consecutively in a full-time, permanent position with an employer that participates in the state insurance program.

For insurance purposes, a member of a retirement system PEBA administers must meet the minimum retirement eligibility requirements established by the system in which he participated when he left covered employment. Retirement systems PEBA administers include the South Carolina Retirement System (SCRS), the Police Officers Retirement System (PORS), the General

Assembly Retirement System (GARS), the Judges and Solicitors Retirement System (JSRS), and the State Optional Retirement Program (State ORP). Please see Page 162 for more information about retiree insurance eligibility requirements.

An eligible spouse

- Can be defined as a spouse by South Carolina law; or
- Include former spouses who are required to be covered by a divorce decree (former spouses may not be enrolled in life insurance benefits).

A spouse eligible for coverage as an employee of any participating group, including a local subdivision or as a state-funded retiree (meaning that a part of his insurance premiums will be paid for him) cannot be covered as a spouse under any plan. A spouse who is a permanent, part-time teacher may be covered as an employee or as a spouse, but not as both. A spouse who is a non-funded retiree may be covered as a retiree or as a spouse, but not as both. You may cover your current spouse or your former spouse, but you cannot cover both spouses under any PEBA insurance program.

An eligible child

- Must be younger than age 26; and
- Must be the subscriber's natural child, adopted child (including child placed for legal adoption), stepchild, foster child¹, a child for whom the subscriber has legal custody or a child the subscriber is required to cover due to a court order².
- If you and your spouse are both eligible for

¹A foster child is a child placed with the subscriber by an authorized placement agency. The subscriber must be a licensed foster parent.

²A child for whom the subscriber has legal custody is a child

for whom the subscriber has guardianship responsibility, not just financial responsibility, according to a court order or other document filed with the courts.

coverage, only one of you can cover your children under any one plan. For example, if one parent covers the children under health and dental, the other parent cannot cover the children under either health or dental. One parent can cover the children under health, however, and the other can cover the children under dental.

A child age 19 to age 25

According to the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, a child age 19 to 25 does not need to be certified as a full-time student or an incapacitated child to be covered under his parent's health, dental, or vision insurance.

A parent may cover a child who is eligible for state benefits because the child works for an employer that participates in PEBA insurance benefits. The child may be covered under his parent's health, dental and vision coverage. If covered by his parent, the child is not eligible for Basic Life, Optional Life, Dependent Life-Child, or Long Term Disability insurance.

A child who is eligible for coverage under a parent but who is also eligible for benefits because he works for a participating employer must choose whether to be covered by his parent as a child or to be covered on his own as an employee. He cannot be covered as a child on one insurance program, such as health, and then enroll for coverage as an employee on another, such as vision. For life insurance purposes, a child who is eligible as an employee under the plan is ineligible to be covered as a dependent.

An incapacitated child

You can continue to cover your child who is age 26 or older if he is incapacitated and you are financially responsible for him. To cover your dependent child who is incapacitated, the child must meet these requirements:

- The child must have been continuously covered by health insurance from the time of incapacitation;
- The child must be unmarried and must remain unmarried to continue eligibility; and
- The child must be incapable of self-sustaining employment because of mental illness or intellectual or physical disability and must remain principally dependent (more than 50 percent) on the covered employee, retiree, survivor, or COBRA subscriber for support and maintenance.

You need to establish incapacitation no later than 31 days after the child's 26th birthday, when he is otherwise no longer eligible for coverage as a child. For Dependent Life-Child coverage, you need to establish incapacitation no later than 31 days after his 19th birthday if he is not a full-time student. Generally, letters will be sent 90 days before coverage will be lost. If you receive such a letter, please take action as soon as possible to prevent issues from occurring during the transition.

You and your child's physician will need to complete an *Incapacitated child certification* form. Please include a copy of your most recent federal tax return, which shows the child is principally dependent on you for support and maintenance. Also attach a completed *Authorized Representative Form* signed by the incapacitated child, and a copy of guardianship papers or a power of attorney that verifies your authority to act for your incapacitated child. Any of these documents give PEBA permission

to discuss or disclose the child's protected health information with the child's Authorized Representative.

PEBA will send your submitted information to Standard Insurance Company for review of the medical information. Additional medical documentation from the child's physician may be required by The Standard. The Standard will provide a recommendation to PEBA; however, PEBA makes the final decision.

Coverage under Dependent Life-Child Insurance

According to state law, only a dependent child age 19 to 24 who is a full-time student may be covered under Dependent Life-Child Insurance. A child of any age who has been certified by PEBA as an incapacitated child may continue to be covered under Dependent Life-Child. For more information about eligibility for Dependent Life-Child coverage, see Pages 116–117.

A survivor

Spouses and children covered under the State Health Plan, the State Dental Plan, or the State Vision Plan are classified as survivors when a covered employee or retiree dies. For more information about survivor coverage, see Pages 31–32.

Initial enrollment

If you are an employee or a retiree of a participating group in South Carolina, you can enroll in insurance coverage within 31 days of the date you become eligible or the date you retire. You can also enroll your eligible spouse and/or children. A participating group is a state agency, higher education institution, public school district, county, municipality,

or other group that is authorized by statute to participate and is participating in the state insurance program.

Your benefits administrator may enroll you online or help you complete a paper *Notice of Election* form.

Your coverage starts on the first calendar day of the month in which you become eligible for coverage³ if you are engaged in active employment⁴ that day.

- If you become eligible on the first working day of the month (the first day that is not a Saturday, Sunday, or observed holiday), and it is not the first calendar day, you may choose to have your coverage start on the first day of that month or the first day of the next month.
- If you become eligible on a day other than the first calendar day or first working day of the month, your coverage starts on the first day of the next month.
- Coverage of your enrolled spouse or children begins on the same day your coverage begins.

Please note that if you do not enroll within 31 days of the date you become eligible for active benefits, retire, or experience a special eligibility situation, you cannot enroll yourself, your eligible spouse, or children until the next annual open enrollment period, which is held in October. Coverage elected during an annual

on the previous regular workday. Coverage will not be delayed if you are absent from work due to a health-related reason when your coverage would otherwise start.

open enrollment period will begin the following January 1.

Information you need at enrollment

Whether your benefits administrator enrolls you online or you complete a paper *Notice of Election* form, you will need to answer some questions. Below is information you may wish to bring to your enrollment meeting.

Information required	
For you	Social Security number, including a copy of the Social Security card if available; personal or work email address; annual salary; date of hire (date you report to work)
For each family member you wish to cover	Social Security number, including a copy of the Social Security card(s) if available; date of birth
For you and any family members who are covered by Medicare Part A or Part B	Medicare number; reason for eligibility; effective date of Medicare coverage
For each beneficiary of your Basic or Optional Life coverage	Social Security number; date of birth
For a beneficiary that is an estate or a trust	Name; address; date trust was signed

Documents you need at enrollment

You must bring photocopies of these documents to the meeting during which you enroll in insurance coverage. You will also need this documentation when you add someone to your coverage during an open

³Life insurance coverage is subject to the Dependent Non-confinement Provision (Page 118) as well as the Actively at Work requirement (Page 113). For more information about initial enrollment in Optional Life Insurance, see Page 114.

⁴Active employment means performing all the regular duties of an occupation on an employer's scheduled workday. You may be working at your usual workplace or elsewhere, if you are required to travel. You are also considered engaged in active employment while on jury duty, on a paid vacation day or on one of your employer's normal holidays if you were engaged in active employment

Action	Information required
To cover a spouse	A copy of marriage license or the Common Law Marriage Affidavit ⁵
To cover a former spouse	A copy of divorce decree ordering subscriber to cover former spouse
To cover a natural child	A copy of long-form birth certificate showing subscriber as parent
To cover a stepchild	A copy of long-form birth certificate showing name of natural parent; proof that natural parent and the subscriber are married
To cover an adopted child or a child placed for adoption	A copy of long-form birth certificate showing subscriber as parent or a copy of legal adoption document from court stating adoption is complete; or a letter of placement from an attorney, an adoption agency, or the South Carolina Department of Social Services stating adoption is in progress
To cover a foster child	A court order or another legal document placing child with subscriber, who is a licensed foster parent
To cover other children	For all other children for whom subscriber has legal custody, a court order or other legal document granting custody of child to subscriber (document must verify subscriber has guardianship responsibility for child, not just financial responsibility)
To cover an incapacitated child	Incapacitated Child Certification Form (see the Incapacitated child section on Page 15 for complete information on the process); plus proof of the relationship
To enroll in the TRICARE Supplement Plan	A copy of subscriber's TRICARE ID card

enrollment period or as a result of a special eligibility situation. Please do not submit original documents to PEBA, as they cannot be returned.

Tips for online enrollment through your benefits administrator

- Your benefits administrator may enroll you online, reducing the potential for enrollment errors that can make resubmitting paperwork necessary.
- If your benefits administrator submits your benefit selections electronically, you will need to register for MyBenefits (www.mybenefits.sc.gov), PEBA's online insurance benefits enrollment system. You will then need to approve your selections by electronically signing a Summary of Enrollment.

⁵A Common Law Marriage Affidavit is a notarized statement signed by both spouses.

- Your benefits administrator can also submit a paper Summary of Enrollment, which you will need to sign.
- Give copies of any documents to your benefits administrator, who will send them to PEBA.

Tips for completing a paper Notice of Election enrollment form

- Fill out the form completely and write clearly.
- Under each benefit, choose a plan or mark "Refuse." When applicable, select a coverage level.
- If you have questions, ask your benefits administrator.
- Be sure to review the form for accuracy, sign it, and provide it to your benefits administrator with copies of the

appropriate documents.

After your initial enrollment

Insurance cards

If you enroll in the State Health Plan Standard Plan, Savings Plan, or Medicare Supplemental Plan, BlueCross BlueShield of South Carolina (BlueCross) will send you health insurance cards for you and your covered family members. You also will receive two pharmacy benefits cards from Express Scripts. Benefits administrators provide State Dental Plan subscribers with a card on which they can write their name and Benefits Identification Number. Dental Plus subscribers also receive an insurance card from BlueCross, which serves as the dental plan contractor. State Vision Plan subscribers receive two paper cards from EyeMed Vision Care.

Please check to make sure that your coverage is active before you go to a doctor or fill a prescription. If you have not received your cards, you can get your Benefits Identification Number by logging into your MyBenefits account at www.mybenefits.sc.gov.

Benefits Identification Number

PEBA assigns each subscriber an eight-number Benefits Identification Number (BIN). This unique number is used instead of a Social Security number in emails and written communication between you, your spouse, your children, and PEBA. It is designed to make your personal information more secure.

The State Health Plan adds a three-letter prefix to your BIN and places this number on your identification card. The BIN, along with the three-letter prefix, is also used on Dental Plus cards. If you are not covered by a plan that uses

the BIN, PEBA will send you your number.

Subscribers need their BIN, without the prefix, to use MyBenefits, PEBA's online insurance benefits enrollment system. If you forget your BIN, visit www.mybenefits.sc.gov and select Get my BIN.

When medical emergencies occur before you receive your card

If you need emergency medical care before you receive your insurance cards, you can still provide proof of your coverage by obtaining your BIN. To do this, visit www.mybenefits.sc.gov and select Get my BIN. You should then give your BIN to your medical care provider. If you have problems or questions when trying to get verification of your benefits, you or the emergency medical care provider should contact BlueCross for assistance.

Enrolling as a transferring employee

As an ongoing employee, PEBA considers you a transfer if you change employment from one participating group to another with no break in insurance coverage, or with a break of employment of no more than 15 calendar days.

If you are transferring to another participating group, be sure to tell the benefits administrator at the workplace you are leaving to avoid a lapse in coverage or delays in processing claims. Check with the benefits administrator at your new employer to be sure that your benefits have been transferred.

If you are an academic employee, you are considered a transfer if you complete a school term and move to another participating academic employer with less than a 26-week

break in employment. Your insurance coverage with the employer you are leaving will remain in effect until you begin work with your new employer, typically September 1. On that date, your new employer will pick up your coverage. If you do not transfer to another participating academic employer, your coverage ends the last day of the month in which you were engaged in active employment.

Ongoing academic employees are considered continuing employees and are eligible to change their coverage if their break in employment is more than 15 calendar days and less than 26 weeks. These ongoing academic employees are treated as new employees if their break in employment is more than 26 weeks. They are eligible to change their coverage.

All other ongoing employees are considered continuing employees eligible to change their coverage if their break in employment is more than 15 calendar days and less than 13 weeks. These ongoing employees are treated as new employees if their break in coverage is more than 13 weeks. They are eligible to change their coverage.

If you are a new variable-hour, part-time, or seasonal employee, check with your benefits administrator for more information.

An open enrollment period occurs every October

During the October open enrollment period, eligible employees, retirees, survivors, and COBRA subscribers may change their coverage⁶

⁶You can add or drop State Dental Plan and Dental Plus coverage only during an open enrollment period in October of odd-numbered years, or within 31 days of a special

eligibility situation.

without having to have a special eligibility situation.

Changing plans or coverage during an open enrollment period

- You can change between the State Health Plan's Savings Plan and Standard Plan during an open enrollment period.
- Retirees and survivors, their eligible spouses, and eligible children who are covered by a health plan may change to the Medicare Supplemental Plan within 31 days of Medicare eligibility or during an open enrollment period.
- Eligible members of the military community may add or drop TRICARE Supplement Plan coverage for themselves and for their eligible dependents during open enrollment.
- You may add or drop State Vision Plan coverage for yourself, your eligible spouse, and eligible children during open enrollment⁷.
- Other changes you may make in your coverage are explained in the *Benefits Advantage*, PEBA's open enrollment newsletter, which you receive each September. Changes made during an open enrollment period become effective the following January 1.

If you are an active employee of a state agency, higher education institution, or public school district, contact your benefits administrator for details. Retirees, survivors, or COBRA subscribers should contact PEBA. If you are an active employee, retiree, survivor, or COBRA

⁷There may be exceptions to this rule. Contact your benefits

administrator for additional information.

subscriber of a local subdivision, contact the benefits administrator at the local subdivision with which you have a coverage relationship.

MyBenefits – PEBA's online insurance benefits enrollment system

The easiest way to change your coverage during an open enrollment period is through the MyBenefits website at www.mybenefits.sc.gov. During October, each section in which you are eligible to make changes includes links to instructions.

If you're the subscriber, you can use MyBenefits throughout the year to:

- Update your contact information.
- Print a list of the insurance plans under which you are covered.
- Get your eight-digit Benefits Identification Number (BIN).
- Update your beneficiaries.
- Approve changes made as a result of a special eligibility situation.

You cannot access any information about the status of any claims or about your benefits through MyBenefits. Please refer to the appropriate chapter in this guide and or visit www.peba.sc.gov/insurance.html.

To protect the confidentiality of your insurance information, you must register the first time you use MyBenefits.

Special eligibility situations

A special eligibility situation is an event that

allows you, as an eligible employee, retiree, survivor, or COBRA subscriber, to enroll in or drop coverage for yourself or eligible family members outside of an open enrollment period⁸. To make a change, you will need to:

- Contact your benefits administrator;
- Complete a *Notice of Election* form within 31 days⁹ of the event; and
- Give your benefits administrator copies of the appropriate documents.

If you are an active employee and are eligible to change your health, dental/Dental Plus, State Vision Plan, or Optional Life Insurance coverage due to a special eligibility situation, you also may enroll in or drop the Pretax Group Insurance Premium Feature, which is explained on Page 144.

Marriage

If you want to add a spouse to your coverage because you marry, complete a *Notice of Election* form and submit it to PEBA along with a copy of your marriage license or an executed *Common Law Marriage Affidavit* within 31 days of the date of your marriage. The forms are available on PEBA's website at www.peba.sc.gov/iforms.html or by contacting PEBA or your benefits administrator for copies.

If you and your eligible dependents are not covered, you may add health, dental/Dental Plus, and State Vision Plan coverage for yourself, your existing eligible dependents, your new spouse, and new stepchildren within 31 days of the date of your marriage. If you add your new spouse or your new stepchildren to your health coverage, you may also change health plans. You may add your new spouse or new stepchildren to dental/Dental Plus

⁸A salary increase or decrease does not create a special eligibility situation.

⁹Changes related to Medicaid or the Children's Health Insurance Program (CHIP), must be made within 60 days.

and State Vision Plan coverage. A copy of the marriage license or *Common Law Marriage Affidavit* is required to cover the new spouse. Long-form birth certificates are required for each stepchild you want to cover. Marriage also allows a covered subscriber to enroll in or increase Optional Life coverage up to \$50,000 without evidence of insurability. For information about eligibility for Dependent Life - Spouse coverage, including amounts in which a newly eligible spouse may enroll without evidence of insurability, see the Dependent Life Insurance section, which begins on Page 116 in the **Life insurance** chapter of this guide.

You cannot cover your spouse if your spouse is eligible, or becomes eligible, for coverage as an employee of a group participating in insurance or as a funded retiree of a participating group who has a part of the spouse's premiums paid for the spouse. If you do not add your new spouse or your new stepchildren within 31 days of the date of marriage, you cannot add them until the next open enrollment period, held in October, or within 31 days of another special eligibility situation.

Legal separation

If you and your covered spouse separate, your spouse may remain on your health, Dental/ Dental Plus, State Vision Plan, and Dependent Life-Spouse coverage until the divorce is final.

If you do not participate in the MoneyPlus pretax premium feature, you can remove your spouse from your coverage when you separate. If you remove your spouse from health, dental, or vision coverage, you must also remove your spouse from the other two programs. For example, if you remove your spouse from dental coverage, you must also remove your

spouse from health and vision coverage. To do so, give your benefits administrator a copy of a court order signed by a Family Court judge. A letter from an attorney is not sufficient documentation. Attach the court order to a completed *Notice of Election* form and give the documents to your benefits administrator within 31 days of the date the court document was stamped. Your spouse's coverage will end the last day of the month after the date of separation. If you do not request your spouse be removed from coverage within 31 days of the date stamp on the order, you must wait until the divorce is final, until the next open enrollment period, or until another special eligibility situation occurs.

Also, if you do not participate in the MoneyPlus pretax premium feature and if your divorce is in process, you may enroll in or increase Optional Life coverage for up to \$50,000 without evidence of insurability. Submit a completed *Notice of Election* form to your benefits administrator within 31 days of the date of a court order signed by a Family Court judge. You can also decrease or cancel your Optional Life coverage.

If you reconcile with your spouse after you drop their health insurance, it cannot be reinstated until the next open enrollment period, held in October, or within 31 days of a special eligibility situation.

Dental/Dental Plus coverage can be reinstated during the next open enrollment period in an odd-numbered year or within 31 days of a special eligibility situation. Vision coverage can be reinstated during the next open enrollment period or within 31 days of a special eligibility situation.

You cannot drop your spouse from your MoneyPlus coverage because you are in the process of a divorce. When a divorce is final, it

is a change-in-status event that permits you to change your MoneyPlus account.

Divorce

If you divorce, your former spouse and former stepchildren are no longer eligible for coverage unless a Family Court requires you to provide coverage. To remove your former spouse and former stepchildren from your coverage, complete a *Notice of Election* form and submit a complete copy of your divorce decree within 31 days of the date stamped on the divorce decree. Coverage for your former spouse and former stepchildren will end the last day of the month after the date stamped on the divorce decree. If you drop your former spouse or former stepchildren from coverage after 31 days of the date stamped on the court order or divorce decree by the court, the change in coverage is effective the first of the month after your signature on a completed *Notice of Election* form dropping your former dependents.

You may continue to provide health, dental, and vision coverage for your former spouse and stepchildren only if a Family Court requires you to do so. To continue coverage, complete a *Notice of Election* form and give it to your benefits administrator along with a copy of the divorce decree ordering you to cover your former spouse and former stepchildren. The court document must list the plans under which your former spouse and former stepchildren must be covered. Retirees of state agencies, higher education institutions, and school districts; survivors; and COBRA subscribers should notify PEBA. Retirees of local subdivisions should notify their benefits administrator at the employer with which they have a coverage relationship.

You cannot continue to cover your former spouse or former stepchildren under

Dependent Life Insurance under any circumstances.

When your divorce is final, you can enroll in or increase your Optional Life coverage by \$50,000 without evidence of insurability. You may also cancel or decrease your Optional Life coverage.

You also may be able to make changes in a Medical Spending Account or a Dependent Care Spending Account.

If you remarry, you may not cover both your former spouse and your current spouse under any PEBA insurance benefits plan. You can, however, cover one spouse under one plan (health, for example) and the other spouse under another plan (dental, for example). Former spouses and former stepchildren who lose coverage due to a qualifying event, such as divorce, may be eligible to continue coverage under COBRA. For more information, contact the subscriber's benefits administrator or PEBA within 60 days after the event or from when coverage would have been lost due to the event, whichever is later.

Please note that an employee who covers an ex-spouse on any benefit is not eligible for the Pretax Group Insurance Premium Feature. This does not affect the employee's eligibility to participate in a Medical Spending Account or a Dependent Care Spending Account.

Adding children

Eligible children may be added by submitting a *Notice of Election* form and completing other requirements within 31 days of:

- Date of birth (effective on the date of birth);
- Marriage of the subscriber to the child's parent (effective on the date of the marriage);

- Gaining custody or guardianship with a court order (effective on the date the court stamped on the order);
- Adoption or placement for adoption (effective on the date of birth if adopted within 31 days of birth; otherwise, effective on the date of adoption or placement for adoption);
- Placement of a foster child (effective on the date of placement); or
- Loss of other coverage (effective on the date of loss of coverage).

The newly eligible child must be offered health, Dental/Dental Plus, and State Vision Plan coverage. If the employee and eligible dependents were not previously covered, they may elect coverage at this time as well. If you and your existing dependents were previously covered, you may elect to change health plans when you add the new child.

If, within 31 days, an employee adds coverage of a newborn or a child who is adopted or placed with the employee for adoption, he can enroll in Optional Life or increase his coverage up to \$50,000 without evidence of insurability.

An employee also may enroll in Dependent Life-Child.

Children must be listed on your *Notice of Election* form to be covered, even if you already have full family or employee/children coverage. You must also submit a copy of the child's long-form birth certificate. Notification to Medi-Call of the delivery of your baby does not add the baby to your health insurance.

To add a stepchild, submit a copy of his long-form birth certificate, showing the name of the child's natural parent, and proof that the natural parent and the subscriber are married.

To add a child under 18 who is adopted or placed for adoption, you must submit a *Notice of Election* form with one of the following:

- A copy of the long-form birth certificate showing the subscriber as the parent;
- A copy of the legal adoption documentation from the court verifying the completed adoption; or
- A letter of placement from an adoption agency, attorney, or the South Carolina Department of Social Services verifying the adoption is in progress.

The effective date of health, dental, and vision coverage is the child's date of birth if the child is placed within 31 days of birth. Otherwise, it is the date of adoption or placement. For information about international adoptions, see your benefits administrator.

To add a foster child to your policy, submit a copy of a court order or another legal document placing the child with you, the subscriber, and showing that you are a licensed foster parent. A foster child is not eligible for Dependent Life coverage.

To add other children for whom you have legal custody, you must submit a copy of a court order or other legal document from the South Carolina Department of Social Services or a placement agency granting you custody or guardianship. The documents must verify that the subscriber has guardianship responsibility for the child and not just financial responsibility.

If a court order is issued requiring you to cover your child, you must notify your employer and PEBA and elect coverage within 31 days of the date the court order was stamped by the court. Please note that if the court order was for health or dental coverage, or for both, you must enroll yourself if you are not already covered. A

copy of the entire court order or divorce decree stamped by the court must be attached to the *Notice of Election* form. It must list the names of the children to be covered and the type of coverage that must be provided.

If you and your spouse are both eligible for coverage, only one of you can cover your children under any one plan. For example, one parent can cover the children under health, and the other can cover the children under dental. Only one parent can carry Dependent Life coverage for eligible dependent children.

You also may be eligible to make changes in your Medical Spending Account or Dependent Care Spending Account.

Dropping a spouse or children

If a covered spouse or child becomes ineligible, you must drop them from your health, dental, vision, and Dependent Life coverage. This may occur because of divorce or separation. To drop a spouse or child from your coverage, you must complete a *Notice of Election* form within 31 days of the date he becomes ineligible and provide documentation to your benefits administrator.

When a child loses eligibility for health, dental, or vision coverage because he turned 26, the child will be dropped automatically the first of the month after they turn 26. If the child is your last covered child to leave coverage, your level of coverage will be changed.

Eligibility for Dependent Life-Child coverage ends at age 19, unless the child is a full-time student or an incapacitated child.

If your child becomes eligible for group health, dental, vision, or life insurance sponsored by an employer, either as an employee or as a spouse, you have the option to drop him from

your health, dental, or vision coverage. You are required to drop him from Dependent Life-Child coverage. Within 31 days of eligibility, you should provide your benefits administrator with a letter from the employer showing the date the child became eligible for coverage. Your child will be dropped from coverage the first of the month after the notice.

Gaining other coverage

If your spouse gains eligibility for coverage as an employee of a group that also offers insurance benefits through PEBA, you must drop your spouse within 31 days by completing a *Notice of Election* form. No further documentation is needed.

If you or your spouse gain coverage through a group that does not offer insurance benefits through PEBA and you wish to drop your PEBA insurance coverage, you have 31 days to cancel the type of coverage gained. You must complete a *Notice of Election* form and return it to your benefits office with proof of the other coverage. To document gain of coverage, you must present a letter on company letterhead that includes the effective date of coverage, names of all individuals covered and the types of coverage gained. Only those who gained coverage may be dropped. If you fail to cancel coverage within 31 days, you must wait until the next open enrollment period. For more information, contact your benefits administrator or PEBA.

Gain of Medicare coverage

If you, your spouse, or your child gains Medicare coverage, the family member who gained coverage may drop health coverage through PEBA within 31 days of the date that Part A becomes effective. Attach a copy of the Medicare card to a *Notice of Election* form

and give it to your benefits administrator within 31 days of the date on the confirmation letter from the Social Security Administration. Coverage will be canceled on the effective date of the Medicare Part A coverage or, in some circumstances, the first of the month after gain of Medicare.

A gain of Medicare coverage does not permit a subscriber to change dental or vision coverage.

For more information, see the *Insurance Coverage for the Medicare-eligible Member* handbook, available at www.peba.sc.gov/iresources.html and from PEBA.

Loss of other coverage

If you refuse enrollment for yourself or your eligible dependents because of other coverage, you may later be able to enroll yourself and your eligible dependents in coverage if you, your spouse, or children lose eligibility for that other coverage (or if the employer stops contributing to the coverage).

- If you are the employee or retiree and you lose other group health coverage, and you are not already covered by health insurance through PEBA, you may enroll yourself and your eligible dependents in health, Dental/Dental Plus, and State Vision Plan coverage. If you are already covered by health, you cannot make changes.
- If your hours were reduced and you lost coverage, and you are otherwise eligible to be covered as a spouse or a child on your spouse's or parent's plan, you may enroll in health, dental, and vision coverage.
- If you are the employee or retiree and have a spouse or child who loses other group health coverage, you may enroll the eligible spouse and children in health, Dental/Dental Plus, and State Vision Plan coverage. If you are not already covered, you must enroll yourself with the individual who lost coverage. Other dependents who did not lose health insurance coverage may not be enrolled. If you are already covered as an employee or retiree, you may change health plans (for example, Savings Plan to Standard Plan) when you add the spouse or children who lost health insurance coverage. Contributions toward your deductible will start over.
- If you, your spouse, or children lose dental coverage, vision coverage, or both but do not lose health coverage, then you, your spouse, or children who lost the dental or vision coverage may enroll in the type of coverage that was lost. If you are not already covered, you must enroll yourself with the individual who lost coverage.
- An employee who lost other life insurance coverage can enroll in Optional Life coverage for \$10,000 without evidence of insurability or for \$20,000 with evidence of insurability.
- If you refused coverage because you were covered under your parent's plan and you lose that coverage, you may enroll yourself and your eligible family members in health, dental, and vision coverage. For information about Optional Life, Dependent Life-Spouse, Dependent Life-Child, or Supplemental Long Term Disability insurance, contact your benefits administrator.
- Loss of TRICARE coverage is a special eligibility situation that permits an eligible employee or retiree and their eligible dependents to enroll in health, dental, and vision coverage.

You must complete a *Notice of Election* form

within 31 days of the date the other coverage ends. To enroll because of a loss of coverage, you must give your benefits office a letter on company letterhead listing the names of those covered and the date coverage was lost, a completed *Notice of Election* form, and copies of appropriate documents showing how any added family member is related to you. If a subscriber, spouse, or child loses health coverage, he also may enroll in vision or dental coverage, even if he did not lose that coverage.

Coverage under Medicaid or the Children's Health Insurance Program (CHIP)

Gain of Medicaid or CHIP coverage

If you or your covered family members become eligible for Medicaid or CHIP coverage, you have 60 days to drop coverage through PEBA. An employee may cancel health, dental, or vision coverage if they gain Medicaid coverage. If a spouse or a child gains Medicaid, only the family member who gained coverage may be dropped. A copy of the Medicaid approval letter must be attached to the *Notice of Election* form.

Eligibility for premium assistance through Medicaid or CHIP

If you or your spouse and/or children become eligible for premium assistance under Medicaid or through CHIP, you may be able to enroll yourself and your spouse and/or children in PEBA-sponsored health insurance. However, you must request enrollment within 60 days of the date you are determined to be eligible for premium assistance.

Loss of Medicaid or CHIP coverage

If you refused coverage in PEBA-sponsored health, dental, and vision insurance for yourself

or for your eligible spouse or children because of coverage under Medicaid or CHIP and then lost eligibility for that coverage, you may be able to enroll in a PEBA plan. Please see your benefits administrator for more information.

Leaves of absence

PEBA does not determine your employment status, only the coverage that is available to you through PEBA's insurance programs.

Premiums while on unpaid leave

If you are enrolled in benefits and remain eligible for coverage, your coverage will continue. You should contact your benefits administrator to discuss payment arrangements.

If you are on unpaid leave and you can no longer afford premiums for the health plan in which you are enrolled through PEBA, you may drop all of your coverage with PEBA only if you intend to enroll in another health plan through the Health Insurance Marketplace. Because you are voluntarily dropping coverage, neither you nor any of your dependents will be eligible for continued coverage under COBRA. If you drop coverage, you will only be permitted to re-enroll during open enrollment or within 31 days of gaining eligibility under a provision of the plan, such as a special eligibility situation.

If your coverage is canceled due to failure to pay premiums, you will not be eligible for COBRA continuation coverage, and you will not be eligible to re-enroll in benefits with your employer until the next open enrollment period, if you are eligible, or within 31 days of gaining eligibility under a provision of the plan. For more information on continuation of coverage under COBRA, see Pages 29–31.

Life insurance while on unpaid leave

You may continue your Optional Life, Dependent Life-Spouse, and Dependent Life-Child insurance for up to 12 months from your last day worked. If you elect not to continue your life insurance while you are on unpaid leave you may convert your coverage to an individual whole life policy by completing the appropriate form within 31 days of your last day worked.

Supplemental Long Term Disability Insurance while on paid or unpaid leave

Your Supplemental Long Term Disability (SLTD) insurance will end 30 days from your last day worked. There is no option to continue SLTD. For more information, contact your benefits administrator.

Family and Medical Leave Act (FMLA) leave

Under the Family and Medical Leave Act (FMLA) employers are required to provide job-protected leave, continuation of certain benefits, and restoration of certain benefits upon return from leave for certain specified family and medical reasons. If you are going on FMLA leave or returning from FMLA leave, contact your benefits administrator for information.

Military leave

Under the Uniformed Services Employment and Re-employment Rights Act (USERRA) employers are required to provide certain re-employment and benefits rights to employees who serve or have served in the uniformed services. If you are going on military leave or returning from

military leave, please contact your benefits administrator for information.

Workers' Compensation

If you are on approved leave and receiving workers' compensation benefits under state law, you may continue your coverage as long as you pay the required premium. Insurance offered through PEBA is not meant to replace workers' compensation and does not affect any requirement for coverage for workers' compensation insurance. It is not intended to provide or duplicate benefits for work-related injuries that are within the Workers' Compensation Act. If you need more information, contact your benefits office.

When coverage ends

Your coverage will end:

- The last day of the month in which you were engaged in active employment, unless you are transferring to another participating group;
- The last day of the month in which you become ineligible for coverage (for example, your working hours are reduced from full-time to part-time);
- The day after your death;
- The date the coverage ends for all subscribers; or
- The last day of the month in which your premiums were paid in full. You must pay the entire premium, including the tobacco-use premium, if it applies.

Coverage for your spouse and children will end:

- The date your coverage ends;
- The date coverage for spouses and children is no longer offered; or

- The last day of the month in which your spouse or child's eligibility for coverage ends.

If your coverage or your spouse or child's coverage ends, you may be eligible for continuation of coverage as a retiree, as a survivor, or under COBRA. To drop a spouse or child from coverage, complete a *Notice of Election* form within 31 days of the date the spouse or child is no longer eligible for coverage.

Continuation of coverage (COBRA)

Eligibility

COBRA, the Consolidated Omnibus Budget Reconciliation Act, requires that continuation of group health, vision, dental, or Medical Spending Account coverage¹⁰ be offered to you and your covered spouse and children if you are no longer eligible for coverage due to a qualifying event. Qualifying events include:

- The covered employee's working hours are reduced from full-time to part-time;
- The covered employee voluntarily quits work, retires, is laid off, or is fired (unless the firing is due to gross misconduct);
- A covered spouse loses eligibility due to a legal separation or divorce; or
- A child no longer qualifies for coverage.

If you are a variable-hour or seasonal employee, you are not eligible for a Medical Spending Account and may not enroll in one under COBRA. The other rules discussed in this section apply to you and to your covered dependents. For more information, contact your employer.

PEBA serves as the benefits administrator

for COBRA subscribers of state agencies, higher education institutions, and public school districts. COBRA subscribers from local subdivisions keep the same benefits administrator.

When continued coverage will not be offered

Continued coverage under COBRA will not be offered to an individual who loses coverage:

- For failure to pay premiums;
- When coverage was canceled at the subscriber's request; or
- When a member is otherwise deemed ineligible.

How to continue coverage under COBRA

For a covered spouse or children or both to continue coverage under COBRA, the subscriber or covered family member must notify his benefits office within 60 days after the qualifying event or the date coverage would have been lost due to the qualifying event, whichever is later. Otherwise, the individual will lose his rights to continue his coverage.

To continue coverage under COBRA, a *COBRA Notice of Election* form and premiums must be submitted. The premiums must be paid within 45 days of the date coverage was elected. The first premium payment must include premiums back to the date of the loss of coverage.

Continued coverage starts when the first premium is paid. It is effective the day after your previous coverage ended. Coverage remains in effect only as long as the premiums

¹⁰Individuals eligible for continued coverage under COBRA may continue to participate in a Health Savings Account as long as they remain covered by the Savings Plan and meet other eligibility requirements.

are up to date. A premium is considered paid on the date of the postmark or the date it is hand-delivered, not the date on the check.

Example COBRA scenario

You lost coverage on June 30, elected COBRA coverage on August 15 and paid the initial premium on September 17. You would be required to pay three premiums: one for the month following the date you lost coverage (July); one for the month in which you elected coverage (August); and one for the month in which you made your first payment (September).

How continued coverage under COBRA may end

Continued coverage will end before the maximum benefit period is over if:

1. A subscriber fails to pay the full premium on time;
2. A qualified beneficiary gains coverage under another group health plan;
3. A qualified beneficiary becomes entitled to Medicare;
4. PEBA no longer provides group health coverage;
5. During a disability extension, the Social Security Administration determines the qualified beneficiary is no longer disabled; or
6. An event occurs that would cause PEBA to end the coverage of any subscriber, such as the subscriber commits fraud.

The qualified beneficiary, his personal representative, or his guardian is responsible for notifying PEBA when he is no longer eligible for continued coverage. Continued coverage will be canceled automatically by

PEBA in the above situations numbered 1, 3 and 6. The qualified beneficiary is responsible for submitting a *Notice to Terminate COBRA Continuation Coverage*, along with supporting documents, in situations 2 and 5.

If you decide to terminate your COBRA coverage early, you generally won't be able to get a Health Insurance Marketplace plan outside of the open enrollment period. Furthermore, if the election period expires, and you then choose to terminate your COBRA coverage early, you cannot afterward change your mind and get COBRA coverage at a later date. A qualified beneficiary may cancel COBRA coverage by submitting a completed *Notice to Terminate COBRA Continuation Coverage* form.

When benefits provided under COBRA run out

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) guarantees that persons who have exhausted continued coverage under COBRA and are not eligible for coverage under another group health plan have access to health insurance without being subject to a pre-existing condition exclusion period. However, certain conditions must be met. In South Carolina, the South Carolina Health Insurance Pool provides this guarantee of health insurance coverage. For information, call 803.788.0500, ext. 46401 or 800.868.2500, ext. 46401.

Extending continued coverage

If you enroll in continued coverage under COBRA, an extension of the maximum period of coverage may be available if you, as a qualified beneficiary, are disabled or a second qualifying event occurs. You must notify your COBRA administrator, within certain time frames, of a disability or a second qualifying event to extend

the period of continued coverage. Failure to provide timely notice of a disability or a second qualifying event may affect the right to extend the period of continued coverage under COBRA.

Other coverage options

Under the federal Affordable Care Act, you can buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a tax credit that lowers your monthly premium. Information about premiums, deductibles, and other out-of-pocket costs is available before enrollment. Eligibility for COBRA does not limit your eligibility for a tax credit through the Marketplace.

If your working hours are reduced and you can no longer afford premiums for the health plan in which you are enrolled through PEBA, you may drop that coverage only if you intend to enroll in another health plan through the Marketplace. Contact your benefits administrator to complete the appropriate form.

You also may qualify for special enrollment in another group health plan for which you are eligible, such as a spouse's plan, even if the plan generally does not accept late enrollees. However, you must request enrollment within 31 days.

Should you voluntarily drop coverage through PEBA because of a reduction in hours but later your hours are increased, you will only be permitted to re-enroll during open enrollment or within 31 days of gaining eligibility under a provision of the plan, such as a special eligibility situation.

Death of a subscriber or covered spouse or child

If an active employee or a retiree of a local subdivision dies, a family member should contact the deceased's employer to report the death, to discontinue the employee's coverage, and to start survivor coverage for his covered spouse and children. If a retiree of a state agency, higher education institution, or public school district dies, a family member should contact PEBA.

To continue coverage, a *Survivor Notice of Election* form must be completed within 31 days of the subscriber's date of death. A new Benefits Identification Number will be created, and identification cards will be issued by the vendors of the programs under which the survivors are covered.

If your covered spouse or child dies, please contact your benefits administrator. PEBA serves as the benefits administrator for retirees of state agencies, higher education institutions, and public school districts. Retiree subscribers of local subdivisions keep the same benefits administrator from their former employer.

Survivors

Coverage for survivors of employees who were not killed in the line of duty

When a covered employee dies, his spouse and children who are covered under the State Health Plan are eligible as survivors to receive a one-year waiver of their health insurance premiums, including the tobacco-use premium if it applies.

When a retiree of a state agency, higher education institution, or public school district

whose insurance premiums were funded in part dies, his qualified survivors will have their premiums waived for a year. This is not necessarily the case with a retiree of a local subdivision because local subdivisions may choose to waive the premiums of survivors of retirees but are not required to do so. A survivor of a retiree of a participating local subdivision should check with the retiree's benefits administrator to determine whether the waiver applies.

After the premium has been waived for a year, a survivor must pay the subscriber and employer share of the premium to continue coverage. If the deceased and his spouse are either covered employees or retirees at the time of death, the surviving spouse is not eligible for the premium waiver.

Dental and vision premiums are not waived, although survivors, including survivors of a subscriber covered under the TRICARE Supplement Plan, may still continue dental and vision coverage by paying the full premium.

Coverage for survivors of employees who were killed in the line of duty

If a covered employee, employed by a participating group, is killed in the line of duty while working for a participating group, his covered spouse and children will have their health and dental insurance premiums waived for the first year after the death. Survivors must submit verification that the death occurred in the line of duty.

In cases where an employee who is covered by the TRICARE Supplement Plan is killed in the line of duty while working for a participating group, any covered spouse or children will have their dental premiums waived for the first year after the death. Also in this case, survivors must

submit verification of death in the line of duty.

After the end of this one-year waiver, a covered surviving spouse and covered surviving children can choose to continue coverage by paying the employer-funded rate, in cases where the deceased employee worked for a state agency, higher education institution, or a public school district employee. They may continue at this rate until they become ineligible. The survivor coverage premium rate can differ in cases where the deceased worked for a participating local subdivision. The local subdivision can choose to contribute to a survivor's insurance premium, but is not required to do so. Even when employers do not contribute, survivors may continue coverage by paying the full rate for as long as they remain eligible.

Ongoing eligibility and open enrollment for survivors

A surviving spouse may continue coverage until the spouse remarries. A child can continue coverage until he is no longer eligible. See the Eligible children section on Page 15 for more information. Please notify PEBA within 31 days of loss of eligibility for coverage. A person who is no longer eligible for coverage as a survivor may be eligible to continue coverage under COBRA. Contact PEBA for details.

As long as a survivor remains covered by health, vision, or dental insurance, he can add health and vision during the annual October open enrollment period, or within 31 days of a special eligibility situation. Dental coverage can be added or dropped but only during open enrollment in an odd-numbered year or within 31 days of a special eligibility situation.

If a survivor drops health, vision, and dental insurance, he is no longer eligible as a survivor and cannot re-enroll in coverage, even during

open enrollment.

If a surviving spouse becomes an active employee of a participating employer, he can switch to active coverage. When he leaves active employment, he can go back to survivor coverage within 31 days, if he has not remarried.

Appeals of eligibility determinations

What if I disagree with a decision about eligibility?

This chapter summarizes the eligibility rules for benefits offered through PEBA, but eligibility determinations are subject to the provisions of the Plan of Benefits and to state law.

If you are dissatisfied after an eligibility determination has been made, you may ask PEBA to review the decision.

- Employees can submit a Request for Review through their benefits office. Benefits administrators may write a letter or use the *Request for Review* form, which is found at www.peba.sc.gov/iforms.html, under Other forms.
- Retirees, survivors, and COBRA subscribers of state agencies, public school districts, or higher education institutions can submit requests directly to PEBA, which serves as their benefits administrator.
- Retirees, survivors, or COBRA subscribers of local subdivisions can submit requests through the benefits office of their former employer, which serves as their benefits administrator.

If the request for review is denied, you may then appeal by writing to the PEBA Appeals Committee within 90 days of notice of the

decision. Please include a copy of the denial with your appeal. Send the request to:

Appeals Department
S.C. PEBA
202 Arbor Lake Drive
Columbia, SC 29223

If your appeal relates to a pregnancy, newborn child, or the preauthorization of a life-saving treatment or drug, you may send your request to PEBA by email or fax to:
urgentappeals@peba.sc.gov.

A healthcare provider or benefits administrator may not appeal to PEBA on your behalf. Only you, the member, or your authorized representative may initiate an appeal through PEBA. A provider or benefits administrator may not be an authorized representative.

PEBA will make every effort to process your appeal within 180 days of the date it receives your appeal information. However, this time may be extended if additional material is requested or you ask for an extension. PEBA will send you periodic updates on the status of your review. When PEBA's review of your appeal is complete, you will receive a written determination in the mail.

If the denial is upheld by the PEBA Appeals Committee, you have 30 days to seek judicial review at the Administrative Law Court, as provided by Sections 1-11-710 and 1-23-380 of the S.C. Code of Laws, as amended.



Health insurance

Your State Health Plan choices

The State Health Plan offers the Standard Plan, the Savings Plan (Page 36) and, if you are retired and enrolled in Medicare, the Medicare Supplemental Plan (Page 37). Eligible members of the military community may enroll in the GEA TRICARE Supplement Plan (Page 79).

In this chapter, you can learn more about how your out-of-pocket costs are determined, provider networks, what services are covered, and other features that are common to the health insurance programs offered through PEBA.

The Standard Plan

The Standard Plan has higher premiums but lower annual deductibles than the Savings Plan. When one family member meets their deductible, the Standard Plan will begin to pay benefits for them, even if the family deductible has not been met. When you buy a prescription drug with the Standard Plan, you pay only the required copayment rather than paying the full allowed amount. An allowed amount is defined as the most a health plan allows for a covered service or product, whether it is provided in-network or out-of-network. When providers join the network, they agree to provide prescriptions when members provide only a copayment.

The Savings Plan

As a Savings Plan subscriber, you save money through lower premiums and you take greater responsibility for your health care costs through a higher annual deductible. You pay the full allowed amount for covered medical benefits, including behavioral health benefits such as

mental health and substance use benefits, as well as prescription drug benefits, until you reach the deductible. With the Savings Plan, the family deductible must be met before any member receives payment for benefits.

The Savings Plan's status as a tax-qualified, high-deductible health plan means that it offers the advantage of a Health Savings Account (HSA). HSAs are available only when you meet several criteria:

- You are enrolled in the Savings Plan; and
- You are not enrolled in any other plan, except in cases where the other plan is also a high-deductible plan (Medicare is not high-deductible, and so would exclude you); and
- You are not claimed as a dependent on another person's tax return.

Funds in an HSA may be used to pay qualified medical expenses and can roll over from one year to the next.

The Medicare Supplemental Plan

To learn more about how the Standard Plan and the Medicare Supplemental Plan work with Medicare, see the *Insurance Coverage for the Medicare-eligible Member* handbook, which is available at www.peba.sc.gov/assets/medicarehandbook.pdf and from PEBA.

Comparing the plans

The following chart illustrates how your deductible, copayments, and coinsurance work together, as well as other features of the Standard Plan and Savings Plan. This overview

Continued on Page 37

Benefits at a glance

Comparison of health plans offered for 2017

Plan ¹	Savings Plan		Standard Plan ²	
	In-network	Out-of-network ³	In-network	Out-of-network ³
Availability	Coverage worldwide		Coverage worldwide	
Annual deductible	Single: \$3,600 Family: \$7,200 ⁴		Single: \$445 Family: \$890	
Coinsurance⁵	Plan pays 80% You pay 20%	Plan pays 60% You pay 40%	Plan pays 80% You pay 20%	Plan pays 60% You pay 40%
Coinsurance maximum	Single \$2,400 Family \$4,800 Excludes deductible	Single \$4,800 Family \$9,600 Excludes deductible	Single \$2,540 Family \$5,080 Excludes deductible and copayments	Single \$5,080 Family \$10,160 Excludes deductible and copayments
Physician's office visits and virtual visits through Blue CareOnDemand⁵	No copayment Plan pays 80% You pay 20%	No copayment Plan pays 60% You pay 40%	\$12 copayment Plan pays 80% You pay 20%	\$12 copayment Plan pays 60% You pay 40%
Hospitalization/emergency care^{6,7}	No copayments for outpatient facility services or emergency care		Outpatient facility services: \$95 copayment Emergency care: \$159 copayment Plan pays 80% You pay 20%	Outpatient facility services: \$95 copayment Emergency care: \$159 copayment Plan pays 60% You pay 40%
Chiropractic	\$500 limit per covered person		\$2,000 limit per covered person	
Prescription drugs⁸	Participating pharmacies and mail order: You pay the State Health Plan's allowed amount until your annual deductible is met. Afterward, the Plan will pay 80% of the allowed amount; you pay 20% in coinsurance. Drug costs are applied to your coinsurance maximum. When the maximum is reached, the Plan will pay 100% of the allowed amount, and you may obtain the medication at no cost.		Participating pharmacies only (up to 30-day supply) Tier 1 (generic-lowest cost alternative): \$9 Tier 2 (brand-higher cost alternative): \$38 Tier 3 (brand-highest cost alternative): \$63 Mail order and retail maintenance network pharmacies (up to 90-day supply) Tier 1: \$22 Tier 2: \$95 Tier 3: \$158 Copoly maximum: \$2,500	
Prescription drug deductible per year			No annual deductible	
Lifetime maximum	None		None	
Tax-favored medical accounts⁹	Health Savings Account Limited-use Medical Spending Account		Medical Spending Account	

Footnotes available on following page.

Plan ¹	Medicare Supplemental Plan
Availability	<ul style="list-style-type: none"> • Same as Medicare • Available to retirees and covered dependents/survivors who are eligible for Medicare
Annual deductible	Pays Medicare Part A and Part B deductibles
Coinsurance⁵	Pays Part B coinsurance of 20%
Coinsurance maximum	None
Physicians office visits⁵	Pays Part B coinsurance of 20%
Hospitalization/emergency care^{6,7}	<p>Inpatient hospital stays Plan pays Medicare deductible, coinsurance for days 61-150; (Medicare benefits may end sooner if the member has previously used any of his 60 lifetime reserve days) Plan pays 100% beyond 150 days (Medi-Call approval required)</p> <p>Skilled nursing facility care Plan pays coinsurance for days 21-100 Plan pays 100% of approved days beyond 100 days, up to 60 days per year</p>
Prescription drugs⁸	<p>Participating pharmacies only (up to 30-day supply)</p> <p>Tier 1 (generic-lowest cost): \$9 Tier 2 (brand-higher cost): \$38 Tier 3 (brand-highest cost): \$63</p> <p>Mail order and retail maintenance network pharmacies (up to 90-day supply)</p> <p>Tier 1: \$22 Tier 2: \$95 Tier 3: \$158</p> <p>Copay maximum: \$2,500</p>

Footnotes for comparison chart

¹State Health Plan subscribers who use tobacco or cover dependents who use tobacco will pay a \$40-per-month premium for subscriber-only coverage and \$60 for other levels of coverage. See Page 187 in the **Premiums** chapter for more information. The tobacco-use premium does not apply to TRICARE Supplement subscribers.

²See the *Insurance Coverage for the Medicare-eligible Member* handbook, located at

www.peba.sc.gov/assets/medicarehandbook.pdf, for information on how this plan coordinates with Medicare.

³An out-of-network provider may bill you for more than the plan's allowed amount for services.

⁴If more than one family member is covered, no family member will receive benefits, other than preventive benefits, until the \$7,200 annual family deductible is met.

⁵The \$12 copayment is waived for routine Pap tests, routine mammograms, and well child care visits. Standard Plan subscribers who receive care at a BlueCross-affiliated PCMH provider will not be charged the \$12 copayment for a physician office visit. After Savings Plan and Standard Plan subscribers meet their deductible, they will pay 10 percent coinsurance, rather than 20 percent, for care at a Patient-Centered Medical Home. More information about Blue CareOnDemandSM is available on Page 39.

⁶\$95 copayment for out-patient facility services is waived for emergency room, physical therapy, speech therapy, occupational therapy, oncology, and dialysis services, routine mammograms and Pap tests, clinic visits, partial hospitalizations, intensive outpatient services, electro-convulsive therapy, and psychiatric medication management.

⁷\$159 copayment for emergency care is waived if admitted.

⁸Prescription drugs are not covered at out-of-network pharmacies.

⁹See the **MoneyPlus** chapter on Page 142 for more information on these accounts, which can allow you to pay medical expenses or in some cases premiums with pretax dollars.

Continued from Page 35

is for comparison only. The Plan of Benefits, which includes a complete description of the plan, governs the Standard, Savings, and Medicare Supplemental plans offered by the state. It is available at www.peba.sc.gov/assets/planofbenefits.pdf, or from your benefits administrator.

Please note that the \$12 Standard Plan physician office visit copayment is not charged for services received at a BlueCross BlueShield of South Carolina (BlueCross)-affiliated Patient-Centered Medical Home (PCMH). Also, Savings Plan and Standard Plan members pay 10 percent coinsurance rather than 20 percent coinsurance at PCMH providers once their deductibles have been met. See Page 71 for more information about Patient-Centered Medical Homes.

Your online State Health Plan tools

These websites cover information specific to your health and dental benefits. Learn more about online tools for your prescription benefits on Page 84 and State Vision Plan benefits on Page 105.

StateSC.SouthCarolinaBlues.com

The BlueCross website for State Health Plan subscribers offers:

- The Find a Doctor tool for locating network providers, including dental providers;
- Coverage information;
- Forms and documents;
- Information on preventive health benefits, such as the No-Pay Copay program, preventive screenings, flu vaccines, and tobacco cessation; and
- The login for My Health Toolkit® for access to member specific information.

My Health Toolkit® (StateSC.SouthCarolinaBlues.com)

Register and log in so you can:

- See how much of your deductible and coinsurance maximum you have satisfied;
- Check the status of claims, preauthorizations, and bills for health and dental providers;
- View your Explanation of Benefits online rather than by a mailed paper copy;
- Request a benefits identification card;
- Take a Rally Health Survey, which can make use of information you gain through a State Health Plan preventive screening like cholesterol, triglycerides, and glucose,

and which shows you how to address your risk factors;

- Use tools like the calorie-burning calculator, body mass index calculator, a personalized exercise guide, ideal body weight calculator, and target heart rate calculator; and
- Send questions to BlueCross Customer Service.

Rally®

Rally® can help you get healthier, one small, convenient step at a time. Coming to the State Health Plan in April 2017, Rally is a website and mobile app that will give you personalized recommendations to help you move more, eat better, and feel great. Rally is a product of Rally Health Inc., an independent company that offers a digital platform on behalf of BlueCross to State Health Plan subscribers. With Rally, you will be able to:

- Take a quick health survey to find out your Rally Age, a snapshot of your overall health.
- Get Rally-recommended missions based on your survey results. Missions are simple activities designed to improve your diet, fitness, and mood.
- Sync your personal fitness device to Rally and join group challenges. Challenges allow you to compete with others while exploring destinations around the world using your own steps on a virtual course.
- Earn rewards – virtual coins – by completing missions and challenges, and even for just logging in. You can use the coins to enter sweepstakes for fitness gear and other great prizes.
- Join online communities made up of people who share your health interests

and concerns.

Look out for Rally in early April 2017!

www.CompanionBenefitAlternatives.com

On the website of Companion Benefit Alternatives, the behavioral health manager, you may find under Members:

- The Find a Doctor tool for locating network behavioral health providers;
- Information about Companion Benefit Alternatives' case management program and behavioral health coaching programs;
- The Balanced Living monthly member e-newsletter that covers current behavioral health topics with helpful advice; and
- Resources for managing mental health issues.

Virtual visits: Blue CareOnDemandSM

Effective January 1, 2017, State Health Plan members enrolled in the Standard Plan or Savings Plan have access to Blue CareOnDemand, a telehealth (or "virtual visit") option offered through the State Health Plan's third party administrator, BlueCross. This platform, operated by BlueCross' partner American Well, focuses on live virtual visits through a computer or portable device, and uses on-demand technology in which you can request a visit and connect with a provider in less than two minutes. Virtual visits are available 24/7/365 and offer an affordable and more convenient alternative to emergency rooms and urgent care centers.

Participating doctors are trained to treat patients through virtual technology, following strict protocols specific to virtual visits and using best practices for website manner. As part of these protocols, the provider panel

treats common urgent care diagnoses including sinusitis, respiratory infection, bronchitis, pink eye, and cough as opposed to more severe conditions requiring comprehensive care. If a virtual visit isn't the right type of service for you, you will promptly be referred to a more appropriate point of service and assisted to ensure you get needed care. Blue CareOnDemand permits doctors to see patient-supplied background information prior to consultations, and connects with BlueCross' membership system to confirm your eligibility and determine the correct amount of your patient cost share.

This new virtual visit option is covered as a traditional office visit under each Plan. For example, if you have the Standard Plan, a visit before you meet your deductible can total \$59, and after you meet your deductible can total \$21.40.

Please note that Blue CareOnDemand is the only virtual visit option covered by the State Health Plan. Medicare does not cover virtual visits, so members enrolled in the Medicare Supplemental Plan are not eligible for this service.

How the State Health Plan pays for covered benefits

PEBA contracts with several companies to process your claims in a cost-effective, timely manner. Information for some of these companies, such as prescription or vision benefits, is found in separate chapters. These third party administrators cover health, dental, and behavioral health treatment:

- BlueCross serves as the medical claims processor, handling health

claims and dental claims. Medi-Call, a division of BlueCross, provides medical preauthorization and case management services. For more information about Medi-Call, see Pages 49–51.

- Companion Benefit Alternatives, a wholly owned subsidiary of BlueCross, is the behavioral health manager, handling mental health and substance use treatment preauthorization, case management, and provider networks. For more information, see Pages 51–54.

Subscribers share the cost of their benefits by paying deductibles, copayments, and coinsurance for covered benefits.

Allowed amount

The allowed amount is the maximum amount a plan will pay for a covered service. Network providers accept the allowed amount as their total fee, leaving you responsible only for copayments and any coinsurance after your annual deductible is met. (Savings Plan subscribers do not pay copayments, but rather pay the full allowed amount until the deductible is met.) For out-of-network services, you pay more in coinsurance and the provider may charge more than the allowed amount. See balance billing on Page 48.

Paying health care expenses with the Standard Plan

Annual deductible

The annual deductible is the amount you pay each year for covered medical benefits, including behavioral health benefits, before the plan begins to pay a percentage of the cost of your covered medical benefits. The annual

deductibles are:

- \$445 for individual coverage and
- \$890 for family coverage

Families enrolled in the Standard Plan have the same deductible, no matter how many family members are covered. The family deductible may be met by any combination of two or more family members' covered medical expenses as long as they total \$890. For example, if four people each have \$222.50 in covered expenses, the family deductible has been met, even if no one person has met the \$445 individual deductible. If only one person has met the \$445 individual deductible, the plan will begin paying a percentage of the cost of that person's benefits but not a percentage of the cost of the rest of the family's benefits until the family deductible has been met. No family member's claims may contribute more than \$445 toward the family deductible.

If the subscriber and the subscriber's spouse, who is also covered on the subscriber's own as an employee or retiree, select the same health plan, they share the family deductible. Both spouses will need to be listed on the same *Notice of Election* form in this case.

Payments for non-covered services, copayments, and penalties for not calling Medi-Call, National Imaging Associates, or Companion Benefit Alternatives for the appropriate preauthorization do not count toward the annual deductible.

Copayments

A copayment is a fixed amount you pay for a service in addition to your deductible and coinsurance. Copayments do not apply to your annual deductible or your coinsurance maximum. After you meet your annual deductible, and even after you reach your

coinsurance maximum, you continue to pay copayments.

Standard Plan subscribers pay these copayments:

- Copayments for services in a professional provider's office; for virtual visits; for outpatient facility services, which may be provided in an outpatient department of a hospital or in a freestanding facility; and for care in an emergency room.
- Copayments for prescription drugs.

The copayment for each visit to a professional provider's office is \$12. This copayment is waived for routine Pap tests, routine mammograms, and well child care visits. The \$12 Standard Plan copayment for services received in a provider's office is not charged for services at a BlueCross-affiliated Patient-

Centered Medical Home. See Page 71.

The above example uses a physician's office visit that has a \$56 allowed amount in the Standard Plan.

The copayment for outpatient facility services, which includes outpatient hospital services other than emergency room visits and ambulatory surgical center services, is \$95. This copayment is waived for dialysis, routine mammograms, routine Pap tests, physical therapy, speech therapy, occupational therapy, clinic visits, oncology services, electro-convulsive therapy, psychiatric medication management, and partial hospitalization and intensive outpatient behavioral health services. The copayment for each emergency room visit is \$159. This copayment is waived if you are admitted to the hospital.

A prescription drug copayment is a fixed total amount a Standard Plan subscriber pays each time a prescription is filled at an in-network pharmacy. The prescription drug copayment maximum for each family member covered is \$2,500. Prescription drug copayments do not apply to the annual deductible or the coinsurance maximum. For more information, see Page 84.

Annual deductible has not been met	
Allowed amount	\$56
Copayment	<u>- \$12</u>
Remaining allowed amount, which goes toward the annual deductible	\$44
Copayment	\$12
Applied to deductible	<u>+ \$44</u>
Your total payment	\$56
Annual deductible has been met	
Allowed amount	\$56
Copayment	<u>- \$12</u>
Remaining allowed amount	\$44
Remaining allowed amount	\$44
	<u>x 20%¹⁰</u>
Coinsurance	\$8.80
Copayment	\$12.00
Coinsurance	\$8.80
Your total payment	\$20.80

¹⁰In this example, the Standard Plan paid 80 percent of the \$44 allowed amount remaining after the copayment, totaling \$35.20.

Coinsurance

After you meet your annual deductible, the Standard Plan pays 80 percent of the allowed amount for your covered medical and behavioral health benefits, if you use in-network providers. You pay 20 percent of the allowed amount as coinsurance, which applies to your coinsurance maximum.

If you use out-of-network providers, the plan pays 60 percent of the plan's allowed amount for your covered medical and behavioral health benefits. You pay 40 percent of the allowed

amount as coinsurance, which applies to your out-of-network coinsurance maximum. An out-of-network provider may bill you in excess of the allowed amount. Any charge above the plan's allowed amount for a covered medical or behavioral health benefit is your responsibility. See Pages 48–49 to learn more about balance billing and the out-of-network differential.

Standard Plan members pay 10 percent coinsurance, rather than 20 percent coinsurance, for services received at a BlueCross-affiliated Patient-Centered Medical Home.

A different coinsurance rate applies for infertility treatments and prescription drugs associated with infertility. See Page 70.

Coinsurance maximum

The coinsurance maximum is the amount in coinsurance a subscriber must pay for covered benefits each year before he is no longer required to pay coinsurance. Under the Standard Plan, it is \$2,540 for individual coverage and \$5,080 for family coverage for in-network services, and \$5,080 for individual coverage and \$10,160 for family coverage for out-of-network services.

Please note that the coinsurance for in-network services does not apply to the out-of-network coinsurance maximum. The coinsurance for out-of-network services does not apply to the in-network coinsurance maximum. For example, if you have individual coverage, the network coinsurance maximum is \$2,540 and you have paid \$2,000 for in-network coinsurance and \$600 for out-of-network coinsurance, you have not met your in-network coinsurance maximum.

Standard Plan subscribers continue to pay copayments even after they meet their annual

deductible and coinsurance maximum.

Copayments for services in a provider's office, a virtual visit, an outpatient facility, and in an emergency room do not apply to the annual deductible or to the coinsurance maximum. Prescription drug copayments apply to the \$2,500 prescription drug copayment maximum but do not apply to the annual deductible or the coinsurance maximum.

Payments for non-covered services, as well as the deductibles and the penalties that are incurred when you do not call Medi-Call, National Imaging Associates, or Companion Benefit Alternatives for the appropriate preauthorization, do not count toward the coinsurance maximum.

Paying health care expenses with the Savings Plan

Annual deductible

The annual deductible is the amount you will need to pay each year for covered medical, behavioral health, and prescription drug benefits before the Savings Plan begins to pay a percentage of the cost of your covered benefits. The annual deductibles are:

- \$3,600 for individual coverage and
- \$7,200 for family coverage.

There is no individual deductible if more than one family member is covered. If the subscriber and spouse, who is also covered as an employee or retiree, select the same health plan, they will share the family deductible. The deductible is not met for any covered individual until the total allowed amount paid for covered benefits exceeds \$7,200. For example, even if one family member has paid \$3,601 for covered

medical benefits, the plan will not begin paying a percentage of the cost of his covered benefits until his family has paid \$7,200 for covered benefits. However, if the subscriber has paid \$2,199 for covered benefits, the spouse has paid \$3,001 for covered benefits, and a child has paid \$2,000 for covered benefits, the plan will begin paying a percentage of the cost of the covered benefits for all family members.

If you are covered under the Savings Plan, you also pay the full allowed amount for covered prescription drugs, which is applied to your annual deductible.

Copayments

There are no copayments under the Savings Plan. Until you meet your deductible, you pay the full allowed amount for services, which is applied to your annual deductible.

Coinsurance

After you meet your annual deductible, the Savings Plan pays 80 percent of the allowed amount for your covered medical, prescription drug, and behavioral health benefits if you use in-network providers. You pay 20 percent of the allowed amount as coinsurance. After you meet your coinsurance maximum, the plan will pay 100 percent of the allowed amount.

Savings Plan members pay 10 percent coinsurance, rather than 20 percent coinsurance, of the allowed amount for services received at a BlueCross-affiliated Patient-Centered Medical Home.

If you use out-of-network providers, the plan pays 60 percent of the plan's allowed amount for your covered medical and behavioral health benefits. You pay 40 percent of the allowed amount as coinsurance. An out-of-network provider may bill you in excess of the allowed

amount. Any charge above the plan's allowed amount for a covered medical or behavioral health benefit is your responsibility. See Pages 48–49 to learn more about balance billing and the out-of-network differential. Prescription drug benefits are paid only if you use an in-network pharmacy.

A different coinsurance rate applies for infertility treatments and prescription drugs associated with infertility. See Page 70.

Coinsurance maximum

The coinsurance maximum is the amount in coinsurance a subscriber must pay for covered benefits each year before he is no longer required to pay coinsurance. Under the Savings Plan it is \$2,400 for individual coverage or \$4,800 for family coverage for in-network services and \$4,800 for individual coverage or \$9,600 for family coverage for out-of-network services.

Please note that the coinsurance for in-network services does not apply to the out-of-network coinsurance maximum. The coinsurance for out-of-network services does not apply to the in-network coinsurance maximum. For example: If you have individual coverage and have paid \$2,000 for in-network coinsurance and \$400 for out-of-network coinsurance, you have not met your in-network coinsurance maximum.

Payments for non-covered services, deductibles, and penalties for not calling Medi-Call, National Imaging Associates, or Companion Benefit Alternatives do not count toward the coinsurance maximum.

Paying health care expenses if you're eligible for Medicare

To learn more about how the Standard Plan and the Medicare Supplemental Plan work with Medicare, see the *Insurance Coverage for the Medicare-eligible Member* handbook, which is available at www.peba.sc.gov/assets/medicarehandbook.pdf and from PEBA.

Coordination of benefits with your spouse's coverage

Some families, such as those in which one spouse works for a participating employer and the other works for an employer not covered through PEBA's insurance benefits, may be eligible to be covered by two health plans. While the additional coverage may mean that more of their medical expenses are paid by insurance, they will probably pay premiums for both plans. Weigh the advantages and disadvantages before purchasing extra coverage.

All State Health Plan benefits are subject to coordination of benefits, a process which is used to make sure a person covered by more than one insurance plan will not be reimbursed more than once for the same expenses.

With coordination of benefits, the primary plan pays first. The secondary plan pays after the primary plan. Here are some examples of how this works:

- The plan that covers a person as an employee typically pays before the plan that covers the person as a dependent.

- When both parents cover a child, the plan of the parent whose birthday comes earlier in the year pays first. Keep in mind that other rules may apply in special situations, such as when a child's parents are divorced.
- If you are eligible for Medicare and are covered as an active employee, your State Health Plan coverage pays before Medicare. Exceptions may apply in the case of Medicare coverage due to kidney disease. Contact your local Social Security Administration office for details.
- If a person is covered by one plan because the subscriber is an active employee and by another plan because the subscriber is retired, the plan that covers him as active employee typically pays first. There may be exceptions to this rule.

The State Health Plan is not responsible for filing or processing claims for a subscriber through another health insurance plan.

As part of coordination of benefits with the Standard Plan and the Savings Plan, your *Notice of Election* form asks you if you are covered by more than one group insurance plan. While your response to this is recorded in your file, BlueCross may send you a coordination of benefits questionnaire every year. Complete this form and return it to BlueCross as soon as you are able, because claims will not be processed or paid until BlueCross receives your information. You can also update this information by visiting StateSC.SouthCarolinaBlues.com and going to Resources, then Forms and Documents, and Other Health/Dental Insurance, or by calling BlueCross at 803.736.1576 or 800.868.2520.

This is how the State Health Plan works as secondary insurance:

- For a medical or behavioral health claim, you or your provider files the Explanation of Benefits from your primary plan with BlueCross.
- The State Health Plan will pay the lesser of:
 - What it would pay if it were the primary payer; or
 - The balance after the primary plan's network discounts and payments are deducted from the total charge.
- The State Health Plan's prohibition on balance billing does not apply. Because of this, consider using a provider in your primary plan's network. See Pages 38–47.
- You also will be responsible for the State Health Plan copayments, deductible, and coinsurance (if the coinsurance maximum has not been met).

Please note that if your coverage with any other health insurance program is canceled, you need to request a letter of termination and submit this letter to BlueCross promptly, as claims cannot be processed or paid until BlueCross receives your information.

Using State Health Plan provider networks

Because the State Health Plan operates as a preferred provider organization, it has networks of physicians and hospitals, ambulatory surgical centers, and mammography testing centers. You will notice that the letters “PPO” are printed on your State Health Plan identification card. The Plan also makes networks available to subscribers for durable medical equipment, labs, radiology and X-ray, physical therapy, occupational therapy, speech therapy, skilled nursing facilities, long term acute care facilities, hospices, and dialysis centers. When joining

the network these providers agree to accept the plan's allowed amount for covered benefits as payment in full. In-network providers will charge you for your deductible, copayments, and coinsurance when the services are provided. They also will file your claims.

If you use an out-of-network medical or behavioral health provider or your physician sends your laboratory tests to an out-of-network provider, you will pay more for your care.

Please note that even if you are at an in-network hospital or at an in-network provider's office, the provider may employ out-of-network contract providers or technicians. If an out-of-network provider renders services, even in an in-network facility, it can still balance bill you, and you will still pay the out-of-network differential. For more information, see Pages 48–49.

Finding a medical or behavioral health network provider

To view the online provider directory, go to the BlueCross state-specific website, StateSC.SouthCarolinaBlues.com, and select Find a Doctor. Here you may:

- Search for a provider by name, location, and specialty;
- Search for emergency room alternatives, which are places you can go for care other than an emergency room, such as urgent care centers and walk-in clinics; and
- Narrow your search to just those providers found in State Health Plan network providers by keying in ZCS, which are the three letters that appear at the beginning of your Benefits Identification Number (BIN).
- You can also call BlueCross at

803.736.1576 or 800.868.2520 to request a list of State Health Plan providers in your area.

Companion Benefit Alternatives serves as the behavioral health benefits manager, including mental health and substance use benefits. For behavioral health providers, you can use the Find a Doctor tool at StateSC.SouthCarolinaBlues.com. For help selecting a provider, call Companion Benefit Alternatives at 800.868.1032.

Lists of providers from the network directory are also available from your benefits office or, if you are a retiree, survivor, or COBRA subscriber, from BlueCross. If you have questions about network providers, call BlueCross. If you use an out-of-network provider, you will pay more for your care.

Finding a network provider out of state or overseas

State Health Plan members have access to BlueCross' network of participating doctors and hospitals throughout the United States and around the world through the BlueCard® program. Be sure to always carry your health plan and prescription drug identification cards when traveling because you may still use them out of state. If you are covered by the State Health Plan and need behavioral health care outside South Carolina, call 800.810.2583.

Inside the United States

With the BlueCard® program, you can choose in-network doctors and hospitals that suit you best. Here's how to use your health coverage when you are away from home but within the United States:

1. Locate nearby doctors and hospitals by visiting

StateSC.SouthCarolinaBlues.com or by calling BlueCard Access at 800.810.2583.

2. Call Medi-Call within 48 hours of receiving emergency care. The toll-free number is on your State Health Plan identification card.
3. The provider should file claims with the BlueCross affiliate in the state where the services were provided.

You should not need to complete any claim forms nor pay up front for medical services other than the usual out-of-pocket expenses (deductibles, copayments, coinsurance, and non-covered services). BlueCross will mail an Explanation of Benefits to you.

For information about out-of-network benefits, see Pages 48–49.

Outside the United States

Through the BlueCard Worldwide® program, your State Health Plan identification card gives you access to doctors and hospitals in more than 200 countries and territories worldwide and to a broad range of medical services.

Please note that Medicare does not offer benefits outside the United States. Because the State Health Plan's Medicare Supplemental Plan does not allow benefits for services not covered by Medicare, Medicare Supplemental Plan subscribers do not have coverage outside the United States. See PEBA's *Insurance Coverage for the Medicare-eligible Member* handbook, located at www.peba.sc.gov/assets/medicarehandbook.pdf, for more information.

Here's how to take advantage of the BlueCard Worldwide program:

1. If you have questions before your trip, call the phone number on the back of your State Health Plan identification

card to check your benefits and for preauthorization, if necessary. Your health care benefits may be different outside of the United States.

2. The BlueCard Worldwide Service Center can help you find providers in the area where you are traveling. It can also provide other helpful information about health care overseas. Go to www.bluecardworldwide.com. You must accept the terms and conditions and login with the first three letters of your BIN. Then you may Select a Provider Type. You also can choose a specialty, city, nation, and distance from the city. You can also call toll-free at 800.810.2583, or collect at 804.673.1177 as toll-free numbers do not always work overseas.
3. If you are admitted to the hospital, call the BlueCard Worldwide Service Center toll-free at 800.810.2583 or collect at 804.673.1177 as soon as possible.
4. The BlueCard Worldwide Service Center will work with your plan to arrange direct billing with the hospital for your inpatient stay. When direct billing is arranged, you are responsible for the out-of-pocket expenses (non-covered services, deductibles, copayments, and coinsurance) you normally pay. The hospital will submit your claim on your behalf.
5. Please note that if direct billing is not arranged between the hospital and your plan, you must pay the bill up front and file a claim. For outpatient care and doctor visits, pay the provider when you receive care and file a claim.
6. To file a claim for services you paid for when you received care or paid to providers that are not part of the BlueCard Worldwide network, complete a BlueCard

Worldwide International Claim Form and send it to the BlueCard Worldwide Service Center with this information: the charge for each service; the date of each service and the name and address of each provider; a complete, detailed bill, including line-item descriptions; and descriptions and dates for all procedures and surgeries. This information does not have to be in English. Be sure to get all of this information before you leave the provider's office.

7. The claim form is on the BlueCross website, StateSC.SouthCarolinaBlues.com under Member Resources. You may also call the service center toll-free at 800.810.2583 or collect at 804.673.1177. The address of the service center is on the claim form. BlueCard Worldwide will arrange billing to BlueCross.

If you need proof of insurance for overseas travel, please request it from PEBA in writing. You can do this by going to www.peba.sc.gov/contactus.html or in a letter. The request must be made least 10 working days in advance to ensure you receive it by the desired time.

Prescription drug provider network

For more information about your prescription drug provider network, see Pages 84–86.

Vision care provider network

For more information about the State Vision Plan network, see Pages 105 and 108.

Out-of-network benefits

You can still receive some coverage when you use providers for medical and behavioral health care that are not part of the network.

Before the State Health Plan will pay 100 percent of the plan's allowed amount for out-of-network benefits, Standard Plan subscribers will need to meet their annual deductible and then meet the \$5,080 individual coinsurance maximum or \$10,160 family coinsurance maximum. Savings Plan subscribers will need to meet their annual deductible and then meet the \$4,800 individual coinsurance maximum or \$9,600 family coinsurance maximum. Subscribers to both plans also may need to fill out claim forms.

Please note that no benefits can be paid for advanced radiology services (CT, MRI, MRA or PET scans) that are not preauthorized by National Imaging Associates.

There is no coverage available for prescription drugs filled at an out-of-network pharmacy in the United States. Limited drug coverage is offered to members enrolled in the State Health Plan Prescription Drug Program who become ill while traveling overseas. For more information, see Pages 90–91.

Balance billing

If you use a provider that is not part of the network, you may be balance billed. When the State Health Plan is your primary coverage, in-network providers are prohibited from billing you for covered benefits except for copayments, coinsurance, and the deductible. However, an out-of-network provider may bill you for more than the plan's allowed amount

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Standard Plan

In-network provider	
Billed charge	\$5,000
Allowed amount ¹¹	\$4,000
Annual deductible	- \$445
Allowed amount after annual deductible	\$3,555
Allowed amount after annual deductible	\$3,555
	<u>x 20%</u> ¹²
Coinsurance, which goes toward your coinsurance maximum	\$711
Copayment ¹³	\$12
Annual deductible	+ \$445
Coinsurance	+ \$711
Your total payment	\$1,168

Out-of-network provider	
Billed charge	\$5,000
Allowed amount	- \$4,000
Balance bill ¹⁴	\$1,000
Allowed amount	\$4,000
Annual deductible	- \$445
Allowed amount after annual deductible	\$3,555
Allowed amount after annual deductible	\$3,555
	<u>x 40%</u> ¹⁵
Coinsurance, which goes toward your coinsurance maximum	\$1,422
Copayment ¹³	\$12
Annual deductible	+ \$445
Coinsurance	+ \$1,422
Balance bill	+ \$1,000
Your total payment	\$2,879

¹¹In-network providers are not allowed to charge more than the allowed amount.

¹²In this example, the Standard Plan paid 80 percent of the \$3,555 allowed amount after the deductible, totaling \$2,844.

¹³This assumes that the service is an office visit.

¹⁴Out-of-network providers can charge you any amount they choose above the allowed amount and bill you the balance above the allowed amount.

¹⁵In this example, the Standard Plan paid 60 percent of the \$3,555 allowed amount after the deductible, totaling \$2,133.

Savings Plan

Network provider	
Billed charge	\$5,000
Allowed amount ¹⁶	\$4,000
Annual deductible	- \$3,600
Allowed amount after annual deductible	\$400
Allowed amount after annual deductible	\$400
	$\times 20\%$ ¹⁷
Coinsurance, which goes toward your coinsurance maximum	\$80
Annual deductible	\$3,600
Coinsurance	+ \$80
Your total payment	\$3,680
Out-of-network provider	
Billed charge	\$5,000
Allowed amount	- \$4,000
Balance bill ¹⁸	\$1,000
Allowed amount	\$4,000
Annual deductible	- \$3,600
Allowed amount after annual deductible	\$400
Allowed amount after annual deductible	\$400
	$\times 40\%$ ¹⁹
Coinsurance, which goes toward your coinsurance maximum	\$160
Annual deductible	\$3,600
Coinsurance	+ \$160
Balance bill	+ \$1,000
Your total payment	\$4,760

¹⁶Network providers are not allowed to charge more than the allowed amount.

¹⁷In this example, the Savings Plan paid 80 percent of the \$400 allowed amount after the deductible, totaling \$320.

¹⁸Out-of-network providers can charge you any amount they choose above the allowed amount and bill you the balance above the allowed amount.

¹⁹In this example, the Savings Plan paid 60 percent of the \$400 allowed amount after the deductible, totaling \$240.

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for the covered benefit (up to the provider charges), which will increase your out-of-pocket cost. The difference between what the out-of-network provider charges and the allowed amount is called the balance bill. The balance bill does not contribute toward meeting your annual deductible or coinsurance maximum.

Out-of-network differential

In addition to balance billing, if you receive services from a provider that does not participate in the State Health Plan, Companion Benefit Alternatives, or BlueCard® networks, you will pay 40 percent of the allowed amount instead of 20 percent in coinsurance. These examples show how it will cost you more to use an out-of-network provider.

In both the preceding examples, you have subscriber-only coverage under the State Health Plan and you have not met your deductible. The allowed amount is \$4,000. The provider charged \$5,000 for the service.

Getting preauthorization for your medical care

Health care preauthorization

With the State Health Plan, some covered services require preauthorization by a phone call to Medi-Call before you receive them. Your health care provider may make the call for you, but it is your responsibility to ensure the call is made.

Please note that in addition to regular health coverage, some behavioral health care services as well as radiology (imaging service) and prescription drug benefits also require preauthorization. See Page 51 for behavioral

health, Page 52 for radiology, and Page 89 for prescription drugs.

Penalties for not calling

If you do not preauthorize treatment when required, you will pay a \$200 penalty for each hospital, rehabilitation, skilled nursing facility, or behavioral health admission. In addition, the coinsurance maximum will not apply.

How to preauthorize your treatment

Medi-Call numbers are:

- 803.699.3337
- 800.925.9724
- 803.264.0183 (fax)

You can reach Medi-Call by phone from 8:30 a.m. to 5 p.m., Monday through Friday, except holidays. You may also fax information to Medi-Call 24 hours a day; Medi-Call will respond within one business day. If you send a fax to Medi-Call, provide, at a minimum, the following information so the review can begin:

- Subscriber's name;
- Patient's name;
- Subscriber's BIN or SSN;
- Information about the service requested; and
- A telephone number at which you can be reached during business hours.

Medi-Call promotes high-quality, cost-effective care for you and your covered family members through reviews that assess, plan, implement, coordinate, monitor, and evaluate health care options and services required to meet an individual's needs. You will need to contact Medi-Call at least 48 hours or two working days, whichever is longer, before receiving any of

these medical services at any hospital in the United States or Canada:

- Any type of inpatient care in a hospital, including admission to a hospital to have a baby²⁰;
- A preauthorized outpatient service that results in a hospital admission – you must call again for the hospital admission;
- Outpatient surgery for a septoplasty (surgery on the septum of the nose);
- Outpatient or inpatient surgery for a hysterectomy;
- Sclerotherapy (vein surgery) performed in an inpatient, outpatient, or office setting;
- A new course of chemotherapy or radiation therapy (one-time notification per course);
- Admission to a hospital in an emergency – your admission must be reported within 48 hours or the next working day after a weekend or holiday admission;
- A radiology (imaging) procedure (See Page 52 for more information);
- Pregnancy – you are encouraged to notify Medi-Call within the first three months of your pregnancy (see Page 62 for more information);
- An emergency admission during pregnancy²¹;
- Birth of a child (if you plan to file a claim for any birth-related expenses)²¹;
- Baby has complications at birth;

²⁰For behavioral health services, you must call Companion Benefit Alternatives at 800.868.1032. See Pages 51–54 for more information.

²¹Contacting Medi-Call for the delivery of your baby does not add the baby to your health insurance. You must add your child by submitting a completed *Notice of Election* form and the required documentation, a long-form birth certificate, within 31 days of birth for benefits to be payable.

- Are going to be, or have been, admitted to a long-term acute care facility, skilled nursing facility, or need home health care, hospice care, or an alternative treatment plan;
- Need durable medical equipment;
- Undergoing in vitro fertilization, GIFT, ZIFT or any other infertility procedure – this includes you and your covered spouse;
- Need to be evaluated for a transplant – includes you or your covered spouse or family member;
- Need inpatient rehabilitative services and related outpatient physical, speech, or occupational therapy.

A preauthorization request for any procedure that may be considered cosmetic must be received in writing by Medi-Call seven days before surgery. Procedures in this category include blepharoplasty, reduction mammoplasty, augmentation mammoplasty, mastopexy, TMJ or other jaw surgery, panniculectomy, abdominoplasty, rhinoplasty or other nose surgery, etc. Your physician should include photographs if appropriate.

A determination by Medi-Call that a proposed treatment is within generally recognized medical standards and procedures does not guarantee claim payment. Other conditions, such as eligibility requirements, other limitations or exclusions, payment of deductibles, and other provisions of the plan must be satisfied before BlueCross will make payment on behalf of the State Health Plan. Remember, if you use an out-of-network provider, you will pay more.

Behavioral health service preauthorization

Preauthorization and case management of

behavioral health benefits, such as mental health and substance use benefits, are handled by Companion Benefit Alternatives, the State Health Plan's behavioral health benefits manager.

Services that need preauthorization

Office visits to a behavioral health provider, such as a psychologist, a clinical social worker, or a professional counselor, do not require preauthorization unless they are one of the services listed below. These services must be preauthorized by Companion Benefit Alternatives:

- Inpatient hospital care;
- Intensive outpatient hospital care;
- Partial hospitalization care;
- Outpatient electroconvulsive therapy – hospital and physician services;
- Repetitive transcranial magnetic therapy;
- Applied behavior analysis therapy; and
- Psychological/neuropsychological testing.

To preauthorize services, your provider must call Companion Benefit Alternatives at 800.868.1032 before you are admitted or, in an emergency situation, within 48 hours or the next working day. For professional services listed above, your provider must call before services are rendered. To assess medical necessity, Companion Benefit Alternatives will require clinical information from the behavioral health provider treating you. Your provider can submit the clinical information online through the Forms Resource Center found at forms.companionbenefitalternatives.com, or fax the information to 803.714.6456. Although your provider may contact Companion Benefit Alternatives for you, it is your responsibility to see that the call is

made and the preauthorization has been granted. A determination by Companion Benefit Alternatives does not guarantee payment. Other conditions, including eligibility requirements, other limitations and exclusions, payment of deductibles, and other provisions of the plan must be satisfied before BlueCross makes payment.

Penalties for not calling for needed behavioral health service preauthorizations

If behavioral health outpatient services that require preauthorization (i.e., applied behavior analysis therapy and psychological/neuropsychological testing) are not preauthorized, they will not be covered.

Penalties for not calling for needed facility service preauthorizations

If your provider does not call Companion Benefit Alternatives when required, you will pay a \$200 penalty for each hospital admission. In addition, the coinsurance maximum will not apply. You will continue to pay your coinsurance, no matter how much you pay out-of-pocket.

Advanced radiology preauthorization: National Imaging Associates

The State Health Plan has a process for obtaining preauthorization for CT, MRI, MRA, and PET scans. Network South Carolina physicians, radiology (imaging) centers, and outpatient hospital radiology centers are responsible for requesting advanced radiology preauthorization from National Imaging Associates prior to completing a test.

Doctors can get more information at StateSC.SouthCarolinaBlues.com, or by calling

800.444.4311. To request preauthorization online, providers may visit www.RadMD.com or call 866.500.7664, Monday through Friday, from 8 a.m. to 8 p.m.

If a subscriber or a covered family member is scheduled to receive a CT, MRI, MRA, or PET scan from an out-of-network provider in South Carolina or any provider outside of South Carolina, the subscriber has responsibility for making sure their provider calls for preauthorization. You may begin the process by calling 866.500.7664. You should provide National Imaging Associates the name and phone number of the ordering physician and the name and phone number of the imaging center or the physician who will provide the radiology service.

National Imaging Associates will make a decision about non-emergency preauthorization requests within two business days of receiving the request from the provider. If the situation is urgent, a decision will be made within one business day of receiving the request from the provider. The process may take longer, however, if additional clinical information is needed to make a decision.

You can check the status of a National Imaging Associates preauthorization request online through your My Health Toolkit® account at StateSC.SouthCarolinaBlues.com.

Penalties for not calling

If an in-network South Carolina physician or radiology center does not request preauthorization for advanced radiology services, the provider will not be paid for the service, and it cannot bill the subscriber for the service.

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South Carolina public employees help make the Palmetto State a better place — and PEBA helps make life better for public employees. In 2017, we are promoting several key preventive health benefits. It's always better to address a health issue early, before it becomes a health crisis. We hope you'll take action, especially since these programs are available at no cost to you at network providers. The goal is to improve the state of your health — and the state of South Carolina.



Featured value-based benefits at no cost to you

Coming Attractions – maternity management

This program offers pregnant women and new moms educational materials and counseling sessions conducted by nurses. Sign up for the program to learn how to receive an electric or manual breast pump from a participating health care provider – at no cost to you.

Colorectal cancer screenings

Colorectal cancer (CRC) is the second most common cause of cancer deaths in both the United States and South Carolina. Early stage CRC can be detected through various screening methods so that the cancer can be halted or prevented. The State Health Plan provides coverage for routine and diagnostic colonoscopies and for a convenient, less invasive, early detection take-at-home test. Both screenings are available to eligible members at no cost.

Flu vaccines

The flu vaccine can protect you from influenza or make your symptoms milder. Other shots for adults can save your life or improve your quality of life by preventing serious infectious diseases. Following recommendations from the Centers for Disease Control and Prevention (CDC), adult vaccines

for pneumonia, HPV and other diseases are covered and available at no cost to qualifying primary members. You can get the vaccines from network pharmacies and network health care providers.

Tobacco cessation

Tobacco use is the number one preventable cause of death and disease in the United States. A health coach can help you make a plan and guide you through the steps to becoming tobacco free. For eligible participants, there is a \$0 copayment for some tobacco cessation drugs at network pharmacies, too.

Stress management

Prolonged stress can lead to serious health problems. A health coach – at no cost to you – can teach you effective strategies to prevent, relieve and manage your stress.

Weight management

Weight loss can improve your health right away. But weight loss can be challenging. That's when a personal health coach can help! You can learn ways to beat temptation and see that small steps can add up to big results.

**Get on-the-go health information
sent to your mobile phone by dialing
844.284.5417.**

**For details about PEBA Perks,
visit www.PEBAperks.com.**



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If a subscriber or a covered family member receives advanced radiology services from an out-of-network provider in South Carolina or from any provider outside of South Carolina without preauthorization, the provider will not be paid by BlueCross and the subscriber will be responsible for the entire bill.

Managing your health

PEBA Perks

If the State Health Plan is your primary health insurance coverage, PEBA offers value-based benefits at no cost to you at network providers and pharmacies. These benefits can help make it easier for you and your family to stay healthy.

Adult checkup for Savings Plan participants

Savings Plan participants age 19 and older may receive an annual checkup at an in-network provider's office that includes:

- A preventive, comprehensive examination;
- A complete urinalysis, if coded as a preventive screening;
- A preventive EKG;
- A fecal occult blood test, if coded as a preventive screening;
- A general health laboratory panel blood work, if coded as a preventive screening — this benefit does not include a more comprehensive executive blood panel test; and
- A preventive lipid panel once every five years for testing cholesterol and triglycerides.

If your network physician sends tests to an out-of-network physician or lab, the tests will not be covered.

Before you leave your physician's office, you may want to remind your physician's staff that you are covered under the Savings Plan and your exam should be coded as a routine physical. If a service that would have otherwise been covered is coded as a diagnostic procedure, it will apply to the member's deductible or be paid as a diagnostic procedure at the contract rate.

To learn how to use this benefit in conjunction with your Pap test benefit, see Page 58.

Adult immunization benefits *(Coverage schedule for adult immunizations is on next page)*

Adult vaccinations at intervals recommended by the Centers for Disease Control are covered at no cost to Savings Plan, Standard Plan, and Medicare Supplemental Plan members at participating providers. To learn which vaccinations are covered, contact your network physician or go to www.cdc.gov/vaccines/schedules and select Adults (19 years and older).

Colorectal cancer screenings

Colorectal cancer screenings, both diagnostic and routine, are provided at no cost to members at in-network providers for State Health Plan primary members. Covered screenings include colonoscopies and a fecal occult blood test. Routine colonoscopies and fecal occult blood tests are covered within the age ranges recommended by the United States Preventive Services Task Force. Coverage includes the consultation, generic prep kit,

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Coverage schedule for adult immunizations

Immunization ²²	Primary coverage	
	State Health Plan ²³	Medicare ²⁴
Flu <i>Ages 19 years and up</i>	Pays at 100% of allowed amount with no member cost share amounts.	Medicare benefits are available under Medicare Part B for these immunizations. Medicare Supplement members: Your medical plan will pay remaining Medicare deductible and coinsurance if Medicare pays. Medicare carve-out members: Your medical plan will coordinate with Medicare to determine if any secondary benefits are available.
Hepatitis A <i>Ages 19 years and up</i>	Pays at 100% of allowed amount with no member cost share amounts.	Medicare benefits are available under Medicare Part D for these immunizations. Benefits available only at participating pharmacies. Pays at 100% of allowed amount with no member cost share at pharmacy.
Hepatitis B <i>Ages 19 years and up</i>	Pays at 100% of allowed amount with no member cost share amounts.	Medicare benefits are available under Medicare Part B for these immunizations. Medicare Supplement members: Your medical plan will pay remaining Medicare deductible and coinsurance if Medicare pays. Medicare carve-out members: Your medical plan will coordinate with Medicare to determine if any secondary benefits are available.
Hib (Haemophilus Influenzae B) <i>Ages 19 years and up</i>	Pays at 100% of allowed amount with no member cost share amounts.	Medicare benefits are available under Medicare Part D for these immunizations. Benefits available only at participating pharmacies. Pays at 100% of allowed amount with no member cost share at pharmacy.
HPV (Human papillomavirus) <i>Adults ages 19 through 26 years</i>	Pays at 100% of allowed amount with no member cost share amounts.	Medicare benefits are available under Medicare Part D for these immunizations. Benefits available only at participating pharmacies. Pays at 100% of allowed amount with no member cost share at pharmacy.
Meningococcal <i>Ages 19 years and up</i>	Pays at 100% of allowed amount with no member cost share amounts.	Medicare benefits are available under Medicare Part D for these immunizations. Benefits available only at participating pharmacies. Pays at 100% of allowed amount with no member cost share at pharmacy.
MMR (Measles, Mumps, Rubella) <i>Ages 19 years and up</i>	Pays at 100% of allowed amount with no member cost share amounts.	Medicare benefits are available under Medicare Part D for these immunizations. Benefits available only at participating pharmacies. Pays at 100% of allowed amount with no member cost share at pharmacy.
Pneumococcal <i>Ages 19 years and up</i>	Pays at 100% of allowed amount with no member cost share amounts.	Medicare benefits are available under Medicare Part B for these immunizations. Medicare Supplement members: Your medical plan will pay remaining Medicare deductible and coinsurance if Medicare pays. Medicare carve-out members: Your medical plan will coordinate with Medicare to determine if any secondary benefits are available.
Polio <i>Ages 19 years and up</i>	Pays at 100% of allowed amount with no member cost share amounts.	Medicare benefits are available under Medicare Part D for these immunizations. Benefits available only at participating pharmacies. Pays at 100% of allowed amount with no member cost share at pharmacy.

Continued on next page

Immunization ²²	Primary coverage	
	State Health Plan ²³	Medicare ²⁴
Tetanus, Diphtheria, Pertussis <i>Ages 19 years and up</i>	Pays at 100% of allowed amount with no member cost share amounts.	Medicare benefits are available under Medicare Part D for these immunizations. Benefits available only at participating pharmacies. Pays at 100% of allowed amount with no member cost share at pharmacy.
Varicella <i>Ages 19 years and up</i>	Pays at 100% of allowed amount with no member cost share amounts.	Medicare benefits are available under Medicare Part D for these immunizations. Benefits available only at participating pharmacies. Pays at 100% of allowed amount with no member cost share at pharmacy.
Zoster (shingles) <i>Ages 60 years and up</i>	Pays at 100% of allowed amount with no member cost share amounts.	Medicare benefits are available under Medicare Part D for these immunizations. Medicare Supplement and carve-out members: If you receive this vaccine at your pharmacy, Medicare Part D will cover the cost. If you receive this vaccine at your medical provider's office, the State Health Plan will cover the vaccine at 100% of the allowed amount with no member cost share.

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procedure, and associated anesthesia. Please note that if you choose a non-generic prep kit, additional charges will apply. Any associated lab work as a result of the screening may be subject to patient liability. Visit your in-network provider to find out which screening option is best for you.

²²Benefits are available only when performed by a medical or pharmacy network provider. Any associated office visit costs are not covered.

²³Members who have another coverage primary to a State Plan other than Medicare will have their claims coordinated with the other carrier to determine if benefits are available. Routine office visits and related services that may be given on the same day for Standard Plan members are not covered. See the Plan of Benefits, found at www.peba.sc.gov/assets/planofbenefits.pdf, for more information on which routine services are covered and not covered.

²⁴Medicare may pay for some adult immunization services normally covered under Part D under your Part B benefit if the service was given as a treatment of an injury or direct exposure to a disease or condition instead of as a vaccination. If this occurs, the deductible and coinsurance amounts for services covered under Medicare Part B will be paid by the Medicare Supplement Plan. For Medicare carve-out members, your plan will coordinate with Medicare to determine if any secondary benefits are available.

Diabetes education

Diabetes health education is offered at no cost to State Health Plan primary members at a network provider. Diabetes education trains diabetics to manage their condition to avoid disease-related complications. People who receive diabetes education are more likely to use primary care and preventive services, to take medications as prescribed, and to control their blood glucose, blood pressure, and cholesterol levels. Visit an in-network provider for more information.

Flu vaccine

The flu vaccine is available at no charge to all members whose primary coverage is the Standard or Savings plans. Members may get the shot from an in-network pharmacy for a \$0 copayment. If a member receives the shot in an in-network doctor's office, the flu vaccine and the administration fee will be paid in full; however, any associated office visit charges will be processed according to regular Plan coverage rules.

Mammography benefit

Routine mammograms are covered at 100 percent as long as you use a provider in the mammography network and meet eligibility requirements. A doctor's order is not required for plan coverage of a routine mammogram but some centers may ask for one. Mammography benefits include:

- One base-line mammogram (four views) for women age 35 through 39; and
- One routine mammogram (four views) every year for women over age 40.

Consider scheduling your mammogram after your birthday to help you remember it every year. You can find a mammography network provider in the Find a Doctor tool at StateSC.SouthCarolinaBlues.com. You can also call BlueCross at 803.736.1576 or 800.868.2520 for assistance.

Charges for routine mammograms performed at nonparticipating facilities are not covered, except for procedures performed outside South Carolina. Out-of-network providers are free to charge you any price for their services, so you may pay more.

Routine, preventive mammogram benefits are in addition to benefits for diagnostic mammograms. Any charges for additional mammograms beyond the preventive mammogram are subject to copayments, deductibles, and coinsurance.

Women age 40 and older who are covered as retirees and are enrolled in Medicare should contact Medicare or see the 2017 *Medicare & You* handbook for information about coverage. The State Health Plan is primary for a woman covered as active employee or as the spouse of an active employee regardless of Medicare eligibility.

No-Pay Copay

The No-Pay Copay program gives eligible²⁵ State Health Plan members with high blood pressure, high cholesterol, congestive heart failure, cardiovascular disease, coronary artery disease, or diabetes a copayment waiver for generic drugs that treat these conditions²⁶. The program encourages members to be more engaged in their health — and saves them money. Participants qualify for the program on a quarterly basis. By completing certain activities in one quarter, they are able to receive certain generic drugs at no cost the next quarter.

Members are identified for one of the qualifying conditions automatically by BlueCross.

BlueCross notifies members of eligibility and directs them to register for the Rally® online

²⁵Employees, retirees, COBRA subscribers, survivors, and their covered spouses are eligible to qualify if the State Health Plan is their primary insurance. If a subscriber is enrolled in the Medicare Supplemental Plan but covers a spouse who is not eligible for Medicare, the spouse is eligible for the program. Effective Jan. 1, 2017, dependent children are not eligible, regardless of age.

If a member qualified for No-Pay Copay during 2016, their current waiver will continue through June 30, 2017. Eligible members identified for participation between January 1 and March 31, 2017, may participate through June 30, 2017. Between April 1 and June 30, they will need to take the Rally health survey to qualify for the first quarter afterward. Eligible members who are identified after April 1, 2017 will also need to take the Rally health survey to participate.

If a member who qualified for No-Pay Copay before April 1, 2017, is receiving the waiver and becomes Medicare eligible, the waiver will continue only until June 30, 2017. If a member qualifies for No-Pay Copay after April 1, 2017, and then becomes Medicare eligible, then the waiver will end at the end of the quarter. These waiver end dates do not apply to members who enroll in Express Scripts Medicare, the State Health Plan's Medicare Part D program. Enrollment in Express Scripts Medicare means that the waiver ends immediately.

²⁶Diabetes testing supplies (test strips, control solution, lancet, syringes, pen needles, etc.) purchased at an in-network pharmacy are also covered at no charge. A glucometer will be provided by the manufacturer separately.

platform. Rally is a product of Rally Health, an independent company that offers a digital health platform on behalf of BlueCross. Rally lets members track their status in the program and their progress toward meeting the qualifications. They can complete some activities through Rally, such as taking a health survey, accessing educational information and contacting a health coach. Compliance activities are geared to a member's condition and health risks.

Once a member who participates in No-Pay Copay becomes enrolled in Medicare as their primary insurance, their copayment waiver is no longer in effect. This is the case whether or not the member is enrolled in Employer Group Waiver Plan coverage.

For detailed information about the No-Pay Copay program, go to StateSC.SouthCarolinaBlues.com or call BlueCross Customer Service at 800.868.2520. If you think you qualify for the program but have not been notified of your eligibility, call 855.838.5897. BlueCross administers the program, but you may call Express Scripts, the pharmacy benefits manager, at 855.612.3128 for more information about eligible generic prescriptions.

Pap test benefits

For Standard Plan members, the plan covers only the cost of the lab work associated with a Pap test each calendar year. Before you receive this service, please consider the following:

- The cost of the portion of the office visit associated with the Pap test is covered.
- Costs for the portion of the office visit not associated with the Pap test, charges associated with a pelvic exam, breast exam, or a complete or mini-physical

exam and any other laboratory tests, procedures, or services associated with receiving the Pap test benefit are not covered and are the member's responsibility.

- If the test is performed by an out-of-network provider, the member may be billed for the amount of the charge above the State Health Plan allowed amount for the test.

You should consider contacting the provider before scheduling an office visit to determine the cost of the exam and related services. The amount the member pays for additional non-covered services does not count toward her annual deductible.

Savings Plan participants have the same Pap test benefit as Standard Plan members; however, Savings Plan members older than 18 are entitled to a routine annual exam. They may receive a routine annual exam or an exam performed in conjunction with the Pap test, but not both. If both are performed in the same year, the first one filed will be allowed.

Based on the recommendation of the United States Preventive Services Task Force, the Standard Plan and Savings Plan both cover the human papillomavirus (HPV) test every five years in conjunction with a Pap test at no cost to eligible women ages 30 through 65.

Preventive screenings

This benefit is provided at no cost to employees, retirees, COBRA subscribers, and their covered spouses if their primary coverage is the Standard Plan or the Savings Plan. This type of screening typically costs \$300 or more. The screening includes blood work, a health risk appraisal, height and weight measurements, blood pressure, and lipid panels. After the

screening, you will receive a confidential report with your results and recommendations for improving your health. Taking this report to your doctor may eliminate the need for tests. In addition to taking part in a screening at your workplace, there are other options for taking advantage of this benefit.

Attend a regional preventive screening

If your worksite doesn't offer a screening, or if you missed it, you can learn how to register for a regional screening on PEBA's Upcoming events page at www.peba.sc.gov/events.html.

Visit a participating screening provider

Visit one of our participating screening providers to have a preventive screening. A voucher is available at www.PEBAPerks.com to take with you when you visit for a screening.

No matter how you take advantage of this benefit, there are required tests and appraisals that will be included in your confidential report. Some screening providers may, however, provide additional results above the minimum requirements.

In addition to the required tests and appraisals, participating screening providers may offer optional tests for an additional fee. You may contact the screening provider about out-of-pocket expenses associated with these tests. Please note, optional tests may vary based on screening provider.

Tobacco cessation program

PEBA will provide a comprehensive tobacco cessation program at no charge to State Health Plan subscribers, their covered spouses, and covered dependent children age 13 or older. The tobacco cessation program offered will include tobacco cessation counseling with trained professionals and nicotine replacement

therapies at no member cost to assist program participants in their efforts to quit tobacco. Tobacco cessation counseling will include a customized quit plan, motivation to quit, help identifying triggers to using tobacco, and developing coping mechanisms to be successful in a quit attempt.

A tobacco cessation counselor may also recommend that a doctor prescribe a tobacco cessation drug, such as bupropion or Chantix, which is available through the State Health Plan's prescription drug coverage. Prescription drugs for tobacco cessation, including Chantix and bupropion, are provided to Savings Plan and Standard Plan primary members at no cost to the member when obtained from an in-network provider.

Please note that PEBA is currently involved in the solicitation process for securing a tobacco cessation vendor for 2017. More information on the tobacco cessation program will be announced following the award for a tobacco cessation vendor.

Well child benefits

Well child care benefits, including checkups and immunizations, aim to promote good health and both early detection and prevention of illness in children enrolled in the State Health Plan. Covered children are eligible for well child care exams until they turn age 19.

How it works

This benefit covers well child care exams and immunizations, which must be performed by a network professional. When these services are received from a State Health Plan or BlueCard network doctor, benefits will be paid at 100 percent of the allowed amount. The State Health Plan covers services specific to certain ages as recommended by the American

Immunization schedule for children

Immunization	Recommended schedule
Hepatitis B (HepB)	Birth, 1-2 months, 6-18 months
Rotavirus	2 months, 4 months, 6 months
Inactivated Polio vaccine (IPV)	2 months, 4 months, 6-18 months, 4-6 years
Diphtheria-Tetanus-Pertussis (Whooping cough)	2 months, 4 months, 6 months, 15-18 months, 4-6 years, 11-12 years
Haemophilus (HIB)	2 months, 4 months, 6 months (optional), 12-15 months
Pneumococcal conjugate (PCV7)	2 months, 4 months, 6 months, 12-15 months
Influenza	Yearly from age 6 months until age 19 (two doses the first year)
Measles-Mumps-Rubella	12-15 months, 4-6 years
Varicella (Chickenpox)	12-15 months, 4-6 years
Hepatitis A	First dose at 12-23 months; second dose: 6-18 months after first dose
Meningococcal	11-12 years, booster at 16 years
Tetanus	Booster at 11-12 years
Human papillomavirus (HPV) (females and males)	1st dose at 11-12 years; Second dose: 2 months after first dose Third dose: 6 months after first dose

Academy of Pediatrics.

The State Health Plan will not pay for services from out-of-network providers. Some services may not be considered part of Well Child Care. For example, if during a well-child visit a fever and sore throat were discovered, the lab work to verify the diagnosis would not be part of the routine visit. These charges, if covered, would be subject to the copayment, deductible, and coinsurance, as would any other medical expense.

Well child exams

The plan pays 100 percent of the allowed amount for approved routine exams, Centers for Disease Control-recommended immunizations, American Academy of Pediatrics-recommended services specific to certain ages, and lab tests when an in-network doctor provides these checkups:

- Younger than 1 year old (up to six visits);
- 1 year old (up to three visits);
- 2 years old (up to two visits);

- 3 years old until he turns 19 years old (one visit a year).

The well child care exam must occur after the child's birthday.

Health management programs

Managing a chronic condition can be difficult. The available health management programs are designed to help Standard Plan and Savings Plan subscribers and their covered family members who have certain behavioral or chronic medical conditions manage their symptoms, and delay or even prevent many of the complications of these diseases. Health coaching is offered for the following health management conditions.

BlueCross identifies participants by reviewing medical, pharmacy, and laboratory claims. If you are identified as someone who could benefit from one of the available health management programs, either through your claims or your responses to the Rally Health Survey, you are automatically enrolled, but the programs are voluntary and you can opt out

at any time. You may also self-enroll in one or more of the available health management programs. If you have high blood pressure, high cholesterol, congestive heart failure, cardiovascular disease, coronary artery disease, or diabetes, BlueCross may send you a notification indicating that you also are eligible for the No-Pay Copay program.

As a participant in the health management program(s), you will receive educational materials and a welcome letter that will provide the name of and contact information for your BlueCross health coach. Your health coach will be a registered nurse who will help you learn more about your condition and how to manage it. Your health coach will also help you work with your physician to develop a plan to take charge of your illness, contacting you by phone or through Rally. You can contact your health coach as often as you like with questions or to ask for advice. For more information, call 855.838.5897, option 2.

To self-enroll, log in to your My Health Toolkit account. Select Wellness, then Health Coaching. From your Activity Center, complete the health assessment specific to your condition. You may also self-enroll by calling BlueCross at 855.838.5897.

In compliance with federal law, your health information will always be kept confidential. Your employer does not receive the results of any surveys you complete, and enrolling will not affect your health benefits.

Back pain management

If your primary coverage is the State Health Plan, you can get help for your aching back as well as tips for keeping your back healthy. You can talk by telephone with a health coach who can help you create an action plan that's

right for you and support you every step of the way. Health coaches educate members with back pain on techniques to help prevent or reduce the frequency and severity of their pain, proper lifting techniques, exercises to help them strengthen their posture and abdominal core, and weight management. To arrange for health coaching services, call BlueCross at 855.838.5897.

Behavioral health management

Health coaches work one-on-one and offer support to members diagnosed with the following diseases and categories. Health coaches encourage members to follow their treatment plan, help the members set goals, and teach the members how to handle symptoms.

- Addiction recovery
- Attention deficit/hyperactivity disorder (ADHD)
- Bipolar disorder
- Depression
- Mom support – a program to help mothers develop strategies to manage depression, pre-pregnancy or post-pregnancy

Chronic disease management

Health coaches work one-on-one with members diagnosed with the following chronic diseases. The coaches will help participants learn more about their condition and how to manage it. The health coach will also work with the member's physician to develop a plan to take charge of your illness.

- Asthma
- Chronic obstructive pulmonary disease (COPD)
- Congestive heart failure (CHF)

- Coronary artery disease (CAD)
- Diabetes (adult and pediatric)
- High cholesterol
- Hypertension (high blood pressure)
- Metabolic syndrome

Coming Attractions: the maternity management program

If you are a mother-to-be, you are encouraged to enroll and participate in the free maternity management program. Medi-Call administers PEBA's comprehensive maternity management program, Coming Attractions. This program supports mothers throughout their pregnancy and post-partum care. It also assists with Neonatal Intensive Care Unit infants or other babies with special needs until they are one year old. Once enrolled in the Coming Attractions program, expectant mothers will receive a welcome mailer and educational materials throughout their pregnancy and the baby's first year of life. You do not have to wait until you have seen your physician to enroll in Coming Attractions, and enrollment is easy.

To enroll:

1. Visit StateSC.SouthCarolinaBlues.com and log in to your My Health Toolkit® account. Select Wellness, then click on Health Coaching. From My Activity Center, click on Assessments and complete the available maternity health screening, which is listed as MM Maternity Screening.
2. Call Medi-Call at 803.699.3337 or 800.925.9724 to talk to a maternity nurse to complete a maternity health screening.

A Medi-Call maternity nurse will complete a Maternity Health Screening when you enroll. It is used to identify potential high-risk factors during your first trimester. If high-risk factors

are identified, you will be scheduled for follow-up calls. If no risks are identified, you are encouraged to call with any changes in your condition. Otherwise, your maternity nurse will call you during your second and third trimesters. Your maternity nurse also will call you after your baby is born to assist with any needs.

If you enroll in the program through the Member Portal, you can use the online system to correspond with your nurse and receive articles of interest from recognized medical sources. Also, you can call your maternity nurse at any time if you have questions. A nurse will be there to help you with both routine and special needs throughout your pregnancy and the postpartum period.

Please note that if you do not preauthorize a hospital admission related to your pregnancy or to have your baby, you will pay a \$200 penalty for each admission, as you would for any admission, whether the admission was maternity related or not. Also, the coinsurance you pay will not count toward your coinsurance maximum. For more information, see Page 42 or call your maternity nurse.

For more information about maternity benefits, including coverage of some breast pumps, see Pregnancy and pediatric care on Pages 71–72.

Migraine management

This program encourages members to work with their doctors to create a plan to ease the pain of migraine headaches. A health coach helps the member learn to identify migraine triggers, develop healthy habits to prevent migraines, and comply with his treatment plan. Members, who must be at least age 18, are invited to participate based on medical and pharmacy claims. You can also enroll by calling

855.838.5897, option 2.

Healthy weight for kids and teens program

This confidential program is for overweight and obese children between the ages of 2 and 17. It is designed to teach children and their parents healthy habits, support their efforts and help them work with their doctor on weight management. Members are enrolled based on medical claims, or they may be referred by a doctor. Also, a parent can enroll his covered child by calling 855.838.5897, option 2.

Stress management program

Stress is a factor in all of our lives. We can't avoid it, but we can take steps to reduce it and lessen its potential harmful side effects. A new stress management program is now available to State Health Plan members. This program offers techniques and support to help members effectively manage and reduce stress levels. For additional information, go to StateSC.SouthCarolinaBlues.com and log into My Health ToolKit®. Select the Wellness tab and click on Health Coaching. You can self-enroll in the program there or by calling BlueCross at 855.838.5897.

Weight management for adults

The BlueCross Weight Management program is designed to help you achieve weight-loss goals through small changes you can make in your lifestyle. You will receive information about weight management and a confidential survey will help a registered nurse tailor the program to meet your needs. Program candidates are identified through claims analysis, a preauthorization for services, doctor referral, or self-referral. If you think you qualify but have not received a letter or would like more information, call 855.838.5897 and select option

2.

Medical case management programs

The case management programs available to State Health Plan members facing serious illnesses or injuries are intended to help them locate support and treatment information. Each program includes teams of specially trained nurses and doctors. They aim to assist participants in coordinating, assessing and planning health care, and do so by giving a patient control over their care and respecting their right to knowledge, choice, a direct relationship with their physician, privacy, and dignity. None of the programs provide medical treatment. Each program may involve a home or facility visit to a participant, but only with permission.

For more information on any of these programs, call 800.925.9724 and ask to be transferred to a case management supervisor.

BlueCross Medi-Call case management program

This program is designed for State Health Plan members who have specific catastrophic or chronic disorders, acute illnesses, or serious injuries. The program facilitates continuity of care and support of these patients while managing health plan benefits in a way that promotes high-quality, cost-effective outcomes.

Case managers talk with patients, family members, and providers to coordinate services among providers and support the patient through a crisis or chronic disease. Case management intervention may be short- or long-term. Case managers combine standard preauthorization services with innovative approaches for patients who require high

levels of medical care and benefits. Case managers can often arrange services or identify community resources available to meet the patient's needs.

The case manager works with the patient and the providers to assess, plan, implement, coordinate, monitor, and evaluate ways of meeting a patient's needs, reducing readmissions and enhancing quality of life. Your Medi-Call nurse case manager may visit you at home, with your permission, or in a treatment facility or your physician's office when the treatment team determines it is appropriate.

A Medi-Call nurse stays in touch with the patient, caregivers, and providers to assess and re-evaluate the treatment plan and the patient's progress. All communication between BlueCross and the patient, family members or providers complies with Health Insurance Portability and Accountability Act (HIPAA) privacy requirements. If a patient refuses medical case management, Medi-Call will continue to preauthorize appropriate treatment.

For more information, call 800.925.9724 and ask to be transferred to a case management supervisor.

Complex care management program

Some members are referred to complex care management, a program designed to assist the most seriously ill patients. They may include members with complex medical conditions and frequent hospitalizations or critical barriers to their care.

The complex care management program provides you with information and support through a case manager, who is a registered nurse. This nurse coordinator can help you identify treatment options; locate supplies

and equipment recommended by your doctor; coordinate care; and research the availability of transportation and lodging for out-of-town treatment. The nurse stays in touch weekly with patients and caregivers to assess and re-evaluate the treatment plan and the patient's progress. This program helps you make informed decisions about your health when you are seriously ill or injured. Participation is voluntary, and you can leave the program at any time, for any reason. Your benefits will not be affected by your participation.

BlueCross will refer you to the program if it may benefit you. You will receive a letter explaining the program, and a representative will contact you. A team of specially trained nurses and doctors will then review your medical information and treatment plan. (Your medical history and information will always be kept confidential among your caregivers and the complex care management team.) Your nurse case manager will be your main contact. You and your doctor, however, will always make the final decision about your treatment. Be sure to always check with your doctor before following any medical advice.

Renal disease case management program

Renal disease case management is available to select State Health Plan members receiving renal dialysis. This program's nurses provide education and care coordination that may help prevent acute illnesses and hospitalizations.

When a member who is receiving renal dialysis is referred to the program, a nurse contacts the member to confirm that he is a good candidate for renal case management. The nurse, who has many years of renal dialysis experience, provides education and helps coordinate care.

As the link between you, your providers, and dialysis team, the nurse identifies your needs through medical record review and consultations with you, your family, and your health care team. Needs may be medical, social, behavioral, emotional, and financial. The nurse coordinates services based on long-term needs and incorporates these needs into a plan agreed upon by you, your physician(s), the dialysis team, and other providers. Your nurse will call you frequently and receive updates from your providers.

Natural BlueSM and Member Discounts

Natural Blue is a discount program available to State Health Plan subscribers and offered by BlueCross. The program has a network of licensed acupuncturists, massage therapists, and fitness clubs that may be used at lower fees, often as much as a 25 percent discount. Natural Blue also offers discounts on health products, such as vitamins, herbal supplements, books, and tapes.

Like Natural Blue, Member Discounts offers savings on other products and services that BlueCross makes available but that are not State Health Plan benefits. Member Discounts include:

- Discount network;
- Vitamins and supplements;
- TruHearing Digital Hearing Aid;
- Bosley Hair Restoration;
- Walking Works[®];
- Vision One EyeCare Program;
- Cosmetic surgery;
- Allergy relief;

- Jenny Craig;
- Doctors Wellness Center;
- Blue 365;
- Fitness centers;
- Healthy products; and
- My Gym Children's Fitness Center.

For more information on Natural Blue or Member Discounts, go to StateSC.SouthCarolinaBlues.com, select Resources, then select Member Discounts or call BlueCross Customer Service at 800.868.2520.

Companion Global Healthcare is offered through BlueCross, but it is not a State Health Plan benefit. It assists with providing lower-cost medical care in countries ranging from Costa Rica to Ireland to Thailand. All care is offered at facilities accredited by the Joint Commission International. Members also may be able to save money on major dental work through Companion Global Dental. For more information, call 800.906.7065 or go to www.companionglobalhealthcare.com.

Additional State Health Plan benefits

The Standard Plan and the Savings Plan pay benefits for treatment of illnesses and injuries if the Plan of Benefits defines the treatment as medically necessary. While this section provides a general description of many of these benefits, the Plan of Benefits, found at www.peba.sc.gov/assets/planofbenefits.pdf, contains a complete description of all benefits. Its terms and conditions govern all health benefits offered by PEBA.

Earlier in this chapter, several benefits, including preventive benefits such as

immunizations, benefits specific to women and children as well as benefits available to Savings Plan members only, are covered in their own section. Behavioral health benefits are also featured in their own section. Prescription drug benefits, dental benefits, and vision benefits are covered in later chapters.

Some services and treatment require preauthorization from Medi-Call, National Imaging Associates, Companion Benefit Alternatives or Express Scripts. For details read the Medi-Call section beginning on Page 49, the National Imaging Associates section on Page 52 and the behavioral health section on Page 51.

Within the terms of the State Health Plan, a medically necessary service or supply is:

- Required to identify or treat an existing condition, illness, or injury; and
- Prescribed or ordered by a physician; and
- Consistent with the covered person's illness, injury, or condition and in accordance with proper medical and surgical practices in the medical specialty or field of medicine at the time provided; and
- Required for reasons other than the convenience of the patient; and
- Results in measurable, identifiable progress in treating the covered person's condition, illness or injury.

The fact that a procedure, service, or supply is prescribed by a physician does not automatically mean it is medically necessary under the terms of the State Health Plan.

Advanced practice registered nurse

Expenses for services received from a licensed, independent advanced practice registered nurse are covered even if these services are not performed under the immediate direction of a doctor. An advanced practice registered nurse is a nurse practitioner, certified nurse midwife, certified registered nurse anesthetist, or a clinical nurse specialist. All services received must be within the scope of the nurse's license and needed because of a service allowed by the plan.

Alternative treatment plan

An alternative treatment plan is an individual program to permit treatment in a more cost-effective and less intensive manner.

An alternative treatment plan requires the approval of the treating physician, Medi-Call, and the patient. Services and supplies authorized by Medi-Call as medically necessary because of the approved alternative treatment plan will be covered.

Ambulance service

Ambulance service, including air ambulance service, is covered to the nearest hospital to obtain medically necessary emergency care. Ambulance service is also covered to transport a member to the nearest hospital that can provide medically necessary inpatient services when those services are not available at the current facility. No benefits are payable for ambulance service used for routine, non-emergency transportation, including, but not limited to, travel to a facility for scheduled medical or surgical treatments, such as dialysis or cancer treatment. All claims for ambulance service are subject to medical review.

Ambulance services are reimbursed at 80

percent of the allowed amount; however, non-participating providers can balance bill you up to the total of their charge for the service. Please note, all ambulance services, including air ambulance service, may not be in-network. If you have any questions about whether or not an ambulance service is in-network, contact BlueCross. For information on balance billing, see Page 48.

Autism spectrum disorder benefits

Applied behavior analysis therapy for treatment of autism spectrum disorder is covered subject to Companion Benefit Alternatives' guidelines and preauthorization requirements.

Behavioral health benefits

There is no limit on the number of visits allowed to a provider of behavioral health care, such as mental health and substance use service, as long as the care is medically necessary under the terms of the plan. There is not an annual or lifetime maximum for behavioral health benefits.

Some services require preauthorization by Companion Benefit Alternatives, the behavioral health manager. For more information, see Page 51. Your behavioral health provider will be required to conduct periodic medical necessity reviews, similar to Medi-Call for medical benefits.

For customer service and information about claims for behavioral health care, call BlueCross at 800.868.2520.

Behavioral health case management

Case management is designed to support members with catastrophic or chronic illnesses.

Participants are assigned a case manager, who will help educate you on the options and services available to meet your behavioral health needs and assist in coordinating services.

Case managers are licensed nurses and social workers. They can assist you by answering questions and helping you get the most out of your mental health, medical, and pharmacy benefits. This may include care planning, patient/family education, benefits review, and coordinating other services and community resources. When you are enrolled in this program, you can receive access to a personal case manager, educational resources, and web tools that will help you learn more about your health and how to better manage your condition. Participation is voluntary and confidential.

For more information, call 800.868.1032, ext. 25835.

Bone, stem cell, and solid organ transplants

State Health Plan transplant contracting arrangements include the BlueCross BlueShield Association national transplant network, Blue Distinction Centers for Transplants. All Blue Distinction Centers for Transplants facilities meet specific criteria that consider provider qualifications, programs, and patient outcomes.

All transplant services must be approved by Medi-Call (see Pages 49-51). You must call Medi-Call, even before you or a covered family member is evaluated for a transplant.

Through the Blue Distinction Centers for Transplants network, State Health Plan members have access to the leading organ transplant facilities in the nation. Contracts are also in effect with local providers for

transplant services so members may receive transplants at those facilities. You will save a significant amount of money if you receive your transplant services at a Blue Distinction Centers for Transplants network facility or a South Carolina network transplant facility. If you receive transplant services at one of these network facilities, you will not be balance billed. You will be responsible only for your deductible, coinsurance, and any charges not covered by the plan. In addition, these network facilities will file all claims for you.

Transplant services at nonparticipating facilities are covered by the plan; however, the State Health Plan pays only the State Health Plan-allowed amount for transplants performed out-of-network. If you do not receive your transplant services at a network facility, you may pay substantially more. In addition to the deductible and coinsurance, members using out-of-network facilities are responsible for any amount in excess of the allowed amount, or balance bill, and pay 40 percent coinsurance. Costs for transplant care can vary by hundreds of thousands of dollars. For information on balance billing, see Page 48. You may also call Medi-Call for more information.

Chiropractic care

You are covered for specific office-based services from a chiropractor, including detection and correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the body to remove nerve interference and the effects of such nerve interference, where such interference is the result of, or related to, distortion, misalignment, or subluxation of or in the vertebral column. Diagnostic X-rays are covered if medically necessary. Both the Standard Plan and Savings Plan are limited to one manual therapy per

visit, which is subject to the plan maximum. For Standard Plan members, chiropractic benefits are limited to \$2,000 per person each year. With the Savings Plan, chiropractic benefits are limited to \$500 per person each year for each covered person after the annual deductible has been met. Services of a massage therapist are not covered.

Colonoscopies

Colorectal cancer screenings are considered PEBA Perks. Colonoscopies, both diagnostic and routine, are provided at no cost to members at network providers for State Health Plan primary members. See Pages 54-56 for more information about benefits for colonoscopies and other colorectal cancer screenings.

Contraceptives

Routine contraceptive prescriptions, including birth control pills and injectables, filled at a participating pharmacy or through the plan's mail-order pharmacy, are covered at no cost to State Health Plan primary subscribers and covered spouses. Birth control implants and injectables given in a doctor's office are covered as a medical, not pharmacy, benefit. The office visits for contraceptive implants will be processed with applicable copayments, coinsurance, and deductibles. Contraceptives are covered for covered children only to treat a medical condition and must be preauthorized by Express Scripts, the pharmacy benefits manager. The member still pays the cost share in these cases.

Dental care

Generally, dental care is provided under the State Dental Plan, not the State Health Plan. See the **Dental insurance** chapter on Page 93 for more information.

Dental treatments or surgery to repair damage from an accident are an exception to this, and are covered by the State Health Plan for up to one year from the date of the accident. Dental surgery for bony, impacted teeth is also covered, when supported by X-rays.

Diabetic supplies

Insulin is allowed under the prescription drug program or under the medical plan but not under both. Diabetic supplies, including syringes, lancets, and test strips, are covered at participating pharmacies for a \$9 generic copayment, per item, for each supply of up to 30 days. See Page 13 for more information regarding coverage of diabetic supplies and the Express Scripts National Preferred Formulary. Generic drugs to treat diabetes and diabetes testing supplies are covered at no charge for Standard Plan and Savings Plan members enrolled in the No-Pay Copay program. Because insulin is not a generic drug, it is not eligible for the waiver. For more information, see Page 57. Claims for diabetic durable medical equipment should be filed through your medical coverage.

Please note that diabetes education services offered by network providers are covered at no cost to State Health Plan primary members.

Doctor visits

Treatments or consultations for an injury or illness are covered when they are medically necessary within the terms of the plan and not associated with a service excluded by the plan. Some outpatient visits for behavioral health care, such as mental health and substance use care, still require preauthorization. For details on behavioral health benefits, see Page 67.

Durable medical equipment

Generally, durable medical equipment must be preauthorized by Medi-Call. Some examples include:

- Any purchase or rental of durable medical equipment;
- Any purchase or rental of durable medical equipment that has a nontherapeutic use or a potentially non-therapeutic use;
- C-Pap or Bi-Pap machines;
- Oxygen and equipment for oxygen use outside a hospital setting, whether purchased or rented; and
- Any prosthetic appliance or orthopedic brace, crutch, or lift attached to the brace, whether initial or replacement.

Durable medical equipment provider networks are available to State Health Plan members. They offer discounts while providing high-quality products and care.

Home health care

Home health care includes part-time nursing care, health aide service, or physical, occupational or speech therapy provided by an approved home health care agency and given in the patient's home. You cannot receive home health care and hospital or skilled nursing facility benefits at the same time. These services do not include custodial care or care given by a person who ordinarily lives in the home or is a member of the patient's family or the patient's spouse's family. Benefits are limited to 100 visits per year. These services must be preauthorized by Medi-Call and the member must be home-bound.

Hospice care

The plan will pay up to \$7,500 annually for

hospice care for a patient certified by his physician as having a terminal illness and a life expectancy of six months or less. The benefit also includes a maximum of \$200 for bereavement counseling. These services must be preauthorized by Medi-Call.

Infertility

To be eligible for benefits to treat infertility, the subscriber or covered spouse must have a diagnosis of infertility. Coverage is limited to a lifetime maximum payment of \$15,000. Please note that the limit applies to any covered medical benefits and covered prescription drug benefits incurred by the subscriber or the covered spouse, whether covered as a spouse or as an employee. The limit for the individual applies even if the member was married to someone else at the time.

If either the subscriber or the spouse has had a tubal ligation or a vasectomy, the plan will not pay for the diagnosis and treatment of infertility for either member.

Included in the \$15,000 maximum are diagnostic tests, prescription drugs and up to six cycles of intrauterine insemination (IUI), and a maximum of three completed cycles of zygote or gamete intrafallopian transfer (ZIFT or GIFT) or in vitro fertilization (IVF) per lifetime. A cycle reflects the cyclic changes of fertility with the cycle beginning with each new insemination or assisted reproductive technology (ART) transfer or implantation attempt. ART procedures not specifically mentioned are not covered, including but not limited to: tubal embryo transfer (TET), pronuclear stage tubal embryo transfer (PROUST) oocyte donation, and intracytoplasmic sperm injection (ICSI).

Prescription drugs for treatment of infertility are subject to a 30 percent coinsurance

payment through both the Savings Plan and the Standard Plan. This expense does not apply to the \$2,500 per person prescription drug copayment maximum for the Standard Plan. It does apply to the Savings Plan deductible. The 70 percent plan payment for prescription drugs for infertility treatments applies to the \$15,000 maximum lifetime payment for infertility treatments. Call Express Scripts' Customer Service at 853.612.3128 for more information about prescription drugs.

Benefits are payable at 70 percent of the allowed amount. Your share of the expenses does not count toward your coinsurance maximum. All procedures related to infertility must be preauthorized by Medi-Call. For more information, call Medi-Call at 803.699.3337 or 800.925.9724.

Please note that when you become pregnant, you are encouraged to enroll in the Coming Attractions maternity management program. See Page 62 for more information.

Inpatient hospital services

Inpatient hospital care, including a semi-private room and board, is covered. In addition to normal visits by your physician while you are in the hospital, you are covered for one consultation per consulting physician for each inpatient hospital stay. Inpatient care must be approved by Medi-Call (Page 49) or Companion Benefit Alternatives. For more information, see Page 51.

Outpatient facility services

Outpatient facility services may be provided in the outpatient department of a hospital or in a freestanding facility. Outpatient services and supplies include:

- Laboratory services;

- X-ray and other radiological services;
- Emergency room services;
- Radiation therapy;
- Pathology services;
- Outpatient surgery;
- Infusion suite services; and
- Diagnostic tests.

If you are covered by the Standard Plan, you will be charged a \$95 outpatient facility services copayment. You will be charged a \$159 copayment for emergency room services. These copayments do not apply to your annual deductible or your coinsurance maximum. The copayment for emergency room services is waived if you are admitted to the hospital.

The outpatient facility services copayment does not apply to dialysis, routine mammograms, routine Pap tests, physical therapy, speech therapy, occupational therapy, clinic visits, oncology services, electro-convulsive therapy, psychiatric medication management, and partial hospitalization and intensive outpatient behavioral health services.

Please note that when lab tests are ordered, you may wish to talk with your provider about having the service performed at an independent, in-network lab. Use of an Independent lab may be more cost effective as it would allow you to avoid paying the \$95 copayment for outpatient facility services or the \$12 copayment for a physician office visit.

Also, please remember that a more convenient and affordable alternative may be available to you depending on your circumstances. Consider whether a virtual visit, urgent care center visit, or physician's office visit would be just as effective—you could avoid the facility copayments altogether.

Patient-Centered Medical Homes

A Patient-Centered Medical Home (PCMH) is a primary care physician practice in which a patient has a health care team that typically is led by a doctor. The team may include nurses, a nutritionist, health educators, pharmacists, and behavioral health specialists, and these professionals make referrals to other providers as needed. Communication among the team members and with the patient serves as an important part of the medical practice.

PCMHs focus on coordinating care and preventing illnesses, rather than waiting until an illness occurs and then treating it. The team helps the patient improve his health by working with him to set goals and to make a plan to meet these goals. This approach may be particularly beneficial to members with chronic illnesses, such as diabetes and high blood pressure.

To encourage members to seek care at a PCMH, the State Health Plan does not charge Standard Plan members the \$12 copayment for a physician office visit. After Savings Plan and Standard Plan subscribers meet their deductible, they will pay 10 percent coinsurance, rather than 20 percent, for services at a BlueCross-affiliated PCMH.

PCMHs are available in many South Carolina counties. You can find a list and to learn more about PCMHs at StateSC.SouthCarolinaBlues.com.

Pregnancy and pediatric care

Maternity benefits are provided to subscribers and their covered spouses. Covered children do not have maternity benefits. Maternity benefits include necessary prenatal and postpartum

care, including childbirth, miscarriage, and complications related to pregnancy. When you become pregnant, you are encouraged to enroll in the Coming Attractions maternity management program. See Page 62 for information.

Breast pumps

In 2017, specific models of breast pumps will be covered and available at no cost to female subscribers and female spouses of subscribers. To use this coverage, you will need to obtain the pump through a BlueCross-contracted provider. While a physician prescription is not required, having a prescription is preferred and will help the order to be processed more quickly. For more information, go to StateSC.SouthCarolinaBlues.com/links/pregnancy.

Length of hospital stay

By federal law, group health plans generally cannot restrict benefits for the length of any hospital stay in connection with childbirth for the mother or the newborn to fewer than 48 hours after a vaginal delivery or fewer than 96 hours after a caesarean section. The plan may pay for a shorter stay, however, if the attending physician, after consultation with the mother, discharges the mother or newborn earlier.

Also by federal law, group health plans may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, a plan may not require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). A member may be required to obtain precertification to use certain providers or facilities, or to reduce out-of-pocket costs.

Midwife services

The State Health Plan recognizes only certified nurse midwives as providers of midwife covered services. A certified nurse midwife is an advance practice registered nurse who is licensed by the State Board of Nursing, or by a sister state having substantially-equivalent license standards, as a midwife. Services from an active practice registered nurse are covered even if these services are not performed under the immediate direction of a doctor. The services of lay midwives and midwives licensed by the South Carolina Department of Health and Environmental Control are not reimbursed.

Prescription drugs

See the **Prescription benefits** chapter on Page 83 for more information.

Reconstructive surgery after a medically necessary mastectomy

The plan will cover, as required by the Women's Health and Cancer Rights Act of 1998, mastectomy-related services, which include:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications in all stages of mastectomy, including lymphedema.

These services apply only in post-mastectomy cases. All services must be approved by Medi-Call.

Rehabilitation care

The plan provides benefits for physical rehabilitation designed to restore a bodily function that has been lost because of trauma or disease.

Rehabilitation care is subject to all terms and conditions of the plan.

- Preauthorization is required for any inpatient rehabilitation care, regardless of the reason for the admission.
- The rehabilitation therapy must be performed in the most cost-effective setting appropriate to the condition.
- The provider must submit a treatment plan to Medi-Call.
- There must be reasonable expectation that sufficient function can be restored for the patient to live at home.
- Significant improvement must continue to be made.
- An inpatient admission must be to a rehabilitation facility accredited by the Joint Commission on Accreditation of Healthcare Organizations or the Commission on Accreditation of Rehabilitation Facilities.

Rehabilitation benefits are not payable for:

- Vocational rehabilitation intended to teach a patient how to be gainfully employed;
- Pulmonary rehabilitation (except in conjunction with a covered and approved lung transplant or as a perioperative conditioning component for lung volume reduction surgery);
- Cognitive (mental) retraining;
- Community re-entry programs;
- Long-term rehabilitation after the acute

phase; or

- Services by a massage therapist.

Rehabilitation – acute

Acute-phase rehabilitation often is done in an outpatient setting. In complex cases, the rehabilitation may be done in an acute-care facility and then a sub-acute rehabilitation facility or an outpatient facility. Acute rehabilitation begins soon after the start of the illness or injury and may continue for days, weeks, or several months. Cardiac and pulmonary rehabilitation require preauthorization.

Rehabilitation – long-term

Long-term rehabilitation refers to the point at which further improvement is possible, in theory, but progress is slow and its relationship to formal treatment is unclear. Long-term rehabilitation after the acute phase is generally not covered.

Second opinions

If Medi-Call advises you to seek a second opinion before a medical procedure, the plan will pay 100 percent of the cost of that opinion. These procedures include surgery and treatment (including hospitalization).

Skilled nursing facility

The plan will pay limited benefits for medically necessary inpatient services at a skilled nursing facility for up to 60 days. Physician visits are limited to one a day. These services require approval by Medi-Call.

Speech therapy

The plan covers short-term speech therapy to restore speech or swallowing function that has been lost as a result of disease, trauma, injury

or a congenital defect, such as cleft lip or cleft palate. Speech therapy must be prescribed by a physician and provided by a licensed speech therapist. Speech therapy, whether it is offered as an inpatient service or in the member's home, requires preauthorization by Medi-Call. For more information, contact BlueCross Customer Service at 803.736.1576 or 800.868.2520.

Maintenance therapy begins when the therapeutic goals of a treatment plan have been achieved or when no further functional progress is documented or expected to occur. Maintenance therapy is not covered.

Speech therapy is not covered when associated with any of the following:

- Verbal apraxia or stuttering;
- Language delay;
- Communication delay;
- Developmental delay;
- Attention disorders;
- Behavioral disorders;
- Cognitive (mental) retraining;
- Community re-entry programs; or
- Long-term rehabilitation after the acute phase of treatment for the injury or illness.

Please note that BlueCross may still review speech therapy services after a claim has been paid to determine if the services are indeed a benefit covered by the plan.

Surgery

Physician charges for medically necessary inpatient surgery, outpatient surgery, and use of surgical facilities are covered if the care is associated with a service allowed by the plan.

Other covered benefits

These benefits are covered if they are determined to be medically necessary and associated with a service allowed by the plan:

- Blood and blood plasma, excluding storage fees; and
- Nursing services (part-time/intermittent).

Extended care is covered as an alternative to hospital care only if it is approved by Medi-Call.

Exclusions – services not covered

There are some medical expenses the State Health Plan does not cover. The Plan of Benefits, available at www.peba.sc.gov/assets/planofbenefits.pdf, contains a complete list of the exclusions.

- Services or supplies that are not medically necessary within the terms of the plan.
- Routine procedures not related to the treatment of injury or illness, except for those specifically listed in the preventive benefits section.
- Routine physical exams, checkups (except well child care and preventive benefits according to guidelines), services, surgery (including cosmetic surgery) or supplies that are not medically necessary. The Savings Plan covers an annual physical by a network physician for each participant age 19 and older.
- Routine prostate exams, screenings, or related services are not covered under the plan. A diagnostic prostate exam, screening, and laboratory work will be covered when medically necessary but not as part of the Savings Plan annual physical exam. The diagnostic exam will be subject

to the State Health Plan's usual deductibles and coinsurance.

- Routine prostate-specific antigen tests.
- Eyeglasses²⁷.
- Contact lenses²⁷, unless medically necessary after cataract surgery and for the treatment of keratoconus, a corneal disease affecting vision.
- Routine eye examinations²⁷.
- Refractive surgery²⁷, such as radial keratotomy, laser-assisted in situ keratomileusis (LASIK) vision correction, and other procedures to alter the refractive properties of the cornea.
- Hearing aids and examinations for fitting them.
- Dental services²⁸, except for removing impacted teeth, treatment within one year of a condition resulting from an accident, treatment made necessary by the loss of teeth due to cancer treatment, and treatment necessary as a result of a congenital birth defect.
- TMJ splints, braces, guards, etc. Medically-necessary surgery for TMJ is covered if preauthorized by Medi-Call. TMJ, temporomandibular joint syndrome, is often characterized by headache, facial pain, and jaw tenderness caused by irregularities in the way joints, ligaments, and muscles in the jaws work together.
- Custodial care, including sitters and companions or homemakers/caretakers.
- Admissions or portions thereof for

custodial care or long-term care, including:

- Respite care;
- Long-term acute or chronic psychiatric care;
- Care to assist a member in the performance of activities of daily living, (i.e., custodial care including, but not limited to: walking, movement, bathing, dressing, feeding, toileting, continence, eating, food preparation, and taking medication); and
- Psychiatric or substance use long-term care, including: therapeutic schools, wilderness/boot camps, therapeutic boarding homes, half-way houses, and therapeutic group homes.
- Any item that may be purchased over the counter, including but not limited to medicines and contraceptive devices.
- Surgery to reverse a vasectomy or tubal ligation if elective and not medically necessary to treat a pre-existing condition.
- Diagnosis or treatment of infertility for a subscriber or a spouse if either member has had a tubal ligation or vasectomy.
- Assisted reproductive technologies (fertility treatment) except as described on Page 70.
- Weight loss treatments and all weight loss surgery, including, but not limited to: gastric bypass, gastric banding or stapling; intestinal bypass and any related procedures; the reversal of such procedures; and conditions and complications as a result of such procedures or treatment.
- Equipment that has a nontherapeutic use (such as humidifiers, air conditioners, whirlpools, wigs, artificial hair replacement,

²⁷Although vision benefits are generally not covered by the State Health Plan, coverage and discounts are available through the State Vision Plan. See the **Vision Care** chapter on Page 104.

²⁸Dental benefits are available through the State Dental Plan and Dental Plus. See the **Dental Insurance** chapter on Page 93.

vacuum cleaners, home and vehicle modifications, fitness supplies, speech augmentation or communication devices, including computers, etc.), regardless of whether the equipment is related to a medical condition or prescribed by a physician.

- Air quality or mold tests.
- Supplies used for participation in athletics (that are not necessary for activities of daily living), including but not limited to splints or braces.
- Physician charges for medicine, drugs, appliances, supplies, blood, and blood derivatives, unless it is a covered medical benefit under the Plan.
- Medical care by a doctor on the same day or during the same hospital stay in which you have surgery, unless a medical specialist is needed for a condition the surgeon could not treat.
- Physician's charges for clinical pathology, defined as services for reading any machine-generated reports or mechanical laboratory tests. Interpretation of these tests is included in the allowance for the lab service.
- Fees for medical records and claims filing.
- Food supplements, including but not limited to, infant formula, enteral nutrition, Boost/Ensure, or related supplements.
- Services performed by members of the insured's immediate family.
- Acupuncture.
- Chronic pain management programs.
- Transcutaneous (through the skin) electrical nerve stimulation (TENS), whose primary purpose is the treatment of pain.
- Biofeedback.
- Complications arising from the receipt of non-covered services.
- Psychological tests to determine job, occupational, or school placement or for educational purposes; milieu therapy; or to determine learning disability.
- Any service or supply for which a covered person is entitled to payment or benefits pursuant to federal or state law (except Medicaid), such as benefits payable under workers' compensation laws.
- Charges for treatment of illness or injury or complications caused by acts of war or military service.
- Cosmetic goods, procedures, surgery, or complications resulting from such procedures or services.
- Smoking cessation or deterrence products or services, except for those covered by the Prescription Drug Program or as authorized by the tobacco cessation program for eligible participants in its tobacco cessation program.
- Sclerotherapy (treatment of varicose veins), including injections of sclerosing solutions for varicose veins of the leg, unless a prior-approved ligation (tying off of a blood vessel) or stripping procedure has been performed within three years and documentation submitted to Medi-Cal with a preauthorization request establishes that some varicosities (twisted veins) remained after the procedure.
- Services performed by service or therapy animals or their handlers.
- Abortions, except for an otherwise legal abortion performed in accordance with federal Medicaid guidelines.
- A covered child's infertility treatment, pregnancy, or complications from

- pregnancy or childbirth.
- Storage of blood or blood plasma.
- Experimental or investigational surgery or medical procedures, supplies, devices, or drugs. Any surgical or medical procedures determined by the medical staff of the third-party-claims processor, with appropriate consultation, to be experimental or investigational or not accepted medical practice. Experimental or investigational procedures are those medical or surgical procedures, supplies, devices, or drugs, which, at the time provided or sought to be provided:
 - Are not recognized as conforming to accepted medical practice in the relevant medical specialty or field of medicine; or
 - The procedures, drugs, or devices have not received final approval to market from appropriate government bodies; or
 - Are those about which the peer-reviewed medical literature does not permit conclusions concerning their effect on health outcomes; or
 - Are not demonstrated to be as beneficial as established alternatives; or
 - Have not been demonstrated, to a statistically significant level, to improve the net health outcomes; or
 - Are those in which the improvement claimed is not demonstrated to be obtainable outside the investigational or experimental setting.

Additional limits in the Standard Plan

- Chiropractic benefits in the Standard Plan are limited to \$2,000 per person per year.

- Chiropractic benefits for manual therapy are limited to one per visit per person.

Additional limits and exclusions in the Savings Plan

- Chiropractic benefits in the Savings Plan are limited to \$500 per covered person per year.
- Chiropractic benefits for manual therapy are limited to one per visit per person.
- Non-sedating antihistamines and drugs for treating erectile dysfunction are not covered by the Savings Plan.

How to file a State Health Plan claim

Claims filed inside South Carolina

If you received services from a provider that participates in a State Health Plan network, you do not have to file a claim; your provider will file it for you. You are responsible for the usual out-of-pocket expenses, such as deductibles, copayments, coinsurance, and non-covered services.

If you did not use a network provider or if you have a claim for a non-network service, you may have to file the claim yourself. You can get claim forms from your benefits office, PEBA, including on the website at www.peba.sc.gov/iforms.html, and from BlueCross. You will need a separate claim form for each individual who received care.

To file a claim:

- Complete the claim form.
- Attach your itemized bills, which must show the amount charged; the patient's name; the date(s) and place of service(s);

the diagnosis, if applicable; procedure codes; and the provider's name, federal Tax Identification Number or National Provider Identifier, if available.

File your claims within 90 days of the date you receive services or as soon as reasonably possible.

For claims to be paid, BlueCross must receive your form by the end of the calendar year after the year in which expenses are incurred.

Mail claims to:

State Business Unit
BlueCross BlueShield of South Carolina
P.O. Box 100605
Columbia, SC 29260-0605

For more information, call BlueCross at 800.868.2520 or 803.736.1576.

Claims filed outside South Carolina

Generally, if you obtain services outside South Carolina or the U.S. from a BlueCard network doctor or hospital, you should not need to pay up-front for care, except for the usual out-of-pocket expenses, such as deductibles, copayments, coinsurance, and non-covered services. The provider should submit the claim on your behalf. Network providers will file claims to the BlueCross affiliate in the state in which the service was provided. Outside the U.S., you should complete a BlueCard Worldwide International Claim Form and send it to the BlueCard Worldwide Service Center. This claim form is available from your benefits administrator, at www.peba.sc.gov/iforms.html and at StateSC.SouthCarolinaBlues.com. If services are received from an out-of-network provider, you may be asked to pay-up front for the full cost of

the services received and may also be required to file the claim to BlueCross yourself.

For more information, call BlueCard Worldwide at 800.810.2583 or 804.673.1177.

Appeals

Claims and preauthorization appeals to third-party claims processors

Subscribers have the right to appeal decisions made by third-party claims processors contracted by PEBA to administer benefits. The following covers initial appeals to BlueCross for health insurance claims as well as Medi-Call for medical preauthorization, and Companion Benefit Alternatives (CBA) for behavioral health benefits preauthorizations. Radiology preauthorization appeals for National Imaging Associates are handled differently from other appeal procedures and are also covered in this section.

In the case of BlueCross, Medi-Call, or CBA you may appeal an initial claim or preauthorization denial within six months of the decision. If you would like for someone else to appeal on your behalf, you may make this request to BlueCross, Medi-Call, or CBA in writing. Contact information is provided below if you have questions about how to file an appeal.

BlueCross Blue Shield of South Carolina

- StateSC.SouthCarolinaBlues.com
- 803.736.1576 or 800.868.2520

Medi-Call

- 803.699.3337 or 800.925.9724

Companion Benefit Alternatives

- www.CompanionBenefitAlternatives.com
- 803.736.1576 or 800.868.2520

Appeal rights and instructions for an appeal are included in the denial letter you receive. Please include the following information in your appeal:

- The subscriber's health ID number, ZCS followed by their eight-digit Benefits Identification Number (BIN);
- The subscriber's name and date of birth;
- A copy of the decision being appealed;
- The claim number of the services being appealed, if applicable (available on your Explanation of Benefits);
- A copy of medical records that support the appeal; and
- Any other information or documents that support the appeal.

National Imaging Associates

- www.RadMD.com
- 866.500.7664

If National Imaging Associates denies a procedure on the grounds that it is not medically necessary, you have three days to file an appeal with National Imaging Associates if the services have not been received. If three days or more have passed, you may request Medi-Call review the decision.

Appeals to PEBA: preauthorizations and services that have been provided

If you are still dissatisfied after the decision has been reexamined, you may request a second-level appeal by writing to PEBA within 90 days of your notice of the denial. Please include

a copy of the previous two denials with your appeal to PEBA. Send the request to:

Appeals Department
S.C. PEBA
202 Arbor Lake Drive
Columbia, SC 29223

If your appeal relates to a pregnancy, newborn child, or the preauthorization of a life-saving treatment or drug, you may send your request to PEBA via email or fax to:
urgentappeals@peba.sc.gov.

A healthcare provider or benefits administrator may not appeal to PEBA on your behalf, even if they appealed the decision to the third-party claims processor. Only you, the member, or your authorized representative may initiate an appeal through PEBA. A provider or benefits administrator may not be an authorized representative.

PEBA will make every effort to process your appeal within 180 days of the date it receives your claim file from BlueCross, Medi-Call, or CBA, as outlined in the Plan. However, this time may be extended if additional material is requested or you ask for an extension. PEBA will send you periodic updates on the status of your review. When PEBA's review of your appeal is complete, you will receive a written determination in the mail.

If the denial is upheld by the PEBA Appeals Committee, you have 30 days to seek judicial review at the Administrative Law Court, as provided by Sections 1-11-710 and 1-23-380 of the S.C. Code of Laws, as amended.

GEA TRICARE Supplement Plan

TRICARE is the Department of Defense health

benefit program for the military community. It consists of TRICARE Prime, a health maintenance organization; TRICARE Extra, a preferred-provider option; and TRICARE Standard, a fee-for-service plan.

The TRICARE Supplement Plan is secondary coverage to TRICARE. It pays the subscriber's share of covered medical expenses under the TRICARE Prime (in-network), Extra, and Standard options. Eligible participants have almost 100 percent coverage. Underwritten by Transamerica Premier Life Insurance Company, the plan is administered by Selman & Company. Federal law requires that the plan be sponsored by an association, not an employer. The plan sponsor is the Government Employees Association.

The TRICARE Supplement Plan is designed for TRICARE-eligible active employees and retired employees until they become eligible for Medicare. It is an alternative to the State Health Plan.

Eligibility

PEBA does not confirm eligibility for the TRICARE Supplement Plan. Eligible individuals must be registered with the Defense Enrollment Eligibility Reporting System (DEERS) and must not be eligible for Medicare. You must drop your State Health Plan coverage to enroll in the TRICARE Supplement Plan.

You should confirm your eligibility for TRICARE with DEERS before enrolling in the TRICARE Supplement. If a dependent's Military ID card has expired or if information, such as a mailing address, has changed, call DEERS at 800.538.9552. The TRICARE Supplement Plan is available to eligible employees including:

- Military retirees receiving retired, retainer, or equivalent pay;

- Spouse/surviving spouse of a military retiree;
- Retired reservists between the ages of 60 and 65 and spouses/surviving spouses of retired reservists;
- Retired reservists younger than 60 and enrolled in TRICARE Retired Reserve (Gray Area retirees) and spouses/surviving spouses of retired reservists enrolled in TRICARE Retired Reserve; and
- Qualified National Guard and Reserve Members (TRICARE Retired Reserve).

There are limited exceptions to the Age 65 Eligibility Rule. Contact Selman & Company for more information.

As a subscriber, you may cover your eligible dependent children; however, dependent eligibility for the TRICARE Supplement Plan is based on TRICARE eligibility rules and is different from PEBA's dependent eligibility rules.

Eligible dependent children

- Unmarried dependent children up to age 21, or, if the child is a full-time student, up to age 23. Documentation that a child, age 21 to 22, is a full-time student must be provided to TRICARE.
- Incapacitated dependents are covered after age 21, 23, or 26, if the child is dependent on the member for primary support and maintenance and is still eligible for TRICARE. Proof of continued incapacity and dependency is required. Documentation must be provided to TRICARE.
- Adult dependent children who are younger than 26 and who are enrolled in TRICARE Young Adult. The child must send a copy of their TRICARE Young Adult Enrollment ID

card to Selman & Company.

How to enroll

If you are eligible for TRICARE and eligible for coverage with the South Carolina state health insurance program, you can enroll yourself and your eligible dependents within 31 days of the date you are hired or become eligible for TRICARE. You also can enroll during open enrollment, which is offered annually in October. If you enroll during open enrollment, coverage becomes effective on January 1.

To enroll

1. Membership in the Government Employees Association is required for enrollment in the TRICARE Supplement Plan. Information about the Government Employees Association is provided in the TRICARE Supplement Plan welcome packet. Dues are included in the plan's monthly premium. For more information, contact the Government Employees Association at 800.446.7600 or www.geausa.org.
2. Complete a *Notice of Election* and check "TRICARE Supplement Plan" in the health plan section. Return the *Notice of Election* to your benefits administrator along with a copy of your military ID or TRICARE ID card. Also, if you are an active employee, your benefits administrator can enroll you using the online Employee Benefits System. As a subscriber, you can enroll through MyBenefits.sc.gov during open enrollment. See Page 21 for more information. If you are a retired employee of a state agency, public school district, or a higher education institution, submit a Retiree *Notice of Election* to PEBA. If you are a local subdivision retiree, submit a Retiree *Notice of Election* to your former employer's benefits office. See Page 170 for more

information. Coverage is not automatic.

3. If you are an eligible subscriber, complete the TRICARE Other Health Insurance form if you were previously enrolled in the State Health Plan. The TRICARE Other Health Insurance form for each region is on the TRICARE website, www.tricare.mil. Fax the completed forms to TRICARE at the number on the form. Remember, the TRICARE Supplement Plan is not considered other health insurance.

Upon enrollment, you will receive a packet with your certificate of insurance, ID card, claim forms, and instructions on how to file claims.

In addition to enrolling in the TRICARE Supplement Plan, during open enrollment, if you're an eligible subscriber, you may drop TRICARE Supplement Plan coverage for yourself or your dependents, or add dependents. See Pages 20-21 for more information.

Plan features

The TRICARE Supplement Plan provides you with additional coverage, which, when combined with the other TRICARE coverage, usually pays 100 percent of your out-of-pocket expenses. Some of the plan's features include:

- No deductibles, coinsurance, or out-of-pocket expenses for covered services;
- Choice of any TRICARE-authorized provider, including network, non-network, participating, and nonparticipating providers (see *TRICARE Supplement Plan Member Handbook*);
- Reimbursement of prescription drug copayments; and
- Portability that allows you to continue coverage by paying the premiums directly to Selman & Company if you leave your

job.

Filing claims

Most providers submit TRICARE Supplement Plan claims. If a provider does not, you may submit the claims to Selman & Company. Information and forms filing doctor/hospital and pharmacy claims is included in the welcome packet and at www.selmantricareresource.com/SC.

Medicare eligibility and the TRICARE Supplement Plan

If, as an active employee, survivor, or retiree, you become eligible for Medicare Part A, you must purchase Medicare Part B to remain eligible for TRICARE. Your TRICARE health benefit changes to TRICARE for Life, a Medicare supplement, and your TRICARE Supplement Plan coverage ends. You may continue the supplement plan coverage for your eligible dependents by making premium payments directly to Selman & Company. Contact Selman & Company for details.

If a dependent becomes eligible for Medicare before the active employee, survivor, or retiree, the dependent is no longer eligible for the TRICARE Supplement Plan.

Loss of TRICARE eligibility

The TRICARE Supplement Plan pays after TRICARE pays. Therefore, if an employee, spouse, or dependent child loses TRICARE eligibility, TRICARE Supplement Plan coverage ends. Dependents who lose TRICARE eligibility are not eligible for continued TRICARE Supplement Plan coverage through COBRA or on portability. Loss of TRICARE eligibility is a special eligibility situation that permits an eligible employee or retiree and their dependents, if the dependents are otherwise

eligible for PEBA insurance coverage, to enroll in health, dental, and vision coverage. Basic life insurance and basic long term disability insurance are provided free to active employees who enroll in the State Health Plan or the TRICARE Supplement Plan.

Loss of a spouse's TRICARE eligibility

- A spouse may lose TRICARE eligibility due to a divorce. When this occurs, they also lose eligibility to continue coverage under the TRICARE Supplement Plan.

Loss of a dependent child's TRICARE eligibility

- A dependent child loses TRICARE eligibility at age 21 if they are not enrolled in school on a full-time basis. A dependent also loses eligibility at midnight on their 23rd birthday, regardless of whether or not they are a full-time student, or on the date they graduate from college, whichever comes first.
- An adult dependent child enrolled in TRICARE Young Adult loses eligibility at midnight the night of their 26th birthday or the date they fail to pay full premiums to their TRICARE regional contractor.

More information

For more information about the Government Employees Association TRICARE Supplement Plan contact Selman & Company at www.selmantricareresource.com/SC or 800.638.2610.

For more information about TRICARE for Life, visit www.tricare4u.com or call 866.773.0404.



Prescription benefits

Prescription drugs are a major part of the benefits available to you and a major part of the cost of PEBA insurance subscribers' self-insured health plan. The State Health Plan contracts with a pharmacy benefits manager to administer the Plan's prescription drug benefits. Express Scripts is the Plan's pharmacy benefits manager.

Using generic drugs saves money for you and your plan. You also can save money and receive the same U.S. Food and Drug Administration- (FDA-) approved drugs when you refill prescriptions through the plan's Retail Maintenance Network or mail-order prescription service. Benefits are paid only for prescriptions filled at network pharmacies or through Express Scripts mail-order pharmacy in the United States. Limited coverage is offered outside the United States. For more information on how to file a claim, see Pages 90–91.

Using your prescription benefits

You will receive one prescription drug benefits card from Express Scripts. Present your card when you fill a prescription, particularly the first time you use your card, and any time you fill a prescription at a different pharmacy.

Member resources

Helpful information about your State Health Plan prescription drug benefits is just a click away at www.Express-Scripts.com and on the Express Scripts mobile app. The app is compatible with most iPhone®, iPad®, Android™, Windows Phone®, Amazon, and BlackBerry® mobile devices and can be downloaded for free from the iTunes, Google Play, Windows Phone, and Amazon app stores. You are encouraged to create an account to get the

most out of these resources. Be sure to have your prescription drug card available when you register. The website and mobile app offer a variety of information and tools:

- Refill and renew your prescriptions;
- See your order status, claims and payment history;
- Find in-network pharmacies near you;
- Find and compare prices with Price a Medication;
- Check for drug interactions and alerts;
- View up-to-date coverage information;
- Contact a pharmacist 24/7; and
- Get instant access to your digital member identification card.

State Health Plan Prescription Drug Program

Standard Plan

Standard Plan members pay a copayment when filling prescriptions at a network pharmacy. Copayments are \$9 for Tier 1 (generic – lowest cost), \$38 for Tier 2 (brand – higher cost), and \$63 for Tier 3 (brand – highest cost) for up to a 30-day supply. The prescription drug copayment is a fixed total amount a member must pay for a covered drug. If the pharmacy's charge is less than the copay, the member pays the lesser amount. The insurance plan pays the cost beyond the copayment, up to the allowed amount. Prescription drug benefits are payable without an annual deductible and there are no claims to file.

The prescription drug benefit has a separate annual copayment maximum of \$2,500 per person. This means that after you spend \$2,500

in prescription drug copayments, the plan will pay 100 percent of the allowed amount for your covered prescription drugs for the rest of the year. Drug expenses do not count toward your medical annual deductible or medical coinsurance maximum.

Savings Plan

Savings Plan members do not pay a copayment when filling prescriptions at a network pharmacy. You pay the full allowed amount for your prescription drugs, and a record of your payment is transmitted electronically to BlueCross Blue Shield of South Carolina (BlueCross). If you have not met your annual deductible, the full allowed amount for the drug will be credited to your annual deductible. If you have met your annual deductible, you will pay 20 percent of the allowed amount for the drug. This amount will be credited to your coinsurance maximum.

Please note that non-sedating antihistamines as well as drugs for erectile dysfunction are not covered under the Savings Plan.

Express Scripts Medicare®

If you are enrolled in the State Health Plan as an active employee and you or your covered dependents become eligible for Medicare, PEBA automatically enrolls the Medicare-eligible member in Express Scripts Medicare®, the State Health Plan's Medicare Part D program. However, you have the option to return to the State Health Plan Prescription Drug Program, which covers members who are not eligible for Medicare. For information about Express Scripts Medicare®, see the *Insurance Coverage for the Medicare-eligible Member* handbook, which is available at

www.peba.sc.gov/assets/medicarehandbook.pdf.

Pharmacy network

Locating participating pharmacies

You can search for a network pharmacy through the Express Scripts website, www.Express-Scripts.com, or Express Scripts mobile app, by signing in to your account and selecting Locate a Pharmacy. Because the State Health Plan does not offer out-of-network coverage for prescription drugs in the United States, you should consider using a network provider when possible.

You can also call Express Scripts at 855.612.3128 to get a list of network pharmacies near you.

Retail pharmacies

Most major pharmacy chains and independent pharmacies participate in the network. When you use a participating pharmacy to purchase medications, be sure to show your prescription drug card.

Retail Maintenance Network

You may buy up to 90-day supplies of prescription drugs at discounted prices at your local network pharmacy through the Retail Maintenance Network. You will pay a lower copayment than if you purchased this medication one month at a time. The discount only applies to prescriptions filled for a 61-to-90 day supply. Copayments for prescriptions filled for a 1-to-60 day supply will follow the normal retail prices. You can search for a pharmacy in the retail maintenance network by logging in to your Express Scripts account at www.Express-Scripts.com or on the Express

Scripts mobile app.

Mail-order through Express Scripts Pharmacy

The State Health Plan Prescription Drug Program and Express Scripts Medicare® offer home delivery for 90-day supplies of prescriptions through Express Scripts Pharmacy. When you use this service, you receive the same discount on the same FDA-approved prescription drugs that you would receive in the Retail Maintenance Network.

Some controlled substances may not be available by mail; call Express Scripts at 855.612.3128 before submitting your prescription to determine if your prescription is available. Be sure to ask your physician to write your prescription for a 90-day supply.

To place an order, log in to your Express Scripts account at www.Express-Scripts.com or on the Express Scripts mobile app. Your mail order purchase will be delivered to your home typically within 10 to 14 business days.

Standard Plan and Medicare Supplemental Plan

The copayments for up to a 90-day supply are:

- Tier 1 (generic – lowest cost) – \$22
- Tier 2 (brand – higher cost) – \$95
- Tier 3 (brand – highest cost) – \$158

Savings Plan

As described above, you pay the full allowed amount when you order prescription drugs through the mail; however, the cost for a 90-day supply will generally be less if you use the Retail Maintenance Network or Express Scripts mail service pharmacy.

How to order drugs by mail

- Ask your doctor to write a prescription for a 90-day supply of the medication with refills, as appropriate. You may also want to ask them to write a prescription for 30-day supply of the drug, which you can fill at a retail pharmacy and use until you receive your drugs in the mail.
- Complete a home delivery order form, available at www.peba.sc.gov/iforms.html under Prescription benefits, or have your physician e-prescribe the prescription to Express Scripts mail order. You may pay by check, money order, or major credit card. If you would like to pay by credit card, you may want to sign up for Express Scripts automatic payment program. If you have already created an Express Scripts account, the method of payment can be selected in advance, and Express Scripts will send you an email when it receives your new prescription and may begin dispensing.
- Mail the prescription, the order form, and the payment to Express Scripts at the address indicated on the form.

How to fill a prescription by fax

- Ask your doctor to write a new prescription for a 90-day supply of the medication, with refills as appropriate. Give your doctor your member identification number, which you can find on the front of your State Health Plan Prescription Drug Program identification card.
- Ask your doctor to fax your prescription to 800.837.0959.

If your doctor has questions about faxing your prescription to Express Scripts, he may call 888.327.9791.

Prescription copayments/formulary

Members covered by the Standard Plan and Express Scripts Medicare® pay copayments for drugs; all drugs are classified by a tier that determines the member's copayment. Express Scripts, the Plan's pharmacy benefits manager, constructs the formulary, or listing of covered and preferred drugs. The drug's placement on the formulary determines the copayment tier for the drugs and, in some cases, if a particular brand product is covered. Express Scripts' independent committee of physicians and pharmacists continually reviews drugs with the objective of assuring member access to needed therapies, while achieving lowest net cost for the Plan.

Tier 1: generic – \$9 copayment

Generic drugs may differ in color, size, or shape, but the FDA requires that the active ingredients be the chemical equivalent of the brand-name alternative and have the same strength, purity, and quality. Because generic drugs have a lower copayment, you typically get the same health benefits for less. You may wish to ask your doctor to mark Substitution Permitted on your prescription. If they do not, your pharmacist will have to provide you the brand-name drug if that is the drug your doctor wrote on the prescription.

Tier 2: preferred brand – \$38 copayment

These brand-name preferred drugs cost more than generic drugs. Drugs classified as Tier 2 may be updated throughout the year.

Tier 3: non-preferred brand – \$63 copayment

These brand-name non-preferred medications have the highest copayment.

A list of drugs by tier is available by logging in to your Express Scripts account at www.Express-Scripts.com or on the Express Scripts mobile app.

Formulary non-covered products

In the State Health Plan Prescription Drug Program only (this does not apply to members enrolled in Express Scripts Medicare®) there are certain brand products in highly interchangeable therapeutic categories that are not covered. There are preferred products covered and available in each of these categories. If you are prescribed a drug that is non-covered or non-preferred, we encourage you to talk to your doctor about prescribing preferred drugs. PEBA's adoption of Express Scripts' National Preferred Formulary results in about 80 pharmacy products, out of roughly 4,000 products on the market, being excluded from coverage for non-Medicare subscribers effective January 1, 2017. As a State Health Plan member, you still have access to comparable medications that are covered by the Plan. Members using any of these pharmacy products received communications from Express Scripts beginning in October 2016 to notify them of the upcoming change and to offer covered alternatives.

Pay-the-difference policy

If you purchase a brand-name drug when an FDA-approved generic equivalent is available, the plan will only pay the allowed amount for the generic equivalent. This pay-the-difference

policy applies even if your doctor prescribes the drug as Dispense as Written or Do Not Substitute.

As a Standard Plan or Medicare Supplemental Plan member¹, if you purchase a Tier 2 or Tier 3 (brand) drug over a Tier 1 (generic) drug, you will be charged the generic copayment plus the difference between the allowed amounts for the brand drug and the generic drug. If the total amount is less than the Tier 2 or Tier 3 (brand) copayment, you will pay the brand copayment. Only the copayment for the Tier 1 (generic) drug will apply toward a member's annual prescription drug copayment maximum.

Savings Plan members do not pay copayments; however, they usually save money by buying generic drugs because these drugs typically cost less. With the Savings Plan, if you purchase a Tier 2 or Tier 3 (brand) drug over a Tier 1

¹The pay-the-difference policy does not apply to members covered by Express Scripts Medicare®, the State Health Plan's Medicare Part D program.

(generic) drug, only the allowed amount for the generic drug will apply toward your deductible. After you have met your deductible, only the patient's 20 percent share of the allowed amount for the generic drug will apply toward your coinsurance maximum.

Specialty pharmacy programs

Specialty pharmacy is a term referring to certain medication that has some or all of the following features:

- Extremely high cost and is needed by a relatively small percent of the population;
- Is complex to manufacture; and
- Requires special handling and administration.

In most cases, the Plan treats specialty pharmacy in a similar manner as non-specialty medication. However, beginning in 2017, there are two categories in which the Plan has

The examples below show how the pay-the-difference policy works in the Standard Plan and Medicare Supplemental Plan.

This is what you pay for a Tier 2 (brand) drug when a Tier 1 (generic) drug is not available.

	Tier 1 (generic)	Tier 2 (brand)
Allowed amount for the drug	N/A	\$125
Generic copayment	N/A	N/A
Amount you pay	N/A	\$38 (brand copayment only)

This is what you pay for a Tier 2 (brand) drug when a Tier 1 (generic) drug is available.

	Tier 1 (generic)	Tier 2 (brand)
Allowed amount for the drug	\$65	\$125
Generic copayment	\$9	N/A
Amount you would have paid had you chosen the generic drug	\$9 (copayment only)	N/A
Amount you pay because you chose the brand drug		\$69 (\$9 generic copayment plus difference between allowed amount for generic drug and brand drug [\$60])

adopted programs administered by Express Scripts to address the challenges presented by specialty pharmacy. Those programs are:

- The Hepatitis C Cure Value Program, affecting medication to treat this disease; and
- The Cholesterol Care Value Program, affecting PCSK9 inhibitors used in rare cases to treat high cholesterol.

Patients seeking specialty medication in either of these two categories should contact Express Scripts at 855.612.3128 for more information.

Coverage reviews

Sometimes a prescription isn't enough to determine if the State Health Plan will provide benefits. When more information is needed to determine how a medication is covered, Express Scripts will start a coverage review to learn more. If the determination is made to cover the medication, you will pay the appropriate copayment. The State Health Plan uses coverage reviews to ensure the safe and effective use of prescription drugs and to encourage the use of lower-cost alternatives when possible. There are three basic types of coverage reviews.

Prior authorization

Some medications will be covered by the State Health Plan only if they are prescribed for certain uses. These drugs must be authorized in advance, or they will not be covered under the plan. Other medications may not be covered by the plan if there are safe and effective lower-cost alternatives available. You can research if a drug requires a prior authorization or other type of coverage review by logging in to your Express Scripts account at www.Express-Scripts.com or on the Express Scripts mobile

app. If the prescribed medication requires prior authorization, you, your doctor, or your pharmacist may begin the review process by contacting Express Scripts at 855.612.3128.

Drug quantity management

The FDA has guidelines for safety and effectiveness that include quantity limits for certain medications. If you are prescribed a quantity of a medication that does not fall within these guidelines, the plan may cover a lesser quantity of the medication. You, your doctor, or your pharmacist may also begin the coverage review process to see if coverage may be allowed for a higher quantity by contacting Express Scripts at 855.612.3128.

Step therapy

The step therapy process is designed to encourage use of generics and over-the-counter drugs that are alternatives to some high-volume, high-priced, brand-name drugs. If you or your doctor thinks you should not use the lower-cost drug, your prescription may require preauthorization or it may be covered at the Tier 3 non-preferred rate.

You or your doctor may request a coverage review by calling Express Scripts at 855.612.3128. As part of the process, you may be required to have tried and failed to successfully use the lower-cost drug. If as a result of the review, the drug is approved, it will be covered at the appropriate tier. If approval is denied, the plan will not cover the drug. For more information, call Express Scripts at 855.612.3128.

Compound prescriptions

A medication that requires a pharmacist to mix two or more drugs, based on a doctor's

prescription, when such a medication is not available from a manufacturer is known as a compound prescription. To be covered, the prescription must be medically necessary and studied for use in this type of preparation. It must also be purchased from a participating network pharmacy.

To be sure that your compound drug is covered under your plan, your pharmacist should submit the prescription to Express Scripts electronically. If one ingredient in the compound is not covered, the compound drug will not be covered by the plan. The pharmacist will receive information on coverage of ingredients and, in some situations, can substitute other covered ingredients to create your compound. If your compound is not covered, you are encouraged to discuss commercially available medications with your physician.

Coordination of benefits

All State Health Plan benefits, including prescription drug benefits, are subject to coordination of benefits, a process that is used to make sure a person covered by more than one insurance plan is not reimbursed more than once for the same expenses. With coordination of benefits, the plan that pays first is the primary plan. The secondary plan pays after the primary plan. See Pages 44–45 for more information about coordination of benefits.

Exclusions

Some prescription drugs, such as those that do not appear on the National Preferred Formulary listing of covered and preferred drugs, are not covered under the plan.

Some covered drugs, including insulin and

other self-injectable drugs administered at home, are subject to plan exclusions and limitations when you use a network pharmacy.

Prescription drugs associated with infertility treatments have a different coinsurance rate. See Page 70 for more information about infertility treatments.

Examples of other drugs that are not covered are:

- Drugs in FDA Phase I, II or III testing; and
- Prescription drugs used for weight loss.

Drugs that are not covered under the Savings Plan but are covered under the Standard Plan are:

- Non-sedating antihistamines; and
- Drugs for treating erectile dysfunction.

Value-based prescription benefits at no cost to you

The following items are covered by the State Health Plan if obtained from a network pharmacy and are provided at no cost to State Health Plan primary members:

- Contraceptives for subscribers and covered spouses.
- Some specific prescription drugs for smoking cessation.
- Adult vaccinations, including the flu shot, as recommended by the Centers for Disease Control and Prevention. See Pages 54-55 for more information about adult vaccinations.

Filing a prescription drug claim

If you fail to show your prescription drug card

at a participating pharmacy in the United States, or if you are enrolled in the State Health Plan Prescription Drug Program or Express Scripts Medicare® and have prescription drug expenses while traveling outside the United States, you will pay the full retail price for your prescription. You can then file a claim with Express Scripts for reimbursement. After you meet your deductible, if applicable, your reimbursement will be limited to the plan's allowed amount, less the copayment or coinsurance, if any. Claims should be filed with Express Scripts within one year of the date of service.

To file a claim for prescription drug expenses incurred at a participating pharmacy or outside the United States, complete the Express Scripts Prescription Drug Reimbursement form. The form is available online at www.peba.sc.gov/iforms.html under Prescription benefits. You may also request a copy by calling Express Scripts at 855.612.3128.

If you are enrolled in the State Health Plan Prescription Drug Program, send the form with receipts for your prescriptions to:

Express Scripts
Attn: Commercial Claims
P.O. Box 14711
Lexington, KY 40512-4711

If you are enrolled in Express Scripts Medicare®, send the form with receipts for your prescriptions to:

Express Scripts
Attn: Medicare Part D
P.O. Box 14718
Lexington, KY 40512-4718

Remember, benefits are not payable if you use a non-participating pharmacy in the United States.

Appeals

If Express Scripts denies prior authorization for your medication, you will be informed promptly. If you have questions about the decision, check the information in this chapter. You or your prescriber may also call Express Scripts for an explanation. If you believe the decision was incorrect, you may ask Express Scripts to re-examine its decision. The request for a second review should be made in writing within six months after notice of the decision to:

Express Scripts
Attn: Benefit Coverage Review Department
P.O. Box 66587
St Louis, MO 63166-6587

If you are still dissatisfied after the decision is re-examined, you may ask PEBA to review the matter by making a written request to PEBA within 90 days of notice of Express Scripts' denial of your appeal. Please include a copy of the previous two denials with your appeal to PEBA. Send the request to:

Appeals Department
S.C. PEBA
202 Arbor Lake Drive
Columbia, SC 29223

If your appeal relates to a pregnancy, newborn child, or the preauthorization of a life-saving treatment or drug, you may send your request to PEBA via email or fax to:
urgentappeals@peba.sc.gov.

Appeals to PEBA

A healthcare provider or benefits administrator may not appeal to PEBA on your behalf, even if they appealed the decision to the third-party claims processor. Only you, the member, or

your authorized representative may initiate an appeal through PEBA. A provider or benefits administrator may not be an authorized representative.

PEBA will make every effort to process your appeal within 180 days of the date it receives your claim file from Express Scripts, as outlined in the Plan. However, this time may be extended if additional material is requested or you ask for an extension. PEBA will send you periodic updates on the status of your review. When PEBA's review of your appeal is complete, you will receive a written determination in the mail.

If the denial is upheld by the PEBA Appeals Committee, you have 30 days to seek judicial review at the Administrative Law Court, as provided by Sections 1-11-710 and 1-23-380 of the S.C. Code of Laws, as amended.



Dental insurance

Members may enroll in or drop the State Dental Plan and Dental Plus:

- During initial enrollment in PEBA's insurance programs
- During an open enrollment period in an odd-numbered year. The next opportunity will be October 2017.
- Within 31 days of a special eligibility situation, which is also referred to as a change in status in the State Dental Plan. Special eligibility situations are explained on Pages 21–27.

- Review your eligibility and benefits;
- Check claims and view EOBs;
- Check pretreatment estimates; and
- Report other dental coverage.

State Dental Plan

The State Dental Plan offers four classes of treatment: diagnostic and preventive; basic; prosthodontics, and orthodontics. The lifetime orthodontics payment is \$1,000 for each covered child age 18 and younger. State Dental Plan benefits are paid based on the allowed amounts for each dental procedure listed in the plan's *Schedule of Dental Procedures and Allowed Amounts*, found at StateSC.SouthCarolinaBlues.com under Coverage Information and then Dental Fee Schedule. Be aware that your dentist's charge may be greater than the allowed amount.

The maximum yearly benefit for the State Dental Plan alone is \$1,000 for each subscriber or covered person. The State Dental Plan deductible is \$25 annually for each covered person who has dental services under Class II or Class III. See the chart on Page 96 for Class II and Class III descriptions. The deductible for family coverage is limited to three per family per year (\$75).

Dental Plus

Members enrolled in Dental Plus must also be covered by the State Dental Plan. Dental Plus has a higher allowed amount and covers the first three classes of treatment at the same percentage as the State Dental Plan. There are no additional orthodontic benefits under Dental Plus; the only benefit is the lifetime orthodontics payment of \$1,000 for each covered child age 18 and younger through the State Dental Plan. See the chart on Page 96

PEBA offers the State Dental Plan, which helps offset your dental expenses, and Dental Plus, a supplement to the State Dental Plan. To participate in Dental Plus, you must enroll in the State Dental Plan and cover the same family members under both plans.

Online resources

Information about the State Dental Plan and Dental Plus is included on the BlueCross BlueShield of South Carolina (BlueCross) website, StateSC.SouthCarolinaBlues.com, designed for PEBA subscribers. On the site and under the My Health Toolkit member login, you can:

- Sign up for paperless Explanations of Benefits (EOBs);
- Find Dental Plus network providers through the Find a Dentist section;
- Visit the Dental Resource Center (click on Dental under the Coverage Information tab on the home page);

for more information.

Premiums are on Pages 180–186.

BlueCross offers dentists in South Carolina agreements to accept the lesser of their usual charge or the negotiated allowed amount. You are only responsible for any deductibles and coinsurance, plus any non-covered services rendered by an in-network dentist who has accepted BlueCross' agreement. For a list of network dentists, go to

StateSC.SouthCarolinaBlues.com and select Find a Dentist under the Find a Doctor section.

If your dentist has not accepted BlueCross' agreement, your benefits under Dental Plus will not be reduced. You will be responsible for deductibles and coinsurance, plus the difference between the payment and charge for all services rendered by an out-of-network dentist.

The maximum yearly benefit for a person covered by both the State Dental Plan and Dental Plus is \$2,000. There are no additional deductibles under Dental Plus; the State Dental Plan deductible is subtracted from the Dental Plus payment, when applicable.

Not all dental procedures are covered. You will be responsible for any charges related to non-covered services.

Please see Page 97–100 for more information.

BlueCross processes State Dental Plan and Dental Plus claims. Its mailing address is P.O. Box 100300, Columbia, SC 29202-3300. Its Customer Service number is 803.264.7323 or 888.214.6230. The fax number is 803.264.7739.

2017 Dental Plus reimbursement

What is the incentive for you to seek dental treatment from an in-network provider

beginning in 2017?

- Deeper discounts;
- Lower out of pocket expenses; and
- Your \$2,000 annual maximum payment going further toward necessary treatment.

The in-network and out-of-network allowed amounts may vary by dentist and/or location.

Adult cleaning rendered by an in-network dentist

Charge	\$82
Allowed amount	\$61 (average)
Payment ¹	\$61
You pay	\$0

Adult cleaning rendered by an out-of-network dentist

Charge	\$82
Allowed amount	\$82 (average)
Payment ¹	\$82
You pay	\$0

Crown rendered by an in-network dentist

Charge	\$1,150
Allowed amount	\$800 (average)
Payment ¹	\$400
You pay	\$400

Crown rendered by an out-of-network dentist

Charge	\$1,150
Allowed amount	\$1,100 (average)
Payment	\$550
You pay	\$600 (50% coinsurance, plus difference in charge and allowance)

¹The payment includes the State Dental Plan and Dental Plus payments.

Dental benefits at a glance

Class	Plan	Covered benefits	Annual deductible	Percent covered	Maximum payment
I Diagnostic and preventive	State Dental Plan only	Exams; cleaning and scaling of teeth; fluoride	None	100% of allowed amount	\$1,000 per person each year; combined for Classes I, II and III
	State Dental Plan with Dental Plus	treatment; space maintainers (child); x-rays	None	100% of allowed amount	\$2,000 ³ per person each year; combined for Classes I, II and III
II Basic benefits	State Dental Plan only	Fillings; extractions; oral surgery; endodontics (root canals);	\$25 per person. If you have services in Classes II and III, you pay only one deductible. Limited to three per family per year.	80% of allowed amount	\$1,000 per person each year Combined for Classes I, II and III
	State Dental Plan with Dental Plus	periodontal procedures	No additional deductible	80% of allowed amount	\$2,000 ³ per person each year; combined for Classes I, II and III
III Prosthodontics	State Dental Plan only	Onlays; crowns; bridges; dentures; implants; repair of prosthodontic appliances	\$25 per person. If you have services in Classes II and III, you pay only one deductible. Limited to three per family per year.	50% of allowed amount	\$1,000 per person each year; combined for Classes I, II and III
	State Dental Plan with Dental Plus		No additional deductible	50% of allowed amount	\$2,000 ³ per person each year; combined for Classes I, II and III
IV Orthodontics²	State Dental Plan only	Limited to covered children age 18 and younger. Correction of malocclusion consisting of:	None	50% of allowed amount	\$1,000 lifetime benefit for each covered child
	State Dental Plan with Dental Plus	diagnostic services (including models and x-rays); active treatment (including necessary appliances)	No additional benefits with Dental Plus	No additional benefits with Dental Plus	No additional benefits with Dental Plus

²A subscriber must submit a letter from his provider for a covered child, age 18 and younger, stating that the child's orthodontic treatment is not for cosmetic purposes for it to be covered by the State Dental Plan.

³\$2,000 is the maximum yearly payment for benefits when a member is enrolled in both the State Dental Plan and Dental Plus.

Special provisions of the State Dental Plan

Alternate forms of treatment

If you or your dentist selects a more expensive or personalized treatment, the plan will cover the less costly procedure that is consistent with sound professional standards of dental care. BlueCross uses guidelines based on usual and customarily provided services and standards of dental care to determine benefits or denials. Your dentist may bill you for the difference between his charges for the more costly procedure and what the plan allows for the alternate procedure. The plan will not allow you to apply the payment for the alternate procedure to the cost of the more expensive procedure if the more expensive procedure is not a covered benefit. Examples of when a less costly procedure may apply are:

- An amalgam (silver-colored) filling is less costly than a composite (white) filling placed in a posterior (rear) tooth.
- Porcelain fused to a predominantly base metal crown is less costly than porcelain fused to a noble metal crown.

Pretreatment estimates

Although it is not required, PEBA suggests that you obtain a pretreatment estimate of your non-emergency treatment for major dental procedures. To do this, you and your dentist should fill out a claim form before any work is done. The form can be found at www.peba.sc.gov/iforms.html. The completed form should list the services to be performed and the charge for each one. Mail the claim form to BlueCross BlueShield of South Carolina, State Dental Claims Department, P.O. Box 100300, Columbia, SC 29202-3300. Emergency

treatment does not need a pretreatment estimate.

You and your dentist will receive a pretreatment estimate, showing an estimate of the expenses your dental plan will cover. This form can be used to file for payment as the work is completed. Just fill in the date(s) of service, ask your dentist to sign the form and submit it to BlueCross. Your pretreatment estimate is valid for one year from the date of the form. The actual date of service may affect the payment allowed. For example, if you have reached your maximum yearly payment when you have the service performed or if you no longer have dental coverage, you will not receive the amount that was approved on the pretreatment estimate.

If the State Dental Plan is your secondary insurance, the pretreatment estimate will not reflect the estimated coordinated payment, because BlueCross will not know what your primary insurance will pay.

To determine the allowed amount for a procedure, ask your dentist for the procedure code. Then call BlueCross' Dental Customer Service at 888.214.6230 or 803.264.7323.

Exclusions: dental services not covered

There are some dental benefits that the State Dental Plan and Dental Plus do not offer. The dental plan document lists all exclusions, and is found at StateSC.SouthCarolinaBlues.com under Coverage Information and then Dental Fee Schedule. The list below includes many of the exclusions.

General benefits not offered

- Treatment received from a provider other than a licensed dentist. Cleaning or scaling of teeth by a licensed dental hygienist is covered when performed under the supervision and direction of a dentist.
- Services beyond the scope of the dentist's license.
- Services performed by a dentist who is a member of the covered person's family or for which the covered person was not previously charged or did not pay the dentist.
- Dental services or supplies that are rendered before the date you are eligible for coverage under this plan.
- Charges made directly to a covered person by a dentist for dental supplies (i.e., toothbrush, mechanical toothbrush, mouthwash or dental floss).
- Non-dental services, such as broken appointments and completion of claim forms.
- Nutritional counseling for the control of dental disease, oral hygiene instruction, or training in preventive dental care.
- Services and supplies for which no charge is made or no payment would be required if the person did not have this benefit, including non-billable charges under the person's primary insurance plan.
- Services or supplies not recognized as acceptable dental practices by the American Dental Association.

Benefits covered by another plan

- Treatment for which the covered person is entitled under any workers' compensation law.

- Services or supplies that are covered by the armed services of a government.
- Dental services for treatment of injuries as a result of an accident that are received during the first 12 months from the date of the accident. These services are covered under the member's health plan.
- Additional benefits for Dental services for natural and artificial teeth, dentures, bridges, etc., made necessary by loss of teeth due to cancer treatment or as a result of a congenital birth defect, are available under the member's health plan.

Specific procedures not covered

- Space maintainers for lost deciduous (primary) teeth if the covered person is age 19 or older.
- Investigational or experimental services or supplies.
- Any service or charge for a service not medically necessary.
- Onlays or crowns, when used for preventive or cosmetic purposes or due to erosion, abrasion or attrition.
- Services and supplies for cosmetic or aesthetic purposes, including charges for personalization or characterization of dentures, except for orthodontic treatment as provided for under this plan.
- Myofunctional therapy (i.e., correction of tongue thrusting).
- Appliances or therapy for the correction or treatment of temporomandibular joint (TMJ) syndrome.
- Services to alter vertical dimension or for occlusion purposes or due to erosion, abrasion, or attrition.
- Splinting or periodontal splinting, including extra abutments for bridges.

- Services for tests and laboratory examinations, including but not limited to, bacterial cultures for determining pathological agents, caries (tooth or bone destruction) susceptibility tests, viral cultures, saliva samples, genetic tests, diagnostic photographs, and histopathologic exams.
- Pulp cap, direct or indirect (excluding final restoration).
- Provisional intracoronal and extracoronal (crown) splinting.
- Tooth transplantation or surgical repositioning of teeth.
- Occlusal adjustment (complete). Occlusal guards are covered for certain conditions. The provider should file office records with the claim for review by the dental consultant.
- Temporary procedures, such as temporary fillings or temporary crowns.
- Rebase procedures.
- Stress breakers.
- Precision attachments.
- Procedures that are considered part of a more definitive treatment (i.e., an X-ray taken on the same day as a procedure).
- Inlays (cast metal, composite, resin, porcelain, ceramic). Benefits for inlays are based on the allowance of an alternate amalgam restoration.
- Gingivectomy/gingivoplasty in conjunction with or for the purpose of placement of restorations.
- Topical application of sealants per tooth for patients age 16 and older.
- CT scans, CAT scans, MRIs, or any related services.

Limited benefits

- More than two of these procedures during any plan year: oral examination, consultations (must be provided by a specialist), and prophylaxis (cleaning of the teeth). Four oral examinations will be allowed for patients requiring four cleanings a year because of periodontal disease.
- More than two periodontal prophylaxes. (Periodontal prophylaxes, scaling, or root planing are available only to patients who have a history of periodontal treatment/surgery.) Four cleanings a year (a combination of prophylaxes and periodontal prophylaxes) are allowed for patients with a history of periodontal treatment/surgery.
- Bitewing X-rays more than twice during any plan year or more than one series of full-mouth X-rays or one panoramic film in any 36-month period, unless a special need for these services at more frequent intervals is documented as medically necessary by the dentist and approved by BlueCross.
- More than two topical applications of fluoride or fluoride varnish during any plan year.
- Topical application of sealants for patients age 15 and younger; payment is limited to one treatment every three years and applies to permanent unrestored molars only.
- More than one root canal treatment on the same tooth. Additional treatment (retreatment) should be submitted with the appropriate American Dental Association procedure code and documentation from your dentist.

- More than four quadrants in any 36-month period of gingival curettage, gingivectomy, osseous (bone) surgery or periodontal scaling and root planing.
- Bone replacement grafts performed on the same site more than once in any 36-month period.
- Full mouth debridement for treatment of gingival inflammation if performed more than once per lifetime.
- Tissue conditioning for upper and lower dentures is limited to twice per denture in any 36-month period.
- The application of desensitizing medicaments is limited to two times per quadrant per year, and the sole purpose of the medication used must be for desensitization.
- No more than one composite or amalgam restoration per surface in a 12-month period.
- Replacement of cast restorations (crowns, bridges, implants) or prosthodontics (complete and partial dentures) within five years of the original placement unless evidence is submitted and is satisfactory to the third-party claims administrator that: 1) the existing cast restoration or denture cannot be made serviceable; or 2) the existing denture is an immediate temporary denture and replacement by a permanent denture is required, and that such replacement is delivered or seated within 12 months of the delivery or seat date of the immediate temporary denture.
- Addition of teeth to an existing removable partial or fixed bridge unless evidence is submitted and is satisfactory to the third-party claims processor that the addition of teeth is required for the initial placement

of one or more natural teeth.

Prosthodontic and orthodontic benefits

- Benefits are not payable for prosthodontics (i.e., crowns, crowns seated on implants, bridges, partial or complete dentures) until they are seated or delivered. Other exclusions and limitations for these services include:
- Prosthodontics (including bridges, crowns, and implants) and their fitting that were ordered while the person was covered under the plan, but were delivered or seated more than 90 days after termination of coverage.
- Replacement of lost or stolen prosthodontics, space maintainers, or orthodontic appliances, or charges for spare or duplicate dentures or appliances.
- Replacement of broken or lost orthodontic appliances or occlusal guards.
- Replacement of existing cast prosthodontics unless otherwise specified in the dental plan document.
- Orthodontic treatment for employees, retirees, spouses, or covered children age 19 and older.
- Payment for orthodontic treatment over the lifetime maximum.
- Orthodontic services after the month a covered child becomes ineligible for orthodontic coverage.
- Dental Plus does not provide additional benefits for orthodontic services. The only benefit is the lifetime orthodontics payment of \$1,000 for each covered child age 18 and younger through the State Dental Plan.

Coordination of benefits

If you are covered by more than one dental plan, you may file a claim for reimbursement from both plans. Coordination of benefits enables both plans' administrators to work together to give you the maximum benefit allowed. However, the sum of the combined payments will never be more than the allowed amount for your covered dental procedures. The allowed amount is the amount the State Dental Plan lists for each dental procedure in the Schedule of Dental Procedures and Allowed Amounts, found at StateSC.SouthCarolinaBlues.com under Coverage Information, then Dental Fee Schedule. Dental Plus allowed amounts are higher. When your state dental coverage is secondary, it pays up to the allowed amount of your state dental coverage minus what the primary plan paid.

Certain oral surgical procedures are covered under the State Health Plan and State Dental Plans. The most common of these is the surgical removal of impacted teeth. Benefits are applied under the State Health Plan and then coordinated under the State Dental Plan and under Dental Plus, if the member is covered by that plan. The amount paid under the dental plan(s) may be reduced based on the State Health Plan payment, as explained in the last sentence of the paragraph above.

You will never receive more from your state dental coverage than the maximum yearly benefit, which is \$1,000 for a person covered by the State Dental Plan and \$2,000 for a person covered by both the State Dental Plan and Dental Plus. The maximum lifetime benefit for orthodontic services is \$1,000, and it is limited to covered children age 18 and younger.

For more information about coordination of benefits, including how to determine which plan pays first, see Page 44. If your state dental coverage is secondary, you must send the Explanation of Benefits you receive from your primary plan with your claim to BlueCross.

If you have questions, contact BlueCross toll-free at 888.214.6230 or 803.264.7323, your benefits office or PEBA.

How to file a dental claim

The easiest way to file a claim is to assign benefits to your dentist. Assigning benefits means you authorize your dentist to file your claims and to receive payment from the plan for your treatment. To do this, show a staff member in your dentist's office your dental identification card and ask that the claim be filed for you. Be sure to sign the payment authorizations in blocks 36 and 37 of the claim form. BlueCross BlueShield of South Carolina (BlueCross) will then pay your dentist directly. You are responsible for the difference between the benefit payment and the actual charge, or the Plan allowance if you are enrolled in Dental Plus and seek services from an in-network dentist.

If your dentist will not file your claims, you can file to BlueCross. The claim form is available on PEBA's website at www.peba.sc.gov/iforms.html, or StateSC.SouthCarolinaBlues.com. Complete blocks 4–23 on the claim form, and ask your dentist to complete blocks 1–2, 24–35 and 48–58.

If your dentist will not complete their sections of the form, get an itemized bill showing this information:

- The dentist's name and address and

federal Tax Identification Number or National Provider Identifier (NPI);

- The patient's name;
- The date of each service;
- The name of or procedure code for each service; and
- The charge for each service.

Attach the bill to the completed claim form and mail it to the address on the form:

BlueCross BlueShield of South Carolina
State Dental Claims Department
P.O. Box 100300
Columbia, SC 29202-3300.

X-rays, office records, and other diagnostic aids may be needed to determine the benefit for some dental procedures. Your dentist may be asked to provide this documentation for review by BlueCross' dental consultant. The plan will not pay a fee to your dentist for providing this information. A completed claim form must be received by BlueCross within 90 days after the beginning of care or as soon as reasonably possible. It must be filed no later than 24 months after charges were incurred, except in the absence of legal capacity, or benefits will not be paid.

What if I need help?

You can call BlueCross at 888.214.6230. If you cannot call, you can visit StateSC.SouthCarolinaBlues.com or write BlueCross at the address above.

Appeals

If BlueCross denies all or part of your claim or proposed treatment, you will be informed promptly. If you have questions about the decision, check the information in this chapter

or call for an explanation. If you believe the decision was incorrect, you may ask BlueCross to re-examine its decision. The request for a second review should be made in writing within six months after notice of the decision to BlueCross, Attn: State Dental Appeals, AX-B15, P.O. Box 100300, Columbia, SC 29202.

If you are still dissatisfied after the decision is re-examined, you may ask PEBA to review the matter by making a written request to PEBA within 90 days of notice of BlueCross' denial of your appeal. Please include a copy of the previous two denials with your appeal to PEBA. Send the request to:

Appeals Department
S.C. PEBA
202 Arbor Lake Drive
Columbia, SC 29223

If your appeal relates to a pregnancy, newborn child, or the preauthorization of a life-saving treatment or drug, you may send your request to PEBA by email or fax to urgentappeals@peba.sc.gov.

A healthcare provider or benefits administrator may not appeal to PEBA on your behalf, even if they appealed the decision to the third-party claims processor. Only you, the member, or your authorized representative may initiate an appeal through PEBA. A provider or benefits administrator may not be an authorized representative.

PEBA will make every effort to process your appeal within 180 days of the date it receives your claim file from BlueCross, as outlined in the Plan. However, this time may be extended if additional material is requested or you ask for an extension. PEBA will send you periodic updates on the status of your review. When PEBA's review of your appeal is complete, you

will receive a written determination in the mail.

If the denial is upheld by the PEBA Appeals Committee, you have 30 days to seek judicial review at the Administrative Law Court, as provided by Sections 1-11-710 and 1-23-380 of the S.C. Code of Laws, as amended.



Vision care

The South Carolina Public Employee Benefit Authority (PEBA) offers vision care benefits through the State Vision Plan, a fully-insured product provided through EyeMed Vision Care®.

Online vision benefits information

Register and log in to EyeMed's website, www.eyemedvisioncare.com, for:

- The Locate a Provider feature;
- The View Your Benefits feature, including which family members are covered and when everyone will be eligible for particular services next;
- Access to claims status updates;
- A printable ID card and out-of-network claim form;
- The option of going paperless for your Explanations of Benefits (EOB);
- Ordering contact lenses through ContactsDirect; and
- The Vision Wellness section, where you can learn more about eye exams, eye diseases, and selecting eyewear.

State Vision Plan

The State Vision Plan is available to eligible employees; retirees; survivors; permanent, part-time teachers; COBRA subscribers; and their covered family members. Subscribers pay the premium without an employer contribution. Premiums are listed on Pages 180–186.

The program covers comprehensive eye examinations, frames, lenses and lens options, and contact lens services and materials. It also offers discounts on additional pairs of eyeglasses and conventional contact lenses. A discount of 15 percent on the retail price and

5 percent on a promotional price is offered on LASIK and PRK vision correction through the U.S. Laser Network. Medical treatment of your eyes, such as eye diseases or surgery, is covered by your health plan. Discounts on services may not be available at all participating providers. Before your appointment, please check with your provider to determine whether discounts are offered.

A benefit may not be combined with any discount, promotional offering, or other group benefit plan. The sales tax on any benefit, such as eyeglasses or contact lenses, is not covered by the State Vision Plan.

Eye exams

A comprehensive eye exam not only detects the need for vision correction, but it can also reveal early signs of many medical conditions, including diabetes, high blood pressure, and heart disease. A comprehensive exam is covered as part of your EyeMed benefit once a year with a \$10 copay. To assure you are only charged the \$10 vision exam copay, tell your provider you want only the services the State Vision Plan defines as a comprehensive eye exam.

Some providers may offer an optional retinal imaging exam for up to \$39. It provides high-resolution pictures of the inside of the eye. This is a discount, not a covered benefit.

Frequency of benefits

The State Vision Plan covers:

- A comprehensive eye exam once a year;
- Standard plastic lenses for eyeglasses, or contact lenses instead of eyeglass lenses, once a year;

Continued on Page 108

Vision benefits at a glance^{1,2}

Service	In-network member cost	Out-of-network reimbursement
Comprehensive exam with dilation, as necessary (limited to once per year)	\$10 copay	Reimbursed up to \$35
Retinal imaging (covered for members with Type 1 or Type 2 diabetes only)	\$0 copay	Reimbursed up to \$50
Retinal imaging discount (optional; not a covered benefit)	Up to \$39	N/A

*Plan exclusions and limitations may apply. Please refer to Page 100 for details.

Eyeglasses

Service	In-network member cost	Out-of-network reimbursement
Frames (limited to once every two years; this applies to any frames available at the provider's location)	\$0 copay Member receives \$150 allowance and pays 80% of balance over \$150 (This benefit cannot be used with any promotion)	Reimbursed up to \$75
Standard plastic lenses³ (limited to once per year)		
Single vision	\$10 copay	Reimbursed up to \$25
Bifocal	\$10 copay	Reimbursed up to \$40
Trifocal	\$10 copay	Reimbursed up to \$55
Lenticular	\$10 copay	Reimbursed up to \$55
Standard, premium progressive lenses	See chart on next page	See chart on next page
Lens add-ons		
UV treatment, tint (solid, gradient); standard scratch coating; and standard polycarbonate lens (under age 19 only)	\$0 copay for each option	Reimbursed up to \$5 for each option
Standard polycarbonate lens (adults)	\$30 copay	Reimbursed up to \$5
Standard anti-reflective coating	\$45	N/A
Premium anti-reflective coating	See chart on next page	N/A
Polarized	20% off retail price	N/A
Transition plastic lenses	\$60 copay	Reimbursed up to \$5
Other add-ons	20% off retail price	N/A
Additional savings		
Additional pairs of eyeglasses	40% off complete pairs of prescription eyeglasses after the funded benefit has been used	N/A

¹State Vision Plan exclusions and limitations may apply. Please refer to Page 109 for details.

²The benefits below are only available under the State Vision Plan. Eyeglasses, contact lenses, and examinations for the fitting thereof are excluded under the State Health Plan. Please refer to Page 109 for details.

³Glass eyeglass lenses are not covered under the Plan. As a non-covered item, glass lenses are offered at a 20 percent discount.

Contact lenses⁴

Available in place of eyeglass lens benefit; limited to once per year

Service	In-network member cost	Out-of-network reimbursement
Contact lens fit and follow-up (available after a comprehensive eye exam has been completed)	Standard⁵: \$0 copay, paid in full fit and two follow-up visits Premium⁶: 10% off retail price, then \$55 allowance is applied	Standard⁵: Reimbursed up to \$40 Premium⁶: Reimbursed up to \$40
Conventional	\$0 copay Member receives \$130 allowance and pays 85% of balance over \$130	Reimbursed up to \$104
Disposable	\$0 copay Member receives \$130 allowance and pays balance over \$130	Reimbursed up to \$104
Medically necessary contact lenses	\$0 copay, paid in full	Reimbursed up to \$200
Additional savings		
Additional contact lenses	15% off conventional contact lenses after the funded benefit has been used	N/A

Progressive lens and anti-reflective coating⁷

Service	In-network member cost	Out-of-network reimbursement
Progressive lens		
Standard progressive lenses	\$35	Reimbursed up to \$55
Premium progressives (scheduled)	\$55-80 copay	Reimbursed up to \$55
Other premium progressives (non-scheduled)	\$35 copay, 80% of charge less \$120 allowance	Reimbursed up to \$55
Anti-reflective coating		
Standard anti-reflective coating	\$45	N/A
Premium anti-reflective coatings (scheduled)	\$57-\$68	N/A
Other premium anti-reflective coatings (non-scheduled)	80% of charge	N/A
Add-ons		
Other add-ons and services	20% off retail price	N/A

⁴The contact lens allowance includes materials only. The allowance for disposable contact lenses is \$130, and you do not have to use this allowance all at once. For example, you can use \$50 of the allowance when you purchase your first supply of disposable contacts and the remainder of the allowance later.

⁵A standard contact lens fitting includes clear, soft, spherical, daily wear contact lenses for single-vision prescriptions. It does not include extended/overnight wear lenses.

⁶A premium contact lens fitting is more complex and may include fitting for bifocal/multifocal, cosmetic color, post-surgical, and gas-permeable lenses. It also includes extended/overnight wear lenses.

⁷Products listed as premium progressives and premium anti-reflectives are subject to annual review by EyeMed's medical director and may change based on market conditions. The copay listed applies to particular brand names of lenses. Providers are not required to carry all brands at all levels. Providers can give members names and prices of specific products upon request. A complete list of brands is available at www.eyemedvisioncare.com/theme/pdf/microsite-template/eyemedlenslist.pdf.

Continued from Page 105

- Frames once every two years; and
- Members with Type 1 or Type 2 diabetes are eligible for office service visits and diagnostic testing once every six months to monitor for signs of diabetic changes in the eye.

Using the EyeMed provider network

The EyeMed network includes private practitioners and optical retailers in South Carolina and nationwide. Retailers include LensCrafters®, Sears OpticalSM, Target Optical®, JCPenney® Optical and participating Pearle Vision® locations. When you use a network provider, you are only responsible for copays and any charges that remain after allowances and discounts have been applied to your bill. Also, the network provider will file your claim.

To find a network provider

- Check network providers in or near your ZIP code on the list that comes with your membership card.
- For the most current directory, go to www.eyemedvisioncare.com/locator. Then enter your ZIP code or address and select Insight network from the drop-down list.
- Use the Interactive Voice Response system or speak with a representative at the Customer Care Center at 877.735.9314. To speak with a customer service representative, choose your language (1 is for English) and then say, Provider Locator.
- You may also ask your provider if he accepts EyeMed coverage.

When you make an appointment, let the provider know you are covered by EyeMed. You

are not required to bring your State Vision Plan identification card to your appointment, but it may be helpful to do so.

How to order contact lenses online

You can typically save money by using your State Vision Plan network benefit to order contact lenses through ContactsDirect.com. Click on Insurance in the bar at the top of the home page, register, and follow the instructions. You will need a prescription from your doctor and information about your vision insurance. Your contacts will be mailed to your home at no charge.

Out-of-network benefits

Your benefits are lower when you use a provider outside the network. To learn what you will be reimbursed if you use an out-of-network provider for covered services and supplies, see the charts on Pages 106–107.

To receive out-of-network services:

- Request an out-of-network claim form from EyeMed's Customer Care Center. You may also print one at www.peba.sc.gov/iforms.html under Vision care.
- When you receive services, pay for them and ask your provider for an itemized receipt.
- Send the claim form and a copy of your receipt to: First American Administrators⁸ /EyeMed Vision Care, Attn: OON Claims, P.O. Box 8504, Mason, Ohio 45040-7111. Your reimbursement will be sent to you.

For information about out-of-network services,

⁸First American Administrators (FAA) is a wholly-owned subsidiary of EyeMed Vision Care.

call the EyeMed Customer Care Center at 877.735.9314. You may need to have your State Vision Plan identification card handy.

Exclusions and limitations

Some services and products are not covered by your vision care benefits. They include:

- Orthoptic (problems with the use of eye muscles) or vision training, subnormal vision aids, and any associated supplemental testing;
- Aniseikonic lenses (lenses to correct a condition in which the image of an object in one eye differs from the image of it in the other eye);
- Medical or surgical treatment of the eye, eyes, or supporting structures;
- Any eye or vision examination or corrective eyewear required by an employer as a condition of employment;
- Safety eyewear;
- Services that would be provided by the government under any workers' compensation law or similar legislation, whether federal, state, or local;
- Plano (non-prescription) lenses or contact lenses;
- Non-prescription sunglasses;
- Two pairs of glasses instead of bifocals;
- Services provided by any other group benefit plan offering vision care;
- Services provided after the date the enrollee is no longer covered under the policy, except when vision materials ordered before coverage ended are delivered, and the services are provided to the enrollee within 31 days from the date

the materials were ordered;

- Lost or broken lenses, frames, glasses, or contact lenses will not be replaced until they are next scheduled to be replaced under Frequency of Benefits;
- A benefit may not be combined with any discount, promotional offering, or other group benefit plans.

Contact EyeMed

You can reach EyeMed's Customer Care Center at 877.735.9314 or by logging in on EyeMed's home page and then selecting Contact us under Help and Resources. Be sure to have the following information ready:

- The first and last name of the subscriber;
- The subscriber's Benefits Identification Number or Social Security number;
- The group number for the State Vision Plan: 9925991;
- A fax number or address, if asking for information by fax or mail.

EyeMed has an app that provides the same access as EyeMed's member website. Visit your app store and search for the free EyeMed Members app. It is available for iPhone, iPad, iPod Touch, and Android devices.

Appeals

If a claims question cannot be resolved by EyeMed's Customer Care Center, you may write to the Quality Assurance Team at EyeMed Vision Care, Attn: Quality Assurance Dept., 4000 Luxottica Place, Mason, OH 45040. Information may also be faxed to 513.492.3259. This team will work with you to resolve your issue within 30 days. If you are dissatisfied with the team's decision, you may appeal to an EyeMed appeals

subcommittee, whose members were not involved in the original decision. All appeals are resolved by EyeMed within 30 days of the date the subcommittee receives it.

Since the Vision Care Plan is fully insured, you may not appeal EyeMed determinations to PEBA.

Listed on the following page are some examples of what you might pay for services under the State Vision Plan.

Vision Care Discount Program

For those who choose to not enroll in the State Vision Plan, the Vision Care Discount Program provides another option. It is available with no premiums to pay, and no need to be enrolled in any health plan, including the State Health Plan.

Any individual who is eligible for benefits from PEBA may use the discounts. Those who may take advantage of the program include full-time and part-time employees as well as retirees, survivors, COBRA subscribers, and the family members of any of the above. You may need to show employment-related identification to prove you are eligible.

As part of the discount program, providers have agreed to charge no more than \$60⁹ for a routine, comprehensive eye exam. If you are fitted for contact lenses, you may pay more because it can require additional services. Providers, including opticians, also have agreed to give a 20 percent⁹ discount on all eyewear except for disposable contact lenses.

Not all subscribers who participate in the State Vision Program also participate in the Vision

Care Discount Program. Even so, participating providers are found in South Carolina, Georgia, and North Carolina. Consider asking your provider if he provides discounts through the state's Vision Care Discount Program before your appointment.

A member may not use the discount program and his State Vision Plan benefits, if any, at the same time. However, if the member is enrolled in the vision plan, has used the vision plan for an eye exam, and would like a second eye exam during the same year when it cannot yet be covered by the vision plan, the member can have one for \$60 through the discount program.

No claims to file

With the Vision Care Discount Program, you do not file claims and will not receive reimbursement for vision examinations or eyewear, including contacts. Active employees who have a MoneyPlus Medical Spending Account or a Limited-use Medical Spending Account can file for reimbursement for vision care expenses.

⁹These amounts can change yearly. Contact your benefits office, provider, or PEBA for the current amounts.

Example one

Service	Average retail price ¹⁰	State Vision Plan benefits	In-network cost (member out-of-pocket)
Eye examination	\$109	\$10 copay	\$10
Frames	\$200	\$150 allowance, plus 20% off balance	\$40
Lenses			
Single vision	\$72	\$10 copay	\$10
Polycarbonate (adults)	\$62	\$30 copay	\$30
Premium anti-reflective (Crizal Alize)	\$97	\$68 copay	\$68
Total	\$540		\$158

Example two

Service	Average retail price ¹⁰	State Vision Plan benefits	In-network cost (member out-of-pocket)
Eye examination	\$109	\$10 copay	\$10
Frames	\$150	\$150 allowance, plus 20% off balance	\$0
Lenses			
Premium progressive (Tier 2)	\$230	\$65 copay	\$65
Premium anti-reflective (Crizal Alize)	\$97	\$68 copay	\$68
Total	\$586		\$143

Example three

Service	Average retail price ¹⁰	State Vision Plan benefits	In-network cost (member out-of-pocket)
Eye examination	\$109	\$10 copay	\$10
Contact lens fit and follow-up (standard)	\$71	\$0 copay	\$0
Disposable contact lenses	\$130	\$130 allowance	\$0
Total	\$310		\$10

¹⁰Based on industry averages. Prices and costs will vary by market and provider type. Premiums are not included.



Life insurance

The South Carolina Public Employee Benefit Authority's (PEBA's) life insurance program is underwritten by Minnesota Life, an affiliate of Securian Financial Group, Inc. The contract for the life insurance program consists of the policy, which is issued to PEBA, PEBA's application, and your application. The policy is held by PEBA. The insurance contract may be changed at any time as long as Securian and PEBA agree on the change. No one else has the authority to change the contract. All changes must be in writing, made a part of the policy, and signed by an official of Securian and of PEBA.

Eligibility

Generally, to enroll in the life insurance program, you must be a full-time employee who receives compensation from a department, agency, board, commission, or institution of the state; public school district; county government, including county council members; local subdivision; or another eligible employer that is approved by state law and is participating in the state insurance program. Members of the South Carolina General Assembly, clerical and administrative employees of the General Assembly, and judges in the state courts are also eligible for coverage.

For insurance purposes, an employee is classified as full-time if they work at least 30 hours per week. If you work at least 20 hours per week, you may also be eligible in cases where your covered employer has defined

full-time to mean an employee who works at least 20 hours per week. PEBA must also approve this decision. Eligibility also requires that employees are citizens or legal residents of the United States, its territories and its protectorates, excluding temporary, leased, or seasonal employees.

Actively at Work requirement

To become insured or to receive an increase in the amount of your insurance coverage, you must be fully performing your customary duties for your regularly scheduled number of hours at the employer's normal place of business, or at other places the employer's business requires you to travel. Meeting these requirements defines you as "Actively at Work."

If you are not working due to illness or injury, you do not meet the Actively at Work requirements. If you are receiving sick pay, short-term disability benefits, or long-term disability benefits, you also do not meet the requirements.

If you are not Actively at Work on the date coverage would otherwise begin, or on the date an increase in your amount of insurance would otherwise be effective, you will not be eligible for the coverage or the increase until you return to active work. If the absence is on a non-work day, coverage will not be delayed provided you were Actively at Work on the work day immediately preceding the non-work day. Except as otherwise provided for in the insurance certificate, you are eligible to continue to be insured only while you remain Actively at Work.

Any insurance or increase in insurance coverage put in force while you are not Actively at Work will not be eligible for claims. You will receive a refund of premium for any insurance

you paid for which you were not eligible.

Applications

The *Notice of Election* and *Evidence of Insurability* forms that you complete to be covered by this plan are considered your application for life insurance coverage. Securian may use misstatements or omissions in your application to contest the validity of insurance or to deny a claim. Securian will not use your application to contest insurance that has been in force for two years or more during your lifetime. The two-year period can be extended for fraud or as otherwise allowed by law.

Except for fraud or the non-payment of premiums, after the insured's insurance has been in force during their lifetime for two years from the effective date of their coverage, Securian cannot contest the insured's coverage. However, if there has been an increase in the amount of insurance for which the insured was required to apply or for which Securian required evidence of insurability, then, to the extent of the increase, any loss that occurs within two years of the effective date of the increase will be contestable.

Any statements that the insured makes in their application will, in the absence of fraud, be considered representations (true at the time) and not warranties (true at the time and will remain true in the future). Also, any statement an insured makes will not be used to void their insurance, nor defend against a claim, unless the statement is contained in the application.

Basic Life Insurance

Automatic enrollment into the Basic Life Insurance benefit, including Accidental Death and Dismemberment coverage, is provided to eligible employees enrolled in the State Health

Plan or the TRICARE Supplement plan. There are no specific forms to complete to participate, and you receive this benefit at no cost to you. Basic Life Insurance coverage provides:

- \$3,000 in term life insurance to eligible employees age 69 and younger; and
- \$1,500 to eligible employees age 70 or older.

The accidental death and dismemberment coverage amounts are the same as the Basic Life insurance.

Your coverage begins on the first day of the month you are Actively at Work as a full-time employee. If you become eligible on a day other than the first calendar day or first working day of the month, your coverage starts on the first day of the next month. All effective dates of coverage are subject to the Actively at Work requirement (see Page 113).

Optional Life Insurance

The Optional Life Insurance program, with Accidental Death and Dismemberment coverage, is a voluntary benefit in which you pay the entire premium with no contributions from PEBA, the state of South Carolina, or your employer.

Initial enrollment - active employees

If you are an eligible employee, you can enroll in Optional Life Insurance within 31 days of the date you are hired. You will need to complete the required forms, including a *Notice of Election* form. You can elect coverage, in \$10,000 increments, up to three times your basic annual earnings (rounded down to the nearest \$10,000), or to \$500,000, whichever is less, without providing evidence of insurability.

You can apply for a higher benefit level, in increments of \$10,000, up to a maximum of \$500,000, by providing evidence of insurability.

Your coverage begins on the first day of the month you are Actively at Work as a full-time employee. If you become eligible on a day other than the first calendar day or first working day of the month, your coverage starts on the first day of the next month. If you enroll in an amount of coverage that requires evidence of insurability, your coverage effective date for the amount requiring evidence of insurability will be the first of the month after approval.

All effective dates of coverage are subject to the Actively at Work provision (see Page 113).

Late entry

With the Pretax Group Insurance Premium Feature

If you participate in the MoneyPlus Pretax Group Insurance Premium Feature and do not enroll within 31 days of the date you begin employment, you can enroll only within 31 days of a special eligibility situation (see Pages 21–27) or during an annual open enrollment period held each October. In certain special eligibility situations, you may purchase coverage, in \$10,000 increments, up to a maximum of \$50,000 without providing evidence of insurability. Coverage elected as a result of special eligibility situation will be effective the first of the month after you complete and file a *Notice of Election* form. Otherwise, you will need to complete a *Notice of Election* form and an *Evidence of Insurability* form during an open enrollment period (held each October) and return these to your benefits administrator. If approved, your coverage will be effective on the first day of January after the enrollment period or, if approved after January 1, coverage will be

effective the first of the month after approval. All effective dates of coverage are subject to the Actively at Work provision (see Page 113).

Without the Pretax Group Insurance Premium Feature

If you do not participate in the MoneyPlus Pretax Group Insurance Premium Feature and do not enroll within 31 days of the date you begin employment, you can enroll throughout the year as long as you provide evidence of insurability and it is approved by Securian. To enroll, you will need to complete a *Notice of Election* form and an *Evidence of Insurability* form and return these to your benefits administrator. Your coverage will be effective on the first day of the month coinciding with, or the first of the month following, approval. In certain special eligibility situations, you may purchase coverage, in \$10,000 increments, up to a maximum of \$50,000 without providing evidence of insurability. Coverage will be effective the first of the month after you complete and file the *Notice of Election* form. All effective dates of coverage are subject to the Actively at Work requirement (see Page 113).

Premiums

Optional Life premiums are determined by your age on the preceding December 31 and the amount of insurance you select. You can pay premiums for up to \$50,000 of coverage before taxes through MoneyPlus (see Page 144). Retired employees are not eligible to pay premiums through MoneyPlus. Premiums are listed on Pages 180-186. For sample rate calculations, see Page 185.

What if my age category changes?

If your age category changes, your premium will increase on January 1 of the next calendar year. Your coverage will be reduced at age 70,

75, and 80.

Changing your coverage amount

With Pretax Group Insurance Premium Feature

If you participate in the MoneyPlus Pretax Group Insurance Premium Feature, you can increase, decrease, or drop your coverage only during the yearly open enrollment period in October or within 31 days of a special eligibility situation (see Pages 21-27).

To increase your coverage during open enrollment, you will need to provide evidence of insurability and be approved by Securian. If approved, coverage will be effective on January 1 following the enrollment period. All effective dates of coverage are subject to the Actively at Work requirement (see Page 113). If you are increasing your coverage due to a special eligibility situation, you can increase, in increments of \$10,000 up to \$50,000 (\$500,000 serves as the maximum coverage amount) without providing evidence of insurability. If you are enrolling in Optional Life for the first time due to a special eligibility situation, you may enroll, in \$10,000 increments, up to a maximum of \$50,000 without providing evidence of insurability.

Without the Pretax Group Insurance Premium Feature

If you do not participate in the MoneyPlus Pretax Group Insurance Premium Feature, you can apply to increase your amount of coverage at any time during the year by providing evidence of insurability and being approved by Securian. Your coverage at the new level will be effective on the first day of the month following the date of approval. In certain special eligibility

situations, you may purchase coverage, in \$10,000 increments, up to a maximum of \$50,000 without providing evidence of insurability. Coverage will be effective the first of the month after you complete and file the *Notice of Election* form. All effective dates of coverage are subject to the Actively at Work requirement (see Page 113). You can decrease or cancel your coverage at any time. However, if you want to re-enroll or increase coverage at a later date, you must provide evidence of insurability and be approved.

Dependent Life Insurance

Eligible dependents

If you are eligible for life insurance coverage, you may enroll your eligible dependents in Dependent Life Insurance even if you have not enrolled in the Optional Life program or state health insurance coverage.

Eligible dependents include:

- Lawful spouse:
 - May not be legally separated from you.
 - May not be eligible for coverage as an employee or retiree of a participating employer.
- Children:
 - Includes natural children, legally adopted children, children placed for adoption (from the date of placement with the adopting parents until the legal adoption), stepchildren, or children for whom you have legal guardianship.
 - From live birth to age 19, or a child who is at least 19 years old but younger than age 25 who attends school on a full-time basis (as defined by the institution) as his principal activity and is primarily dependent on you for financial support.

Insurance eligibility changes made by the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, do not apply to the Dependent Life-Child Insurance.

Children of any age are eligible if they are physically or mentally incapable of self-support, are incapable of self-support before age 25, and are financially dependent on you for more than one-half of their support and maintenance.

For more information about covering an incapacitated child, see Pages 15-16.

A person who is eligible as an employee or retiree under the policy, or insured under continuation, is not eligible as a dependent. Only one person can insure an eligible dependent child.

PEBA may conduct an audit of the eligibility of an insured dependent. If the dependent is found to be ineligible, no benefits will be paid.

If both husband and wife work for a participating employer, only one can carry dependent coverage for eligible dependent children, and the spouses cannot cover each other.

To file a claim under Dependent Life-Child for a child age 19 through 24, you will be required to show the child was a full-time student at the time of enrollment and at the time of the claim. You will need a statement on letterhead from the educational institution the child was attending that verifies the child was a full-time student and provides the child's dates of enrollment. The statement should be given to the subscriber's benefits administrator, who will send it to Securian with the *Notice of Death*.

To file a claim for an incapacitated child over the age of 25, the subscriber must give

certification of incapacitation to their benefits administrator, who will send it to Securian with the *Notice of Death*.

Excluded dependents

- Any dependent who is eligible as an employee for life insurance coverage, or who is in full-time military service, will not be considered a dependent.
- A former spouse and former stepchildren cannot be covered under Dependent Life Insurance through PEBA, even with a court order.
- A foster child is not eligible for Dependent Life coverage.

Enrollment

Within 31 days of the date you are hired you can enroll in Dependent Life-Spouse insurance up to \$20,000 without providing evidence of insurability. Enrollment in Optional Life is required to enroll in Dependent Life-Spouse coverage for more than \$20,000. You may not cover an ex-spouse.

Eligible children may be added at initial enrollment and throughout the year without providing evidence of insurability.

To enroll in Dependent Life Insurance, you must complete a *Notice of Election* form and return it to your benefits administrator. Each dependent you wish to cover must be listed on the *Notice of Election* form.

Your dependent's coverage begins on the first day of the month if you are Actively at Work on that day as a full-time employee. If you become eligible on the first working day of the month (the first day that is not a Saturday, Sunday or observed holiday), and it is not the first calendar day, you may choose to have coverage start on the first day of that month or the first

day of the next month. If you become eligible on a day other than the first calendar day or first working day of the month, coverage starts on the first day of the next month.

At any time during the year, you can enroll in or add additional Dependent Life-Spouse coverage by submitting evidence of insurability. The additional coverage is effective the first of the month after approval of evidence of insurability.

All effective dates are subject to the Actively at Work requirement (see Page 113) and the dependent non-confinement provision, found later in this section.

Adding a new spouse

If you wish to add a spouse because you marry, you can add coverage of \$10,000 or \$20,000 for your new spouse without providing evidence of insurability. To do this, complete a *Notice of Election* form within 31 days of the date of your marriage. Coverage becomes effective the first of the month after you complete and file the *Notice of Election* form. You cannot cover your spouse as a dependent if your spouse is or becomes an employee of an employer that participates in the plan.

If you divorce, you must drop your spouse from your coverage. You will need to complete a *Notice of Election* form within 31 days of the date of your divorce. After 31 days, you will forfeit premiums.

Spouse's loss of employment

If your spouse's employment with a participating employer ends, you can enroll your spouse in Dependent Life coverage for up to \$20,000 within 31 days of his termination without providing evidence of insurability. If your spouse loses life insurance through an

employer that does not participate in PEBA insurance, he can enroll throughout the year with evidence of insurability.

Late entry

If you do not enroll within 31 days of the date you begin employment or are married, you can enroll your spouse throughout the year as long as you provide evidence of insurability and it is approved by Securian. To do so, complete a *Notice of Election* form and an *Evidence of Insurability* form. Coverage will be effective on the first day of the month after approval. All effective dates of coverage are subject to the Actively at Work requirement and the dependent non-confinement provision.

Adding children

Eligible children may be added throughout the year without providing evidence of insurability by completing a *Notice of Election* form and returning it to your benefits administrator. Coverage will be effective the first of the month after you complete and file the form.

Your eligible child is automatically covered for 31 days from the child's live birth. To continue your child's coverage, you will need to list each child on your *Notice of Election* form within 31 days of birth; otherwise the child's coverage will terminate at the end of the 31-day period.

You must list each child on your *Notice of Election* form within 31 days of birth, even if you have Dependent Life Insurance coverage when you gain a new child.

All effective dates of coverage are subject to the dependent non-confinement provision.

Dependent non-confinement provision

If a dependent is hospitalized or confined

because of illness or disease on the date their insurance would otherwise become effective, their effective date shall be delayed until they are released from such hospitalization or confinement. This does not apply to a newborn child. However, in no event will insurance on a dependent be effective before your insurance is effective.

Dependent Life-Spouse coverage

If you are enrolled in the Optional Life program with more than \$30,000 of coverage, you may cover your spouse in increments of \$10,000 for up to 50 percent of your Optional Life coverage or \$100,000, whichever is less.

However, if you are not enrolled or you are enrolled with \$10,000, \$20,000, or \$30,000 of Optional Life coverage, you can only enroll your spouse for \$10,000 or \$20,000.

Evidence of insurability is required for all coverage amounts greater than \$20,000 and for coverage not elected when your spouse first became eligible or due to a special eligibility situation.

Premiums for Dependent Life-Spouse coverage are the same as the Optional Life premiums, and are based on your age. Your spouse's coverage will be reduced at ages 70, 75, and 80 based on your age. Premiums are paid entirely by you, with no contribution from your employer, and may be paid through payroll deduction.

Spouses enrolled in Dependent Life coverage are also covered for accidental death and dismemberment benefits. They are eligible for the Seat Belt Benefit, Air Bag Benefit, Child Care benefit and Child Education Benefit (see Pages 121-122).

Dependent Life-Child coverage

The Dependent Life-Child benefit is \$15,000. The monthly premium for Dependent Life-Child coverage is \$1.10 regardless of the number of children you cover. Premiums are paid entirely by you, with no contribution from your employer, and may be paid through payroll deduction.

Premiums

Dependent Life-Spouse coverage and Dependent Life-Child coverage are separate programs for which you pay separate premiums.

Premiums for Dependent Life-Spouse are determined by the subscriber's age. Premiums are listed on Page 181.

The premium for Dependent Life-Child coverage is the same, \$1.10, regardless of the number of children covered.

Sample rate calculations

Employee, age 44, with \$100,000 in coverage

Coverage amount	\$100,000
	<u>/ \$100,000</u>
Coverage units	10
Monthly rate	<u>x \$0.76</u>
Monthly cost	\$7.60

Employee, age 70, with \$100,000 in original coverage election

Original coverage amount	\$100,000
Reduction	<u>x 65%</u>
Reduced coverage amount	\$65,000
	<u>/ \$10,000</u>
Coverage units	6.5
Monthly rate	<u>x \$20.02</u>
Monthly cost	\$130.13

Beneficiaries

A beneficiary is the person or people who will receive insurance payments if you die. You can change your beneficiaries at any time, unless you have given up this right. If you have no eligible beneficiaries named, death benefits will be paid to:

1. You lawful spouse, if living; otherwise:
2. Your natural or legally adopted child or children, in equal shares, if living; otherwise:
3. Your parents, in equal shares, if living; otherwise:
4. Your siblings, in equal shares, if living; otherwise:
5. Your estate.

Changing your beneficiaries

You can change your beneficiaries online through [MyBenefits.sc.gov](https://mybenefits.sc.gov), or by notifying your benefits administrator and completing a Notice of Election form. When processed, the change will be effective on the date the request is signed, and will not apply to any payments or other action taken before the request was processed. Please note that Securian will allow beneficiary changes by power of attorney only if the documents specifically state an attorney-in-fact has the power to change beneficiary designations.

Assignment

You may transfer ownership rights for your insurance to a third party, which is known as assigning your insurance. Securian will not be bound by an assignment of the certificate or of any interest in it unless it is made as a written statement, you file the original instrument or a certified copy with Securian's home office, and

Securian sends you an acknowledged copy.

Securian is not responsible for the validity of any assignment. You will need to ensure that the assignment is legal in your state and that it accomplishes your intended goals. If a claim is based on an assignment, Securian may require proof of interest of the claimant. A valid assignment will take precedence over any claim of a beneficiary.

Accidental Death and Dismemberment benefits

This section does not apply to retirees or dependent children.

Schedule of accidental losses and benefits

In addition to any life insurance benefit, Securian will pay Accidental Death and Dismemberment benefits equal to the amount of Basic and Optional Life insurance for which the employee is insured and an amount equal to the amount of Dependent Life-Spouse insurance for which the spouse is insured, according to the schedule below, if:

1. You suffer accidental bodily injury while your insurance is in force;
2. A loss results directly from such injury, independent of all other causes, and is unintended, unexpected, and unforeseen; and
3. Such a loss occurs within 365 days after the date of the accident causing the injury.

Loss of a hand or foot refers to actual and permanent severance from the body at or above the wrist or ankle joint. Loss of sight, speech, or hearing means entire and irrecoverable loss. Loss of both a thumb and index finger of same hand, means actual and

permanent severance from the body at or above the metacarpophalangeal joints.

The amount of the benefit shall be a percentage of the amount of Basic, Optional, and Dependent Life- Spouse insurance. The percentage is determined by the type of loss, as shown in the following table.

Description of loss	Percent of amount of insurance
Life	100%
Both hands, both feet, or sight of both eyes	100%
One hand and one foot	100%
Speech, and hearing in both ears	100%
Either hand or foot, and sight of one eye	100%
Movement of both upper and lower limbs (quadriplegia)	100%
Movement of both lower limbs (paraplegia)	75%
Movement of both legs and one arm, or both arms and one leg	75%
Movement of the upper and lower limbs of one side of body (hemiplegia)	50%
Either hand or foot	50%
Sight of one eye	50%
Speech, or hearing in both ears	50%
Movement of one limb (uniplegia)	25%
Thumb and index finger of same hand	25%

- Alcohol in combination with any drug, medication, or sedative.
- The voluntary use of prescription drugs, nonprescription drugs, illegal drugs, medications, poisons, gases, fumes, or other substances taken, absorbed, inhaled, ingested, or injected unless it is taken upon the advice of a licensed physician in the verifiable prescribed manner and dosage.
- Motor vehicle collision or accident where you are the operator of the motor vehicle and your blood alcohol level meets or exceeds the level at which intoxication is defined in the state where the collision or accident occurred, regardless of any legal proceedings thereto.
- Infection, other than infection occurring simultaneously with, and as a direct and independent result of, the accidental injury.
- Medical or surgical treatment, diagnostic procedures, or any resulting complications, including complications from medical misadventure.
- War or any act of war, whether declared or undeclared.
- Service in the military of any nation, except the United States National Guard.

What is not covered?

Securian will not pay accidental death and dismemberment benefits under this section for any loss caused or contributed to by:

- Intentionally self-inflicted injury.
- Suicide or attempted suicide.
- Committing or attempting to commit a felony.
- Bodily or mental infirmity, illness, or disease.

Accidental Death and Dismemberment benefits

Seat Belt and Air Bag Benefit (Basic, Optional, and Dependent Spouse Accidental death and dismemberment only)

The Seat Belt Benefit is an additional 25 percent of your accidental death benefit. For example, if your amount of life insurance is \$20,000 and you die in an accident, an additional \$20,000

accidental death benefit will be payable. The Seat Belt Benefit increases this accidental death benefit by 25 percent, or \$5,000. The total accidental death benefit will then be \$25,000, which means the entire death benefit will be \$45,000.

The Air Bag Benefit is an additional 5 percent, or \$5,000, whichever is less, of your accidental death benefit. For example, if your amount of life insurance is \$20,000 and you die in an accident, an additional \$20,000 accidental death benefits will be payable. The Seat Belt Benefit increases the accidental death benefit by \$5,000, and the Air Bag Benefit increases the accidental death benefit by \$1,000 (5 percent of \$20,000 = \$1,000), which means the entire death benefit will be \$46,000.

To be eligible for these benefits, the following must apply:

1. The seat in which the insured was seated was equipped with a properly installed air bag at the time of the accident.
2. The private passenger car is equipped with seat belts.
3. The seat belt was in proper use by the insured at the time of the accident as certified in the official accident report or by the investigating officer.
4. At the time of the accident, the driver of the private passenger car was a licensed driver and was not intoxicated, impaired, or under the influence of alcohol or drugs.

Child Care Benefit (Optional and Dependent Spouse Accidental death and dismemberment only)

A child care benefit will be paid to each dependent who is younger than age 7 (at the time of the insured's death) and who is enrolled in a day care program. The benefit for each

child per year will be the lesser of:

1. Five percent of your amount of Accidental death and dismemberment insurance; or:
2. \$10,000; or:
3. Actual incurred child care expenses.

It will be paid for each dependent who qualifies for no more than two years. If this benefit is in effect on the date that the employee or the spouse dies and there is no dependent child who could qualify for this benefit, Securian will pay \$1,000 to the beneficiary.

Dependent Child Education Benefit (Optional and Dependent Spouse Accidental death and dismemberment only)

An education benefit is paid for each dependent who qualifies as a student. A qualified dependent must be either a post-high school student who attends a school for higher learning on a full-time basis at the time of the insured's death or in the 12th grade and will become a full-time post-high school student in a school for higher learning within 365 days after the insured's death. The benefit is a maximum of \$5,000 per academic year with a maximum overall benefit of five percent of the value of the policy. The benefit will be payable at the beginning of each school year for a maximum of four consecutive years but not beyond the date the child turns age 25.

If this benefit is in effect on the date you die or your spouse dies and you do not have a child who could qualify for it, Securian will pay \$1,000 in one sum to your beneficiary.

Felonious Assault Benefit (Optional Accidental Death and Dismemberment, Employee only)

A felonious assault benefit is paid if you

are injured in a felonious assault and the injury results in a loss for which benefits are payable under the Accidental death and dismemberment benefit. The benefit is the lesser of one times your annual earnings, \$25,000, or your amount of Optional Accidental death and dismemberment insurance.

A felonious assault is a physical assault by another person resulting in bodily harm to you. The assault must involve the use of force or violence with intent to cause harm and must be a felony under the laws of the jurisdiction in which the act was committed.

No benefit is payable if the assault is committed by an immediate family member. Immediate family members include your spouse as well as your and your spouse's children, parents, siblings, grandparents, and grandchildren.

Repatriation Benefit (Basic and Optional Accidental Death and Dismemberment, Employee only)

A Repatriation Benefit will be paid if you die in a way that would be covered under the Accidental death and dismemberment benefit and if the death occurs more than 100 miles from your principal residence.

The Repatriation Benefit will be the lesser of:

- The actual expenses incurred for:
 - Preparation of the body for burial or cremation, and
 - Transportation of the body to the place of burial or cremation;
 or
- The maximum amount for this benefit (\$5,000).

Public Transportation (Common Carrier) Benefit (Basic, Optional Accidental Death and Dismemberment, Employee only)

If you die as a result of a covered accident that occurs while you are a fare-paying passenger on a public transportation vehicle, Securian will pay an additional benefit equal to your full amount of Accidental death and dismemberment insurance.

Public transportation vehicle means any air, land, or water vehicle operated under a license for the transportation of fare-paying passengers.

Value-added services

Travel Assistance Services (active employees, spouse, and eligible children)

Travel Assistance Services is available if you are covered under PEBA's group life insurance. It is available for personal or business travel 100 or more miles from home. Included are help replacing lost or stolen luggage, prescriptions or other critical items; medical or security evacuation; medically necessary repatriation; and repatriation of mortal remains.

For service terms and conditions and pre-trip information, visit www.LifeBenefits.com/travel or call 855.516.5433 in the United States and Canada. Elsewhere, call collect 415.484.4677.

Legal, Financial, and Grief Resources (active employees, spouse, and eligible children)

Legal, Financial, and Grief Resources are available to all active employees, their spouse, and dependent children covered under Basic

or Optional Life insurance offered through PEBA. It includes guidance and consultation with professionals over the telephone, comprehensive web and mobile resources, and a 30-minute face-to-face consultation with an attorney for each unique legal issue.

Go to [LifeWorks.com](https://www.lifeworks.com) and sign in with the user name lfg and the password resources. For more information, call 877.849.6034.

Legacy Planning Resources (active employees, retirees, and eligible children)

Legacy Planning Resources are available to active employees, retirees, and their families covered under PEBA's group life insurance. It provides information related to end-of-life planning that can be useful in preparing for one's own death or in dealing with the loss of a loved one. These resources are available at [LegacyPlanningResources.com](https://www.LegacyPlanningResources.com).

Beneficiary Financial Counseling (beneficiaries who receive \$25,000 or more)

Optional Beneficiary Financial Counseling is available to beneficiaries of group life insurance who will receive proceeds of \$25,000 or more. Services are provided by PricewaterhouseCoopers LLP and are designed to provide independent, objective financial counseling at a time when it is needed most.

Services provided by Ceridian HCM, Inc., RedpointWTP LLC, PricewaterhouseCoopers LLP are their sole responsibility. The services are not affiliated with Securian or its group contracts and may be discontinued at any time. Certain terms, conditions, and restrictions may apply when utilizing the services. To learn more, visit the appropriate website.

Claims

To pay benefits, Securian must be given a written proof of loss. This means a claim must be filed as described below.

Your accelerated benefit

If you or your covered dependent is diagnosed by a physician as having a terminal illness, you may request that Securian pay up to 100 percent of your life insurance prior to your death. Any remaining benefits will be paid to your beneficiary upon your death. A terminal illness means that you have a life expectancy of 12 months or less.

To file a claim, notify your employer. Then you, your employer, and the attending physician will each complete a section of Securian's *Notice of Claim for Accelerated Benefit* form.

How to file a claim

When you or your dependent dies, your employer should be notified. This should be done as soon as reasonably possible. The benefits administrator will complete and submit Securian's *Notice of Death* form. Securian will send the beneficiary a beneficiary statement and a condolence letter, which requests an original certified death certificate.

When Securian receives acceptable proof of your covered dependent's death, Securian will pay the life insurance benefit to you. If you are no longer living, it will be paid to your estate.

When a retiree dies, the beneficiary, or the employer on his behalf, should notify Securian of the death by calling 888.658.0193.

Suicide provision

No Optional Life or Dependent Life-Spouse

benefit will be payable if death results from suicide, whether the covered person is sane or insane, within two years of the effective date. If suicide occurs within two years of a coverage increase, the death benefit payable is limited to the amount of coverage in force prior to the increase.

How Accidental Death and Dismemberment claims are paid

In the case of accidental death, your employer should be notified. The benefits administrator will complete and submit Securian's *Notice of Death* form. Securian will pay the accidental death benefit to your beneficiaries.

If you sustained other losses covered under Accidental Death and Dismemberment, you, your employer and your physician must complete the *Notice of Accidental Dismemberment and Loss of Sight Claim* form and submit it to Securian. The benefit for other losses you sustained will be paid to you, if you are living. Otherwise, it will be paid to your estate.

A dependent's Accidental Death and Dismemberment benefit will be paid to you, if you are living. Otherwise, it will be paid to your estate.

Examinations and autopsies

Securian retains the right to have you medically examined at its expense when and so often as it may reasonably require whenever a claim is pending and, where not forbidden by law, Securian reserves the right to have an autopsy performed in case of death.

When your coverage ends

Termination of coverage

Your insurance will end at midnight on the earliest of:

- The last day of the month you terminate your employment.
- The last day of the month you go on unapproved leave of absence.
- The last day of the month you enter a class of employees not eligible for coverage (for example, a change from full-time to part-time status).
- The date PEBA's policy ends.
- The last day of the month you do not pay the required premium for that month.

Retiree coverage will end January 1 after:

- You reach age 70, if you continued coverage and retired before January 1, 1999.
- You reach age 75, if you continued coverage and retired January 1, 1999, and later.

Claims incurred before the date insurance ends will not be affected by coverage termination.

Termination of Dependent Life Insurance coverage

Your dependent's coverage will terminate at midnight on the earliest of:

- The day PEBA's policy ends.
- The day you, the employee, die.
- The last day of the month in which the dependent no longer meets the definition of a dependent.
- The day any premiums for Dependent Life

Insurance coverage are due and unpaid for a period of 31 days.

Claims incurred before the date insurance ends will not be affected by coverage termination.

Extension of benefits

An extension of benefits is provided according to the requirements below. Securian is not required by contract to provide these benefits unless you meet these requirements.

Leave of absence

If you are on an employer-approved leave of absence and you remain eligible for active benefits, you can continue your Optional Life Insurance for up to 12 months from the first of the month after the last day worked, as long as you pay the required premiums. Securian may require written proof of your leave of absence approval before any claims are paid.

Military leave of absence

If you enter active military service and are granted a military leave of absence in writing, your coverage (including Dependent Life coverage) may be continued for up to 12 months from the first of the month after the last day worked, as long as you pay the required premiums. If the leave ends before the agreed-upon date, this continuation will end immediately. If you return from active military duty after being discharged and you qualify to return to work under applicable federal or state law, you may be eligible for the coverage you had before the leave of absence began, provided you are rehired by the same employer and request reinstatement within 31 days of returning to work.

Disability

If you become disabled, your life insurance can be continued for up to 12 months from your last day worked as long as you remain eligible for active benefits and:

- You continue to pay the premiums; and
- The Optional Life insurance policy does not end.

When you lose eligibility for active benefits:

- If you are eligible for retiree insurance, you can convert your coverage to an individual whole life policy or continue your Optional Life insurance until age 75. Securian must receive the form requesting conversion or continuation within 31 days of termination of your active employee coverage.
- If you are not eligible for retiree insurance, you can convert your coverage to an individual whole life policy. Securian must receive the form requesting conversion within 31 days of termination of your active employee coverage.
- If you are later approved for disability retirement benefits, and therefore are eligible for retiree insurance, you may enroll in up to the same amount of Optional Life coverage you had when your eligibility for active benefits ended. To do so, contact Securian within 31 days of your disability retirement approval date. Coverage would begin the first of the month after your approval for disability retirement.

For more information about retiree insurance eligibility, see Pages 162-164.

Continuing or converting your life insurance

The PEBA Coverage Verification Notice of Group

Life Insurance form must be completed and accompany your request for continuation or conversion. The form is available from your benefits administrator.

Please note that Accidental Death and Dismemberment coverage may not be continued or converted.

Continuation

If you are eligible for retiree insurance, you may be able to continue your insurance coverage and pay premiums directly to Securian. To continue your coverage, complete the *Retiree Life Continuation Election* form, which is available at www.peba.sc.gov/iforms.html or from your benefits administrator. Coverage must be elected within 31 days of the date of coverage is lost due to approved retirement or approved disability retirement.

If you have questions about your options for continuing your insurance coverage or would like to request continuation forms, please contact Securian at 866.365.2374. A complete application must be received within 31 days of your benefit termination.

Conversion

If your Basic, Optional, or Dependent Life insurance ends because your employment or eligibility for coverage ends, you may apply to convert your coverage to an individual whole life insurance policy, a permanent form of life insurance, without providing evidence of insurability. To apply, contact Securian at 866.486.5298. Securian will review the conversion option with you and will provide a *Conversion of Group Life Insurance Enrollment* form. Complete the form and mail it with your coverage application and first premium payment to Securian.

When applying for coverage, remember these rules:

1. You may not apply for more than the amount of life insurance you had under your terminated group life insurance.
2. Your new premium for the conversion policy will be set at Securian's standard rate for the amount of coverage that you wish to convert and your age.

The forms must be received by Securian within 31 days of the date your insurance coverage ends.

Group policy is terminated

If your group life insurance ends because of termination by the state of the policy or termination as a class, you may be eligible for a conversion policy. For more information, see the Securian certificate under the Conversion Right section.

Death benefit during conversion period

If you die within 31 days of the date your group insurance was terminated and meet the conversion eligibility requirements, Securian will pay a death benefit regardless of whether or not an application for coverage under an individual policy has been submitted. The death benefit will be the amount of insurance you would have been eligible to convert under the terms of the Conversion Right section.



Long term disability

Basic Long Term Disability

The Basic Long Term Disability (BLTD) Plan, administered by Standard Insurance Company (The Standard), is an employer-funded disability plan provided by the state. It helps protect a portion of your income if you become disabled as defined by the Plan. This benefit is provided at no cost to you.

If you have questions or need more information, please contact The Standard at 800.628.9696 or at www.standard.com/mybenefits/southcarolina.

BLTD plan benefits overview

- Benefit waiting period: 90 days.
- Monthly BLTD benefit¹ percentage: 62.5 percent of your predisability earnings, reduced by deductible income.
- Maximum benefit: \$800 per month.
- Maximum benefit period: To age 65 if you become disabled before age 62. If you become disabled at age 62 or older, the maximum benefit period is based on your age at the time of disability. The maximum benefit period for age 69 and older is one year.

Eligibility

You are eligible for BLTD if you are covered under the State Health Plan or the TRICARE Supplement Plan and are an active, full-time employee as defined by the Plan or a full-time academic employee and you are employed by: a department, agency, board, commission, or

¹BLTD benefits are subject to federal and state income taxes. Check with your accountant or tax advisor regarding your tax liability.

institution of the state;
a public school district; a county government (including county council members); or another group participating in the state's insurance program. Members of the General Assembly and judges in the state courts are also eligible for coverage.

If you become disabled, you may be eligible for additional benefits through PEBA that are separate from the benefits described here. Call 803.737.6800 or visit www.peba.sc.gov/retirement.html for more information.

To receive benefits, you must be actively employed when your disability occurs.

Benefit waiting period

The benefit waiting period is the length of time you must be disabled before benefits are payable. The BLTD plan has a 90-day benefit waiting period, and benefits are not paid during this period.

Certificate

The BLTD certificate is available on the Long term disability page online at www.peba.sc.gov/longtermdisability.html. The BLTD certificate is a contract containing the controlling provisions of this insurance plan. Neither the certificate nor any other material, including this publication, can modify the provisions.

When are you considered disabled?

You are considered disabled and eligible for benefits if you cannot fulfill the requirements

of your occupation due to a covered injury, physical disease, mental disorder, or pregnancy. You also will need to satisfy the benefit waiting period and meet the applicable definitions of disability below during the period to which they apply.

Own occupation disability

You are unable to perform, with reasonable continuity, the material duties of your own occupation during the benefit waiting period and the first 24 months of disability.

“Own occupation” means any employment, business, trade, profession, calling, or vocation that involves material duties² of the same general character as your regular and ordinary employment with the employer. Your own occupation is not limited to your job with your employer, nor is it limited to when your job is available.

Any occupation disability

You are unable to perform, with reasonable continuity, the material duties² of any occupation.

“Any occupation” means any occupation or employment you are able to perform, due to education, training, or experience, which is available at one or more locations in the national economy and in which you can be expected to earn at least 65 percent of your predisability earnings (adjusted for inflation) within 12 months following your return to work, regardless of whether you are working in that or any other occupation. The any occupation period begins at the end of the own occupation period and continues to the end of the

²“Material duties” means the essential tasks, functions, and operations, and the skills, abilities, knowledge, training, and experience generally required by employers from employees engaged in a particular occupation.

maximum benefit period.

Partial disability

You are considered to be partially disabled if during the benefit waiting period and the own occupation period you are working while disabled, but you are unable to earn more than 80 percent of your pre-disability earnings, adjusted for inflation, while working in your own occupation.

You are considered to be partially disabled if during the any occupation period you are working while disabled but you are unable to earn more than 65 percent of your pre-disability earnings, adjusted for inflation, while working in any occupation.

Pre-existing conditions

“Pre-existing condition” means any injury, illness, or symptom (including secondary conditions and complications) that was medically documented as existing, or for which medical treatment, medical service, prescriptions, or other medical expense was incurred at any time during the pre-existing condition period shown in the Coverage Features.

Benefits will not be paid for a disability caused or contributed to by a pre-existing condition unless on the date you become disabled:

- You have been continuously covered under the plan for at least 12 months (this is the exclusion period); or
- Your date of disability falls within 12 months after your BLTD coverage became effective, and you can demonstrate you have not consulted a physician, received medical treatment or services, or taken prescribed drugs during the six-month period preceding your coverage effective

date (this is the treatment-free period).

Claims

Once it appears you will be disabled for 90 days or more, or your employer is modifying your duties due to a health condition, talk to your benefits administrator and download a claim form packet at www.peba.sc.gov/iforms.html under Long term disability. The packet contains:

- *Employee's Statement;*
- *Authorization to Obtain and Release Information;*
- *Authorization to Obtain Psychotherapy Notes;*
- *Attending Physician's Statement;* and
- *Employer's Statement.*

You are responsible for ensuring that these forms are completed and returned to The Standard. You may fax the forms to 800.437.0961 or you can mail them to the address on the claim form. If you have questions, contact The Standard at 800.628.9696.

Provide the completed claim forms to The Standard within 90 days of the end of your benefit waiting period. If you cannot meet this deadline, you must submit these forms as soon as reasonably possible, but no later than one year after the 90-day waiting period. If you do not provide these forms within this time, barring a court's determination of legal incapacity, The Standard may deny your claim.

Active work requirement

If physical disease, mental disorder, injury, or pregnancy prevent you from working the day before the scheduled effective date of your coverage, your coverage will not become effective until the day after you are actively at work for one full day.

Predisability earnings

Predisability earnings are the monthly earnings, including merit and longevity increases, from your covered employer as of the January 1 preceding your last full day of active work, or on the date you became a member if you were not a member on January 1. It does not include your bonuses, commissions, overtime, or incentive pay. If you are a teacher, it does not include your compensation for summer school, but it does include compensation earned during regular summer sessions by university staff.

Deductible income

Your BLTD benefits will be reduced by your deductible income – income you receive or are eligible to receive – from other sources. Deductible income includes:

- Sick pay or other salary continuation (including sick-leave pool);
- Primary Social Security benefits;
- Workers' compensation;
- Other group disability benefits (except Supplemental Long Term Disability benefits described on Page 144);
- Maximum plan retirement benefits; and
- Other income sources.

In addition, Teacher and Employee Retention Incentive (TERI) program funds, at the time they are deferred into your TERI account, are deductible income back to the time you began receiving disability benefits.

Please note that vacation pay is excluded from deductible income.

BLTD insurance serves as income replacement insurance. For example, with the BLTD plan, the Standard will pay you up to 62.5 percent of your

predisability earnings with a maximum of \$800 if you are approved for disability. This means if your predisability earnings are \$1,280 and you do not have any deductible income, your benefit will be \$800, or 62.5 percent of \$1,280. In the same example, if you do have deductible income, your \$800 benefit will be reduced by the amount of your deductible income. The BLTD Plan has no minimum benefit, so if you have enough deductible income your benefit will be reduced to \$0.

In another example, assume that 62.5 percent of your predisability earnings is \$1,200. The Standard will pay the \$800 maximum benefit and your BLTD benefit will be reduced when your deductible income exceeds \$400. In other words, your benefit will be reduced when the maximum benefit of \$800 added together with your deductible income totals an amount that exceeds 62.5 percent of your predisability earnings. In this example, no benefits would be payable if your deductible income exceeded \$1,200.

You must meet deadlines for applying for all deductible income you are eligible to receive. PEBA has different requirements for disability retirement. Please contact PEBA at 803.737.6800 or 888.260.9430 for more information.

When other benefits are awarded, they may include payments due to you while you were receiving BLTD benefits. If the award includes past benefits, or if you receive other income before notifying The Standard, your BLTD claim may be overpaid. This is because you received benefits from the plan and income from another source for the same period of time. You will need to repay the plan for this overpayment.

When BLTD coverage ends

Your BLTD coverage ends automatically on the earliest of:

- The date the plan ends;
- The date you no longer meet the requirements noted in the Eligibility section of this chapter;
- The date your health coverage as an active employee ends; or
- The date your employment ends.

When benefits end

Your benefits will end automatically on the earliest of these dates:

- The date you are no longer disabled under the terms of the BLTD plan;
- The date your maximum benefit period ends (refer to Exclusions and limitations on this page and the next);
- The date benefits become payable under any other group long term disability insurance policy under which you became insured during a period of temporary recovery; or
- The date of your death.

If you are an employee of a local subdivision, your employer becomes responsible for your BLTD benefit payments if your employer stops participating in the state insurance program.

Exclusions and limitations

- Disabilities resulting from war or any act of war are not covered.
- Intentional self-inflicted injuries are not covered.
- Benefits are not payable when you are not under the ongoing care of a physician in the appropriate specialty.

- Benefits are not payable for any period when you are not participating, in good faith, in a course of medical treatment, vocational training, or education approved by The Standard, unless your disability prevents you from participating.
- Benefits are not payable for any period of disability when you are confined for any reason in a penal or correctional institution.
- Benefits are not payable after you have been disabled under the terms of the BLTD plan for 24 months during your entire lifetime, excluding the benefit waiting period, for a disability caused or contributed to by:
 - A mental disorder, unless you are continuously confined to a hospital solely because of a mental disorder at the end of the 24 months.
 - Your use of alcohol, alcoholism, use of any illicit drug, including hallucinogens or drug addiction.
 - Chronic pain, musculoskeletal, or connective tissue conditions.
 - Chronic fatigue or related conditions.
- Chemical and environmental sensitivities.
- During the first 24 months of disability, after the 90-day benefit waiting period, BLTD benefits will not be paid for any period of disability when you are able to work in your own occupation and you are able to earn at least 20 percent of your predisability earnings, adjusted for inflation, but you choose not to work.
- While living outside the United States or Canada, payment of benefits is limited to 12 months for each period of continuous disability.

Appeals

If The Standard denies your claim for basic long term disability benefits, you can appeal the decision to The Standard by sending written notice within 180 days of receiving the denial letter. Send the appeal to:

Standard Insurance Company
P.O. Box 2800
Portland, OR 97208

If The Standard upholds its decision after a review by its Administrative Review Unit, you may appeal that decision by writing to PEBA within 90 days of the Administrative Review Unit's denial. Please include a copy of the previous two denials with your appeal to PEBA. Send the request to:

Appeals Department
S.C. PEBA
202 Arbor Lake Drive
Columbia, SC 29223

A healthcare provider or benefits administrator may not appeal to PEBA on your behalf, even if they appealed the decision to the third-party claims processor. Only you, the member, or your authorized representative may initiate an appeal through PEBA. A provider or benefits administrator may not be an authorized representative.

PEBA will make every effort to process your BLTD appeal within 180 days of the date it receives your claim file from The Standard, as outlined in the Plan. However, this time may be extended if additional material is requested or you ask for an extension. PEBA will send you periodic updates on the status of your review. When PEBA's review of your appeal is complete, you will receive a written determination in the mail.

If the denial is upheld by the PEBA Appeals Committee, you have 30 days to seek judicial review at the Administrative Law Court, as provided by Sections 1-11-710 and 1-23-380 of the S.C. Code of Laws, as amended.

Supplemental Long Term Disability

Supplemental Long Term Disability Insurance (SLTD), fully-insured by Standard Insurance Company (The Standard), is designed to provide additional financial assistance beyond the Basic Long Term Disability plan if you become disabled. Your benefit will be based on a percentage of your predisability earnings. This program is customized for you. The SLTD plan benefits summary on the next page provides more information about your plan, including:

- Your level of coverage;
- How long benefits payments would continue if you remain disabled;
- The maximum benefit amount;
- Your choice of benefit waiting periods; and
- Your premium schedule.

What SLTD insurance provides

- Competitive group rates;
- Survivors benefits for eligible dependents;
- Coverage for injury, physical disease, mental disorder, or pregnancy;
- A return-to-work incentive;
- SLTD conversion insurance;
- A cost-of-living adjustment; and
- Lifetime security benefit.

Eligibility

You are eligible for SLTD insurance if you are:

- An active, full-time employee as defined by

the plan;

- A full-time academic employee, and you receive compensation from:
 - A department, agency, board, commission, or institution of the state;
 - A public school district;
 - A county government, including county council members;
 - Another group participating in the state's insurance program;
- A member of the General Assembly, or a judge in the state courts.

You are not eligible for this coverage if you are an employee of an employer that is covered under any other group long term disability plan that insures any portion of your predisability earnings (other than the BLTD Plan); if you are receiving retirement benefits from PEBA and you have waived active employee coverage; if you are a temporary or seasonal employee; a part-time teacher; or if you are a full-time member of the armed forces of any country.

Enrollment

You can enroll in the SLTD program within 31 days of eligibility. You may choose from one of two benefit waiting periods described below. If you fail to enroll within 31 days of your hire date, you must complete a medical history statement. The Standard may require you to undergo a physical examination and blood test. You also may be required to provide any additional information about your insurability that The Standard may reasonably require, at your own expense. Throughout the year, you may enroll with medical evidence of good health.

Continued on Page 136

SLTD plan benefits summary	
Benefit waiting period	Plan one: 90 days Plan two: 180 days
Maximum SLTD-covered predisability earnings	\$12,307 per month
Monthly benefit ³ percentages	65 percent of the first \$12,307 of your monthly predisability earnings, reduced by deductible income
Minimum benefit	\$100 per month
Maximum benefit	\$8,000 per month
Cost-of-living adjustment	After 12 consecutive months of receiving SLTD benefits, effective on April 1 of each year thereafter; based on the prior year's Consumer Price Index up to 4 percent. This cost-of-living adjustment does not apply when you are receiving the minimum monthly benefit or a monthly benefit of \$25,000 as a result of these adjustments.
Maximum benefit period	To age 65; if you become disabled before age 62 If you become disabled at age 62 or older, the maximum benefit period is based on your age at the time of disability. The maximum benefit period for age 69 and older is one year. In certain circumstances, benefits may continue after the maximum benefit period. See Lifetime security benefit on Page 138 for more information.
Monthly premium ⁴ rate	Multiply the premium factor for your age and plan selection by your monthly earnings.

Age on preceding January 1	90-day waiting period	180-day waiting period
Under 31	.00056	.00045
31-40	.00078	.00060
41-50	.00154	.00117
51-60	.00311	.00239
61-65	.00374	.00287
66 and older	.00457	.00351

Example one

John is 52 years old, earns \$2,250 per month and selected plan one. John's monthly premium is $\$2,250 \times .00311$, or \$7.00 per month. (The premium was rounded up because it was an uneven amount.)

Example two

Mary is 38 years old, earns \$3,000 per month and selected plan two. Mary's monthly premium is $\$3,000 \times .00060$, or \$1.80 per month.

³These benefits are not taxable provided you pay the premium on an after-tax basis.

⁴Premium must be an even amount (amount is rounded up to next even number).

Benefit waiting period

The benefit waiting period is the length of time you must be disabled before benefits are payable. You may choose a 90-day or a 180-day benefit waiting period, and you may change from a 90-day to a 180-day benefit waiting period at any time by completing a Notice of Election form and returning it to your benefits administrator.

To change from a 180-day to a 90-day benefit waiting period, you must complete a *Notice of Election* form and provide medical evidence of good health, which The Standard will consider in determining whether to approve your application.

Certificate

The SLTD certificate is available on the Long term disability webpage at www.peba.sc.gov/longtermdisability.html. The contract contains the controlling provisions of this insurance plan. Neither the certificate nor any other material, including this publication, can modify those provisions.

When are you considered disabled?

You are considered disabled and eligible for benefits if you cannot work due to a covered injury, physical disease, mental disorder, or pregnancy. You will also need to satisfy your appropriate benefit waiting period and meet the following definitions of disability during the period to which they apply.

Own occupation disability

You are unable to perform, with reasonable continuity, the material duties of your own occupation during the benefit waiting period

and the first 24 months SLTD benefits are payable⁵.

“Own occupation” means any employment, business, trade, profession, calling, or vocation that involves material duties⁵ of the same general character as your regular and ordinary employment with the employer. Your own occupation is not limited to your job with your employer, nor is it limited to when your job is available.

Any occupation disability

You are unable to perform, with reasonable continuity, the material duties⁵ of any occupation.

“Any occupation” means any occupation or employment you are able to perform, due to education, training or experience, that is available at one or more locations in the national economy and in which you can be expected to earn at least 65 percent of your pre-disability earnings (adjusted for inflation) within 12 months following your return to work, regardless of whether you are working in that or any other occupation. The any occupation period begins at the end of the own occupation period and continues to the end of the maximum benefit period.

Partial disability

You are considered to be partially disabled if during the benefit waiting period and the own occupation period, you are working while disabled but you are unable to earn more than 80 percent of your pre-disability earnings, adjusted for inflation, while working in your own occupation.

⁵Material duties means the essential tasks, functions, and operations, and the skills, abilities, knowledge, training, and experience generally required by employers from those engaged in a particular occupation.

You are considered to be partially disabled if during the any occupation period, you are working while disabled but you are unable to earn more than 65 percent of your pre-disability earnings, adjusted for inflation, while working in any occupation.

Pre-existing conditions

Pre-existing condition means any injury, illness, or symptom (including secondary conditions and complications) that was medically documented as existing, or for which medical treatment, medical service, prescriptions, or other medical expense was incurred, at any time during the pre-existing condition period shown in the Coverage Features.

No benefits will be paid for a disability caused or contributed to by a pre-existing condition unless on the date you become disabled:

- You have been continuously covered under the plan for at least 12 months (this is the exclusion period); or
- Your date of disability falls within 12 months after your SLTD coverage became effective and you can demonstrate you have not consulted a physician, received medical treatment or services, or taken prescribed drugs during the six-month period preceding your coverage effective date (this is the treatment-free period).

The pre-existing condition exclusion also applies when you change from the plan with the 180-day benefit waiting period to the plan with the 90-day benefit waiting period. The pre-existing condition period, treatment free period, and exclusion period for the new plan will be based on the effective date of your coverage under the 90-day plan. However, if benefits do not become payable under the 90-day plan because of the pre-existing condition

exclusion, your claim will be processed under the 180-day plan as if you had not changed plans.

Claims

Once it appears you will be disabled for 90 days or more, talk to your benefits administrator or download a claim form packet at www.peba.sc.gov/iforms.html. The packet contains:

- *Employee's Statement;*
- *Authorization to Obtain and Release Information;*
- *Authorization to Obtain Psychotherapy Notes;*
- *Attending Physician's Statement;* and
- *Employer's Statement.*

You are responsible for ensuring that these forms are completed and returned to The Standard. You may fax the forms to 800.437.0961 or you can mail them to the address on the claim form. If you have questions, contact The Standard at 800.628.9696.

Provide the completed claim forms to The Standard within 90 days of the end of your benefit waiting period. If you cannot meet this deadline, you must submit these forms as soon as reasonably possible, but no later than one year after the 90-day waiting period. If you do not provide these forms within this time, barring a court's determination of legal incapacity, The Standard may deny your claim.

Active work requirement

If physical disease, mental disorder, injury, or pregnancy prevents you from working the day before the scheduled effective date of your insurance coverage, your coverage will not become effective until the day after you are

actively at work for one full day.

Salary change

Your SLTD premium is recalculated based on your age as of the preceding January 1. Any change in your predisability earnings after you become disabled will have no effect on the amount of your SLTD benefit.

Predisability earnings

Predisability earnings are the monthly earnings, including merit and longevity increases, from your covered employer as of the January 1 before your last full day of active work, or on the date you became a member if you were not a member on January 1. It does not include your bonuses, commissions, overtime pay, or incentive pay. If you are a teacher, it does not include your compensation for summer school, but it does include compensation earned during regular summer sessions by university staff.

Deductible income

Your SLTD benefits will be reduced by your deductible income – income you receive or are eligible to receive – from other sources. Deductible income includes:

- Sick pay or other salary continuation (including sick-leave pool);
- Primary and dependent Social Security benefits;
- Workers' compensation;
- BLTD benefits;
- Other group disability benefits;
- Maximum plan retirement benefit; and
- Other income sources.

In addition, TERI funds, at the time they are deferred into your TERI account, are deductible

income back to the time you began receiving disability benefits.

For example, your SLTD benefit before being reduced by deductible income is 65 percent of your covered predisability salary. The benefit will then be reduced by the amount of any deductible income you receive or are eligible to receive. The total of the reduced SLTD benefit plus the deductible income will provide at least 65 percent of your covered predisability salary. The guaranteed minimum SLTD benefit is \$100, regardless of the amount of deductible income.

You are required to meet deadlines for applying for all deductible income you are eligible to receive. PEBA has different requirements for disability retirement. Please contact PEBA at 803.737.6800 or 888.260.9430 for more information.

When other benefits are awarded, they may include payments due to you while you were receiving SLTD benefits. If the award includes past benefits, or if you receive other income before notifying The Standard, your SLTD claim may be overpaid. This is because you received benefits from your plan and income from another source for the same period of time. You will need to repay the plan for this overpayment.

Lifetime security benefit

SLTD coverage provides lifetime long term disability benefits if, on the last day of the regular maximum benefit period, you are unable to perform two or more activities of daily living or suffer from a severe cognitive impairment that is expected to last 90 days or more, as certified by a physician in the appropriate specialty as determined by The Standard. The lifetime benefit will be equal to the benefit that was being paid on the last day

of the regular long term disability period.

Death benefits

If you die while SLTD benefits are payable, The Standard will pay a lump-sum benefit to your eligible survivor. This benefit will be equal to three months of your SLTD benefit, not reduced by deductible income. Eligible survivors include:

- Your surviving spouse;
- Surviving, unmarried children younger than age 25; and
- Any person providing care and support for any eligible children.

This benefit is not available to any eligible survivors if your SLTD benefits and claim have reached the maximum benefit period before your death. Also, this benefit is not available if you have been approved for or you are receiving the lifetime security benefit.

When SLTD coverage ends

Your SLTD coverage ends automatically on the earliest of:

- The last day of the month for which you paid a premium;
- The date the group policy ends; or
- The date you no longer meet the requirements noted in the Eligibility section of this chapter.

When benefits end

Your benefits will end automatically on the earliest of these dates:

- The date you are no longer disabled;
- The date your maximum benefit period ends, unless SLTD benefits are continued by the lifetime security benefit;
- The date benefits become payable under

any other group long term disability insurance policy for which you become insured during a period of temporary recovery; or

- The date of your death.

Conversion

When your SLTD insurance ends, you may buy SLTD conversion insurance if you meet all of these criteria:

- Your insurance ends for a reason other than:
 - Termination or amendment of the group policy;
 - Your failure to pay a required premium; or
 - Your retirement.
- You were insured under your employer's long term disability insurance plan for at least one year as of the date your insurance ended.
- You are not disabled on the date your insurance ends.
- You are a citizen or resident of the United States or Canada.
- You apply in writing and pay the first premium for SLTD conversion insurance within 31 days after your insurance ends.
- If you have questions about converting your SLTD policy, call The Standard at 800.378.4668. You will need to reference the state of South Carolina's group number, 621144.

Exclusions and limitations

- Disabilities resulting from war or any act of war are not covered.
- Intentional self-inflicted injuries are not

covered.

- Benefits are not payable when you are not under the ongoing care of a physician in the appropriate specialty.
- Benefits are not payable for any period when you are not participating, in good faith, in a course of medical treatment vocational training or education approved by The Standard, unless your disability prevents you from participating.
- Benefits are not payable for any period of disability when you are confined for any reason in a penal or correctional institution.
- Benefits are not payable after you have been disabled under the terms of the SLTD plan for 24 months during your entire lifetime, excluding the benefit waiting period, for a disability caused or contributed to by:
 - A mental disorder, unless you are continuously confined to a hospital solely because of a mental disorder at the end of the 24 months;
 - Your use of alcohol, alcoholism, use of any illicit drug, including hallucinogens or drug addiction;
 - Chronic pain, musculoskeletal, or connective tissue conditions;
 - Chronic fatigue or related conditions;
 - Chemical and environmental sensitivities.
- During the first 24 months of disability, after the benefit waiting period, SLTD benefits will not be paid for any period of disability when you are able to work in your own occupation and you are able to earn at least 20 percent of your predisability salary, adjusted for inflation,

but you choose not to work. After this time, no SLTD benefits will be paid for any period of disability when you are able to work in any occupation and able to earn at least 20 percent of your predisability earnings, adjusted for inflation, but choose not to work.

- Generally, benefits are not payable for any period of disability when you are not receiving disability benefits under the BLTD plan. However, this may not apply if:
 - You receive or are eligible to receive other income that is deductible under the BLTD plan and the amount of that income equals or exceeds the amount of the benefits that would otherwise be payable to you under that plan;
 - Benefits that would otherwise be payable to you under the BLTD plan are being used to repay an overpayment of any claim, or;
 - You were not insured under the BLTD plan when you become disabled.
- While living outside the United States or Canada, payment of benefits is limited to 12 months for each period of continuous disability.

Appeals

If The Standard denies your claim for supplemental long term disability benefits, you can appeal the decision by written notice within 180 days of receiving the denial letter. Send the appeal to:

Standard Insurance Company
P.O. Box 2800
Portland, OR 97208

within 180 days of the receipt of the denial letter. If the company upholds its decision, the

claim will receive an independent review by The Standard's Administrative Review Unit.

Because supplemental long term disability is fully insured by The Standard, you may not appeal SLTD decisions to PEBA.



MoneyPlus

Your tax-favored accounts program

The MoneyPlus program gives employees a way to reduce their taxes when paying for care, and in doing so offers a way to increase

take-home pay. MoneyPlus spending accounts, which are available to active employees and to return-to-work retirees, give you a place to set aside income for expected, eligible costs before that income is taxed.

Learn more in the MoneyPlus Reference Guide, available at www.peba.sc.gov/moneyplus.

The Pretax Group Insurance Premium Feature, which all insurance plan subscribers are enrolled in automatically unless they decline it, allows you to pay your premiums with pretax money.

MoneyPlus also offers several opt-in tax-saving programs, beginning with some accounts that fall under the category of flexible spending accounts. These include a Dependent Care Spending Account (DCSA), a Medical Spending Account (MSA), and a Limited-use MSA. You can place money into these accounts for later use

on a pretax basis. You will need to file for reimbursement from your account within the allotted time period by March of the following calendar year—funds in these accounts cannot be carried over to the next year and cannot be returned to you. When you enroll in an

You must enroll every year to be covered by a DCSA, an MSA or a Limited-use MSA.

MSA, you can use the myFBMC Card®, which works like a debit card, for expenses or you can

submit claims for reimbursement.

Finally, a Health Savings Account (HSA) is available, which works differently than flexible spending accounts. HSAs are available only to people enrolled in a high deductible health plan, a category of insurance plans that includes the State Health Plan Savings Plan. Unlike the other kinds of accounts, HSAs can accumulate funds over years, which allow participants to save up and offset their high deductibles. You can also take an HSA with you when you leave your job, and, after you contribute enough, you can invest money in them for retirement.

For more information about the State Health Plan's Savings Plan, see Page 42.

MoneyPlus accounts have an administrative charge, which is set up to have a minimal impact relative to the tax savings the accounts provide. Because MoneyPlus is governed by the Internal Revenue Code, Internal Revenue Service (IRS) requirements and restrictions exist for program participants.

How MoneyPlus can save you money

The monthly savings example on the following page shows how paying eligible expenses with a pretax payroll deduction may increase your spendable income. This scenario is for a single person with two dependents who is also a member of the South Carolina Retirement System.

The increase of spendable income equals \$179.86 per month, or \$2,158.32 per year.

	Without MoneyPlus	With MoneyPlus
Gross monthly pay	\$2,500.00	\$2,500.00
State retirement	- 187.50	- 187.50
Pretax payroll deduction	- 0.00	- 613.58 ²
Taxable gross income	\$2,312.50	\$1,698.92
Pretax Group Insurance Premium Feature	0.00	- 0.28
Dependent Care Spending Account fee	0.00	- 3.14
Medical Spending Account ¹ fee	0.00	0.00
Payroll taxes (estimate)	- 696.78	- 513.50
Eligible expenses ²	- 613.58 ²	- 0.00
Spendable income	\$1,002.14	\$1,182

Tax-favored spending accounts management tools

www.myFBMC.com

The benefits management website from WageWorks, Inc., which serves as the MoneyPlus program's third-party claims processor, allows you to:

- Review your account and online statement as well as claims information and card transactions;
- Learn about the specific tax benefits available to you;
- Access resources including an online claim form and a Tax Savings Analysis tool; and

¹A subscriber enrolled in both a DCSA and an MSA pays only one administrative fee for these accounts.

²In this illustration, these examples of monthly pretax payroll deductions and eligible, after-tax expenses were used:

Health premium - \$143.86

Dental premium - \$13.72

Dependent care expenses - \$400.00 (this amount is your estimated annual dependent care cost, divided by 12, and if you are enrolled in MoneyPlus, serves as your DCSA contribution)

Out-of-pocket medical expenses - \$56 (this amount represents your estimated annual eligible medical expenses, divided by 12, and if you are enrolled in MoneyPlus, serves as your MSA contribution)

Total - \$613.58

- Set up email notifications for your account.

Interactive voice response (IVR) system

This 24-hour automated phone system, 800.865.3262, enables you to check the status of a MoneyPlus claim, request forms and more.

When you call the IVR for the first time, you will be asked to key in your Social Security number (SSN). The last four digits of your SSN will serve as your first Personal Identification Number (PIN) when using the system. Then you will be asked to select your own confidential PIN. This PIN has no connection to the myFBMC Card®.

Pretax Group Insurance Premium Feature

The Pretax Group Insurance Premium Feature allows you to pay your State Health Plan premiums, including the tobacco-user premium, with money from your paycheck before taxes are withheld.

You may also use your pretax income to pay your premiums for the State Dental Plan, Dental Plus, State Vision Plan, optional life for coverage up to \$50,000, and the TRICARE

Optional Life Insurance premiums for coverage up to \$50,000 are tax exempt.

Supplement Plan.

Eligibility

Everyone who pays a health, dental, vision care, optional life, or TRICARE Supplement Plan premium is enrolled in the Pretax Group Insurance Premium Feature automatically. However, you can decline it on your *Notice of Election* form when you are first setting up your insurance or making changes to it.

If you declined the feature in the past, you can enroll in it during an annual open enrollment period, which takes place in October, or within 31 days of a special eligibility situation. To do this, see Making changes to your flexible spending account coverage, on Pages 146–147. To learn about special eligibility situations, see Pages 21–27.

Please note that an employee who covers an ex-spouse on any benefit is not eligible for the Pretax Group Insurance Premium Feature. This restriction does not affect the employee's eligibility to participate in an MSA or a DCSA, which are flexible spending accounts and are covered in the following section.

Administrative fees per month	
Pretax Group Insurance Premium Feature – fee is deducted from your paycheck before taxes	\$0.28

Flexible spending accounts

Through these MoneyPlus accounts, you can pay eligible medical and dependent care expenses with money you set aside before it is taxed. You authorize deposits to your MoneyPlus account, which take place every pay period. As you have eligible expenses,

you request tax-free withdrawals from your account to reimburse yourself. There are three kinds of flexible spending accounts:

- Dependent Care Spending Account (DCSA);
- Medical Spending Account (MSA); and
- Limited-use medical spending account – this can accompany an HSA, which is available to subscribers enrolled in the Savings Plan

Eligibility

You must be eligible for state group insurance benefits to participate in a MoneyPlus account. You are not required to be covered by an insurance program to participate, nor do you have to enroll in the Pretax Group Insurance Premium Feature to participate in the DCSA or MSA.

Deciding how much to contribute to your account

Funds placed in MSAs and DCSAs for use during a given calendar year cannot be carried forward to the next plan year.

- MSAs and Limited-use MSAs: you will have until March 31, 2018 to request reimbursement for expenses incurred on or before March 15, 2018.
- DCSAs: You will have until March 31, 2018 to request reimbursement for expenses incurred on or before December 31, 2017.

See the IRS restrictions later in this section for more information. To avoid losing funds placed in these accounts, you may want to begin by making conservative estimates of how much you will spend on medical expenses in a year. A worksheet to help you with this is available at

www.peba.sc.gov/assets/moneyplusworksheet.pdf.

Responsibilities for using an account

When you enroll in any MoneyPlus spending account, you certify on the form that you will:

- Hold on to the documentation you will need for your reimbursement claims;
- Use the account only to pay for IRS-qualified expenses eligible under your insurance plan for yourself your IRS-eligible dependents;
- Will first use all other sources of reimbursement, including those provided by your insurance plan or plans, before seeking reimbursement from your spending account; and
- Will not seek reimbursement through any additional source after seeking it from your account.

Earned income tax credit

Contributions made before taxes to a DCSA or an MSA lower your taxable earned income. The lower your earned income, the higher the earned income tax credit. See IRS Publication 596 or talk to a tax professional for more information.

IRS restrictions for spending accounts

- You cannot pay any insurance premiums through any type of flexible spending account. These accounts are separate from the Pretax Group Insurance Premium Feature.
- You cannot transfer money between MoneyPlus accounts. You cannot pay a dependent care expense from your MSA,

or a medical expense from your DCSA.

- Any money left in your in spending accounts after your requests for a plan year have been processed cannot be returned to your or carried over to the next year. For the funds you deposited in any given calendar year, you have these deadlines to spend the funds:
 - MSAs and Limited-use MSAs: You have until March 15 of the following year, 2018, to spend funds from the plan year, 2017. You must then submit all reimbursement requests to WageWorks by March 31, 2018.
 - DCSAs: You have until December 31 of the plan year, 2017, to spend funds from 2017. You still have until March 31, 2018, to submit all reimbursement requests to WageWorks.
- You may not be reimbursed through your MoneyPlus accounts for expenses paid by insurance or by any other source.
- You cannot deduct reimbursed expenses from your income tax.
- You may not be reimbursed for a service that you have not received.

Making changes to your flexible spending account coverage

You have limited circumstances for starting or stopping your flexible spending accounts, or varying the amounts you contribute. Any changes you make to your DCSA or MSA must be consistent with the event that initiates the change. For example, you may wish to start a DCSA if you have a baby or adopt a child. You may want to decrease your MSA contribution if you get a divorce and will no longer be paying for your ex-spouse's out-of-pocket medical expenses.

Within 31 days of one of the events listed below, you will need to complete and submit a *Change in Status* form to your benefits administrator if you wish to make changes in your account. The form is available at www.peba.sc.gov/iforms.html and from your benefits administrator.

Any related claims you submit while WageWorks is processing your change in status will be held until the processing is complete. Birth, adoption, and placement for adoption are effective on the date of the event. All other changes in status are effective on the first of the month following the request.

Some changes in status that permit changes to your account are:

- Marriage, divorce – you cannot make changes because you are in the process of divorce, but may after it is final;
- Birth, placement for adoption, adoption;
- Placement for custody;
- Dependent loses eligibility;
- Death of spouse or child;
- Gain or loss of employment;
- Begin or end unpaid leave of absence;
- Change from full-time to part-time employment or vice versa; and
- Change in day-care provider.

How changes affect your period of coverage

Your MoneyPlus spending account is set up for the entire calendar year, which is your period of coverage. If you make an approved, mid-plan-year election change and then deposit more money, expenses you had before the mid-year change cannot be reimbursed for more money than was in the account at the time of the

change.

Dependent Care Spending Account (DCSA)

A DCSA allows you to pay dependent care expenses with pretax income. This account is only for the paying of day care costs for children and adults, and cannot be used to pay for dependent medical care. The funds can only be used during the plan year.

Enrolling

You can enroll in the DCSA within 31 days of your hire date through your benefits administrator. If you do not enroll then, you can enroll during the next open enrollment period in October. You also can enroll in, or make changes to, this account within 31 days of an approved change in status (see special eligibility situations on Pages 21–27 and Making changes to your flexible spending account coverage on Page 146). You will need to re-enroll every year during the open enrollment period in October to continue your account the following year.

Administrative fees per month

Dependent Care Spending Account – fee is deducted from your paycheck before taxes	\$3.14
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Deciding how much to set aside

- Estimate the amount you will spend on dependent care throughout the year. Take into account vacation and holiday time when you may not have to pay for dependent care. The IRS will not allow any money still in your account after you have claimed all of your expenses at the end of the year to be returned to you, or be carried over into the next calendar year. You will have until March 31 of the

new plan year to file claims for services provided during the previous year.

- The annual amount you decide on will be divided into equal installments and deducted from each paycheck before taxes.

Here are the limits on how much you may set aside:

- If you are married and filing separately, your maximum is \$2,500.
- If you are single and head of household, your maximum is \$5,000.
- If you are married and filing jointly, your maximum is \$5,000.
- If either you or your spouse earns less than \$5,000 a year, your maximum is equal to the lower of the two incomes.
- If your spouse is a full-time student or incapable of self-care, your maximum is \$3,000 a year for one dependent and \$5,000 a year for two or more dependents.

In 2017, the DCSA is capped at \$1,700 for highly compensated employees. This cap is subject to adjustment during the year if PEBA's DCSA does not meet the federal average benefit test. The test is designed to ensure that highly compensated employees do not receive a benefit that is out of proportion with the benefit received by other employees. The 2015 salary used to define highly compensated employees for 2016 was \$120,000 or greater. The IRS will set the salary for 2017 in October 2016.

For more information, talk with your benefits administrator or a tax professional, or contact the IRS at www.irs.gov or 800.829.1040.

People who can be covered by a DCSA

A qualified individual, whose eligible dependent care can be reimbursed by a DCSA, includes a child if he or she:

- Is a U.S. citizen, a U.S. national, or a resident of the U.S., Mexico, or Canada;
- Has a specified family-type relationship to you;
- Lives in your household for more than half of the tax year;
- Is under age 13; and
- Has not provided more than one-half of their own support during the tax year.

Eligible expenses

Generally, child, adult, and elder care costs that allow you and your spouse to work or actively look for work are eligible for reimbursement. If you are married, your spouse must work, be a full-time student, or be mentally or physically incapable of self-care. Examples include:

- Day care facility fees;
- Local day camp fees; and
- Baby-sitting fees for at-home care while you and your spouse are working (you, your spouse, or another tax dependent cannot provide the care).

Ineligible expenses

- Child support payments or child care if you are a non-custodial parent.
- Payments for dependent care services provided by your dependent, your spouse's dependent, or your child who is under age 19.
- Health care costs or educational tuition.
- Overnight care for your dependents,

unless it allows you and your spouse to work during that time.

- Nursing home fees.
- Diaper services.
- Books and supplies.
- Activity fees.
- Kindergarten tuition.

Seeking DCSA reimbursement of eligible expenses

When you have a dependent care expense, you should submit a *MoneyPlus Claim Form* online, by mail or fax, and a copy of your expense documentation from your dependent care provider to WageWorks. Online forms are available at www.myFBMC.com, under My Account and then Online Claim Form. Printed forms can also be found through the website, or through your benefits administrator.

Your claim form and the expense documentation should show the following:

- The dates your dependent received the care, not the date you paid for the service;
- The name and address of the facility and
- The name, address, and signature of the individual who provided the dependent care.

This information is required with each reimbursement request. The claim form may serve as documentation if it includes the provider's signature. Although the form does not request the provider's Tax ID Number or Social Security number, you should be prepared to provide it to the IRS if asked.

WageWorks will process your claim within five working days of receiving it. An approved expense will not be reimbursed until after the last date of service for which you are requesting

reimbursement. For example, if you pay your dependent care provider on October 1 for the month of October, you can submit your reimbursement request for the entire month. Payment will not be made, though, until you receive the last day of care for October.

An approved expense will also not be reimbursed until enough funds are in the DCSA to cover it. On your claim form, you may divide the dates of service into periods that correspond with your payroll cycle. This will allow you to be reimbursed for part of the amount on the documentation when there are enough funds in your account.

Although claims are processed in five working days, your check may take as long as two weeks to arrive. You can sign up for direct deposit if you would like to receive your reimbursement faster. Direct deposit service has no extra fee and includes notifications of when your claims are processed. To apply, complete a MoneyPlus direct deposit authorization form available from your benefits office or www.peba.sc.gov/iforms.html. Processing your direct deposit application may take four to six weeks.

Reporting a DCSA to the IRS

If you participate in a DCSA, you will need to attach IRS Form 2441 to your 1040 income tax return. Otherwise, the IRS may not allow your pretax exclusion. To claim the income exclusion for dependent care expenses on IRS Form 2441, you must be able to list each dependent

care provider's SSN or Employer Identification Number (EIN). If you are unable to obtain one of these numbers, you will need to provide written statement with your IRS Form 2441 explaining the situation and stating that you made a serious effort to get the information.

What happens to your DCSA if you leave your job

If you leave your job permanently or take an unpaid leave of absence, you cannot continue contributing to your DCSA. You can, however, request reimbursement for eligible expenses which happened while you were employed until you exhaust your account or the plan year ends.

What happens to your DCSA after your death

A member's DCSA ends on the date he dies and is not refunded to the survivors. DCSA claims for expenses which occurred up through the date of death may be submitted until the account is exhausted or through the end of the year.

The death of a spouse or child creates a change in status that allows a member to stop, start, or change the amount contributed to a DCSA. You have 31 days from the date of death to make the change. See Pages 146-147 for information about changing your contribution.

Comparing the DCSA to the child and dependent care credit

If you pay for dependent care so you can work, you may be able to reduce your taxes by claiming those expenses on your federal income tax return through the child and dependent care credit instead of using a DCSA. Depending on your circumstances, participating in a DCSA on a salary-reduction basis may

produce a greater tax benefit. To compare these options, go to www.myFBMC.com, then select the Tax Savings Analysis link.

For more information, see IRS Publication 503. For assistance, call the WageWorks Customer Care Center at 800.342.8017.

Medical Spending Accounts (MSAs)

An MSA allows you to pay eligible medical expenses not covered by insurance, including copayments and coinsurance, with pretax income. A full MSA is available to Standard Plan subscribers, not Savings Plan subscribers. For Savings Plan subscribers who have a Health Savings Account (HSA) (see Page 155), a Limited-use MSA is available. The limited-use MSA covers those expenses the Savings Plan does not cover, like dental and vision care.

MSAs offer the myFBMC Card®, which functions like a debit card when spending funds, as an alternative to submitting claims for reimbursement. The funds placed in an MSA can only be used during the plan year, January 1 of the year itself through March 15 of the following year.

Administrative fees per month

Medical Spending Accounts (full and Limited-use) – fee is deducted from your paycheck before taxes	\$3.14
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Enrolling in an MSA

When you participate in an MSA, you will need to re-enroll every year during the open enrollment period in October. If you have a myFBMC Card®, you will need to re-enroll for it separately every year. You can enroll in or make changes to your MSA within 31 days of an

approved change in status (see special eligibility situations on Pages 21–27 and changing your flexible spending account coverage on Pages 146–147).

You may enroll or re-enroll online at www.myFBMC.com during open enrollment. You also may complete a *MoneyPlus Enrollment Form*, available at www.peba.sc.gov/iforms.html or from your benefits administrator. Submit the completed form to your benefits administrator.

Once you sign up for an MSA and decide how much to contribute, the entire amount will be available on January 1. You do not have to wait for the funds to accumulate in your account before being reimbursed for eligible medical expenses.

Deciding how much to set aside

- Estimate the amount you and your family want to set aside in your MSA. Consider only those expenses you and your family can expect to take place between January 1 and December 31. The IRS will not allow any money still in your account after you have claimed all your expenses at the end of the year to be returned to you. If you have money left in your MSA on December 31, you have until March 15 of the next year to spend funds deposited in the account during the previous year. You have until March 31 to ask for reimbursement and submit documentation for eligible expenses incurred during the previous year and through March 15.
- The yearly amount you elect to contribute to your account will be divided into equal installments and deducted from each paycheck before taxes.

For 2017, your annual contribution limit for your MSA is \$2,600. If you are married and your

spouse is eligible for PEBA-sponsored coverage, you may each set aside contributions of up to \$2,600 in payroll deduction through your employers.

People who can be covered by an MSA

An MSA may be used to reimburse eligible expenses for:

- Yourself;
- Your spouse (even they have an MSA);
- Your qualifying child; and
- Your qualifying relative.

An individual is a qualifying child if they are not someone else's qualifying child, although an eligible child of divorced parents is treated as a dependent of both, so either or both parents can establish an MSA. Additionally, a child qualifies if they:

- Do not reach age 27 during the taxable year (if a qualifying child is physically or mentally incapable of self-care, there is no age requirement);
- Have a specified family-type relationship to you: son/daughter, stepson/stepdaughter, eligible foster child, legally adopted child, or child placed for legal adoption; and
- Are a U.S. citizen, a U.S. national, or a resident of the U.S., Mexico, or Canada.

An individual is a qualifying relative if they are a U.S. citizen, a U.S. national, or a resident of the U.S., Mexico, or Canada and:

- Have a specified family-type relationship to you, is not someone else's qualifying child, and receives more than one half of their support from you during the tax year; or
- If no specified family-type relationship to you exists, are a member of and live in

your household (without violating local law) for the entire tax year and receives more than one-half of their support from you during the tax year.

For more information, contact your benefits administrator or tax advisor. You can also contact the IRS at www.irs.gov or 800.829.1040.

Eligible expenses — full MSA

Expenses eligible for reimbursement include your deductibles, coinsurance, and copayments. You can also use your MSA to pay for:

- Annual physical exams;
- Vision care;
- Out-of-pocket dental fees (including orthodontics³);
- Over-the-counter drugs, but only if prescribed by a physician, or are on the list of drugs approved for reimbursement by the IRS (list is available at www.myFBMC.com);
- Non-medicinal over-the-counter items, including diabetic supplies, are still reimbursable without a prescription; and
- Any other out-of-pocket medical expenses deductible under current tax laws, including travel to and from medical facilities.

For more information, call the WageWorks Customer Care Center at 800.342.8017.

Eligible expenses — Limited-use MSA

Limited-use MSAs are available to members who are enrolled in the State Health Plan Savings Plan and a Health Savings Account

³Orthodontics are eligible if medically necessary, but not if cosmetic. You will need to submit additional documentation each year.

(HSA). In this situation, you may use your HSA, but not your Limited-use MSA, for deductibles and coinsurance, but you can use your limited-use MSA for other expenses not covered by the Savings Plan, like dental and vision care.

Ineligible expenses — full MSA and Limited-use MSA

- Insurance premiums;
- Vision warranties and service contracts;
- Health or fitness club membership fees;
- Cosmetic surgery not deemed medically necessary to alleviate, mitigate, or prevent a medical condition;
- Limited-use MSA only – deductibles and coinsurance; and
- Limited-use MSA only – over-the-counter items.

Using MSA funds

You have several means of accessing the funds you have contributed to your MSA. You can use a special debit card to pay for expenses directly, known as a myFBMC Card®, or you can have expenses reimbursed to you through direct deposit by filling out a *MoneyPlus ClaimForm*.

myFBMC Card®

The myFBMC Card®, a debit card issued at no charge to all MSA and Limited-use MSA participants, can be used to pay eligible, uninsured medical expenses for yourself and for your covered family members. When signing up for an MSA, you will receive two cards so

Like any MSA expense, myFBMC Card® transactions must be documented for the IRS. See the next page for more information.

you can give one to your spouse or child.

If you had a myFBMC Card® during a previous plan year, you can continue to use it to pay eligible expenses from your previous year's MSA until March 15. The card will continue to use funds from that previous year until they are exhausted, and will then switch over to the next year's funds. If you have not signed up for an MSA for an upcoming year, you cannot use your myFBMC Card® after December 31.

Activating your card

To activate your myFBMC Card® so you may begin using it, log on to www.myFBMC.com.

Using your card

Although the card works like a debit card for paying health care providers, it needs no PIN. Please remember to keep documentation of your expenses as required by IRS regulations.

The card can only be accepted by providers who use the Inventory Information Approval System, known as IIAS merchants. To find a current list of available IIAS merchants to use as providers, log in to www.myFBMC.com.

Documentation will be required when you use the card for any transaction that does not have a fixed copayment.

Documenting myFBMC Card® transactions

According to the IRS, it is not necessary to submit documentation for:

- Known copayments for services provided through the State Health Plan;
- Eligible prescriptions purchased through your health plan's mail-order pharmacy; or
- IRS-approved over-the-counter items.

For other health care expenses, documentation

is needed. Your quarterly statement highlights transactions requiring documentation in blue. When this happens, you will need to submit a *MoneyPlus Claim Form* and a copy of your documentation to WageWorks either online or by fax.

If an undocumented transaction appears in blue on more than two consecutive quarterly statements, your myFBMC Card® will be suspended and remain suspended until:

- Your documentation is received;
- You submit a paper claim, which is then approved, but enough money is withheld from your reimbursement payment to make up for the card transaction that you have not documented; or
- You repay your account by submitting a check to WageWorks and made out to your employer in the amount of the outstanding transaction.

When the transaction in question is cleared by one of these methods, your card will be automatically reinstated. Any amounts from January 1 of the plan year to March 15 of the following year that are not cleared by March 31 of the following year will not meet IRS guidelines and will be taxed as income.

You should keep all documents substantiating your claims for at least one year and submit them on request.

Lost cards

If your myFBMC Card® is lost or stolen, call 888.462.1909 immediately.

Seeking MSA reimbursement of eligible expenses

Before you file claims for reimbursement, you must first file claims for the benefits

you have received. Out-of-pocket expenses remaining after that may then be submitted to WageWorks for reimbursement from your MSA. The minimum reimbursement is \$5, except for the last reimbursement which brings your account balance to zero.

You can submit a *MoneyPlus Claim Form* to WageWorks online, by mail, or fax, along with a copy of your expense documentation or the Explanation of Benefits from your dependent care provider. Online forms are available at www.myFBMC.com, under My Account and then Online Claim Form. Printed forms are also available from your benefits administrator. You should also note the deadlines described in the IRS restrictions section on Page 146.

When gathering documentation, consider these requirements:

- Documentation can be an invoice or bill from your health care provider listing the date of service, the cost of the service, the type of service, the service provider, and the person for whom the service was provided.
- Documentation can also be an Explanation of Benefits, a statement, or bill showing the name of the patient, the date of service, the type of service, the service provider, and the cost of service.
- For a drug, documentation needs to include the prescription number and the name of the drug. Most pharmacy receipts do not show the name of the drug. You may need to submit a print-out that includes the name of the drug. It may be from the pharmacy, your prescription drug program's website, or the pharmacy's website. The name also may be on a note stapled to the bag from the pharmacy.
- In some circumstances, a written

statement from your health care provider that the service was medically necessary may be needed. This *Letter of Medical Need* is available by calling 800.342.8017.

WageWorks will take up to five working days to process your claim after receiving it. If you have signed up for direct deposit, payment will be issued to your account within 48 hours after WageWorks processes your approved


claim. Direct deposit service has no extra fee and includes notifications of when your claims are processed. To apply, complete a *MoneyPlus Direct Deposit Authorization* form available from your benefits office or www.peba.sc.gov/iforms.html. Processing your direct deposit application may take four to six weeks.

If you file by mail, your reimbursement will be issued within five business days from the time WageWorks receives your properly completed and signed claim. Your check may take up to two weeks to arrive.

When faxing in claim forms and documentation, no cover sheet is needed.

What happens to your MSA when you leave your job

When you have an MSA and you leave your job, COBRA coverage under the MSA will be offered only if your account balance meets certain criteria. The amount you elected to contribute to your account for the plan year, minus any reimbursable claims you have submitted up to



When you are submitting forms or documents, avoid using a highlighter. It will prevent them from being readable if photocopied or faxed.

the date of the COBRA qualifying event, must be equal to or more than the amount you would have contributed to the account, if had you remained employed for the remainder of the plan year.

COBRA coverage will consist of the amount you have in your MSA at the time of the qualifying event, plus additional contributions up to the annual amount you elected to contribute. You will be charged a 2 percent administrative fee. You will still lose any funds remaining in your account after March 15 of the following year, and COBRA coverage will end. WageWorks will contact you about continuation of coverage.

If you do not continue your MSA as permitted under COBRA, you have 90 days from your last day worked to submit eligible MSA expenses incurred before you left employment. Any funds still in your account will not be returned to you.

The Family and Medical Leave Act (FMLA) may affect your rights to continue coverage while on leave. Contact your employer for further information.

What happens to your MSA after you die

A member's MSA ends on the date he dies and the balance is not refunded to the survivors. An IRS-qualified dependent or beneficiary may continue an MSA through the end of the plan year under COBRA. Contact WageWorks or your benefits administrator for more information. If the MSA is not continued through COBRA, the beneficiary has 90 days from the date of death to submit claims for eligible expenses incurred through the member's date of death.

The death of a spouse or child creates a change in status that allows a member to stop, start, or change the amount contributed to an MSA. You

have 31 days from the date of death to make the change. See Pages 146-147 for information about changing your contribution.

Comparing the MSA to claiming expenses on IRS Form 1040

You can only claim itemized medical and dental expenses on your IRS Form 1040 if they exceed 10 percent of your adjusted gross income. If you file a joint tax return, your adjusted gross income includes both your income and your spouse's. The tax-free MSA gives you an alternate way to save taxes on your uninsured, out-of-pocket medical expenses.

For example, if your adjusted gross income is \$45,000, the IRS would only allow you to deduct itemized expenses that exceed \$4,500, or 10 percent of your adjusted gross income. But if you have \$2,000 in eligible medical expenses, a MoneyPlus MSA would save you \$656 on your medical expenses in federal income tax (15 percent), South Carolina state tax (7 percent) and Social Security taxes (7.65 percent).

To learn more about the tax credit, see IRS Publication 502 or use the services of a tax professional.

Health Savings Accounts (HSAs)

Members enrolled in the State Health Plan Savings Plan have the option of participating in an HSA, a tax-free account which offers them several advantages for insurance and even retirement. Unlike other kinds of spending accounts, HSAs do carry over from one year to the next, with funds not needing to be spent in the year they are deposited, and employees can

Learn more
about the State
Health Plan's Savings
Plan on
Page 42.

even take them when they leave their jobs. Because of this, they can use their HSAs to save up over time for future medical expenses, and in doing so can offset the higher deductible of their insurance plan.

Because the \$1.50 monthly service charge for an HSA continues even when your balance reaches \$0, your account can be overdrawn and lead to additional charges.

Also, once you contribute enough to an HSA, you can transfer money from it to a tax-deferred investment account and allocate the funds among available mutual

fund options, although you cannot transfer so much that it would bring the balance of your HSA below the threshold of investment eligibility. When you deposit funds to your HSA through payroll deduction, administrative fees are deducted. There are no transaction fees for investing in mutual fund options.

Administrative fees per month

HSA WageWorks fee – deducted from your paycheck	\$1.50
HSA Optum fee – for HSAs established with Optum, deducted from your account. This fee is waived for accounts with balances of \$2,500 or more. There is no fee for processing checks. There is no fee for a basic order of checks. There is no charge if you use your myFBMC Card®.	\$1.50

Eligibility for an HSA

To be eligible for an HSA, subscribers, including retirees, must be covered by the Savings Plan, which is considered a high deductible health plan. You cannot be covered by any other health plan that is not a high deductible

health plan, including Medicare. You may still be covered for specific injuries, accidents, disability, dental care, vision care, and long-term care. You cannot be claimed as a dependent on another person's income tax return.

Eligible subscribers may establish HSAs offered through any qualified financial institution. If you would like to contribute to an HSA in which you can contribute money pretax through payroll deduction, you must enroll in the MoneyPlus HSA. Although WageWorks administers HSAs, as it does with other MoneyPlus accounts, Optum serves as the custodian for HSAs, meaning that you will work directly with Optum rather than WageWorks when depositing and withdrawing funds from your HSA.

A MoneyPlus MSA, even a spouse's MSA, is considered to be another health plan under HSA regulations, and as such, it prevents you from using an HSA. If you have no funds in your MSA on December 31, you may begin contributing to an HSA on January 1.

If you have a Limited-use MSA, which is not considered another health plan, you may begin making HSA contributions January 1.

Enrolling in an HSA

HSAs have rolling enrollment, meaning that you can add and drop them and change your contributions at any time, and do not need to do so during open enrollment or a special eligibility situation.

Complete a *MoneyPlus Enrollment Form*, choose

the HSA option, and submit it to your benefits administrator. If you would like to open an HSA with Optum, go to www.peba.sc.gov/moneyplus.html and select Open HSA Bank Account with Optum.

If you held an HSA Account with Wells Fargo before the transition to Optum, then your HSA, including HSA investment balances, transferred to Optum, with members receiving communication about this process.

The HSA Custodial Account disclosure statement and funds availability disclosure agreement are also available at www.peba.sc.gov/moneyplus.html, or by contacting WageWorks Customer Care at www.myFBMC.com or 800.342.8017.

Once you enroll in an HSA, you will not need to re-enroll as long as you remain eligible for it.

When active subscribers who are enrolled in the Savings Plan turn 65, they remain eligible to contribute to an HSA if they delay enrollment in Medicare Part A by delaying receiving Social Security. They can delay enrolling in Social Security until they turn age 70 ½. Once they enroll in Social Security, and therefore Medicare Part A, they can no longer make contributions to an HSA. The funds already in the HSA, however, may be withdrawn to pay Medicare premiums, but not Medigap premiums, and may also be used to pay deductibles and coinsurance.

Limited-use MSA

If you have an HSA, you also may be eligible for a Limited-use Medical Spending Account (MSA). That account may be used for expenses not covered by the Savings Plan. Eligible expenses include dental and vision care. See Page 152 for more information.

If you enrolled in a full MSA instead of an HSA, you cannot sign up for an HSA until the next open enrollment period in October or until a special eligibility situation occurs that allows you to end your MSA within 31 days of the event.

Contributions

You may enroll, change, or stop your contributions to your MoneyPlus HSA through payroll deduction once a month. To make the change, fill out a new *MoneyPlus Enrollment Form*, available at <http://www.peba.sc.gov/iforms.html> and complete Box A.

There are no minimum contributions to an HSA, although the IRS specifies maximum contributions. For 2017, HSA annual contribution limits are as follows:

- A subscriber with single coverage - \$3,400.
- A subscriber who covers himself and any other family member - \$6,750.
- Additional catch-up contributions for a subscriber who is age 55 or older - \$1,000.

When subscribers enroll in an HSA, they may begin contributing their maximum beginning on the first of the month in which it goes into effect, but only so long as they will remain eligible for the following 12 months. They may make up to the maximum contribution either in a lump sum or in equal amounts, such as through payroll deduction with MoneyPlus.

WageWorks will monitor your HSA contributions and send an alert to your benefits administrator if you are exceeding your contribution limit. The best way to avoid problems is to divide your desired annual contribution among the number of paychecks you receive. For example, if you have single

coverage, you can deduct a maximum of \$3,400 for 2017. If you receive 24 paychecks each year, you can deduct \$141.65 (rounded down) each pay period.

Subscribers who are transitioning from an MSA to an HSA can face a restriction on when they may begin making HSA contributions. If you still have funds in your MSA in a given year, you cannot contribute to the HSA until the MSA is no longer active, a change that occurs on April 1 of the following year.

When your funds become available

Each contribution to your MoneyPlus HSA will be available after your employer's payroll is received and processed by WageWorks, transferred to Optum and deposited in your account. These deposits are sent to Optum twice a week. Funds should generally be available in your HSA no later than a week after your pay date.

If you use your debit card for a transaction and you do not have enough money in your account, the transaction will not go through or could overdraw your account. If you write a check and you do not have enough money in your account, the check could be returned unpaid.

Optum will provide monthly statements to you. Through the online Optum account manager, found at www.optumbank.com, you can check your balance, make online contributions, review monthly statements and annual tax reporting, transfer funds, set up your HSA investment account, and more.

Eligible expenses and documentation

You may use your HSA funds, tax free, to pay for unreimbursed eligible medical expenses for yourself, your spouse, and your

tax dependents. Medical expenses include the costs of diagnosis, cure, treatment or prevention of physical or mental defects or illnesses, including dental and vision expenses. HSA funds can only be used tax-free to pay for over-the-counter drugs if the drugs were prescribed by a physician.

You should keep receipts for expenses paid from your HSA with your tax returns in case the IRS audits your tax return and requests copies. You may upload scanned copies or pictures of your eligible receipts in your Optum receipt vault, by logging in to your account at www.optumbank.com.

If you use HSA funds for ineligible expenses, you will be subject to taxes on the amount you took from your HSA, as well as a 20 percent penalty if you are younger than age 65.

Using HSA funds

After you enroll in an HSA, you will receive a MasterCard debit card from Optum. You may order additional cards and can order a supply of checks by logging into your account at www.optumbank.com. You may use the card or the checks to reimburse yourself from your HSA. You can also reimburse yourself with a direct deposit to checking or savings account of your choice, by logging on to your account through www.optumbank.com, selecting the Reimburse option, then entering the routing and account number of the account to which you would like to send the reimbursement direct deposit.

Investing HSA funds

Your HSA funds will initially be held in an interest-bearing checking account with Optum. As the account grows, you may be eligible to invest your funds in excess of \$2,000. Unlike funds in an interest-bearing checking account, money invested in a mutual fund is not FDIC-

insured. You could earn a higher rate of return on your investment, but you could lose money, including the original amount invested.

Reporting your HSA to the IRS

After year end, Optum will send you information to use in reporting your HSA contributions and withdrawals when you file your taxes. You should save documentation, including receipts, invoices, and explanations of benefits from your health insurance claims processor in case you are asked to show the IRS proof that your HSA funds were used for qualified expenses.

If you participate in MoneyPlus, pretax HSA contributions will appear on your W-2 Form as employer-paid contributions. This is because this money was deducted from your salary before it was taxed. You should not deduct this money on your return. Only after-tax contributions may be deducted. Consult with a tax professional for more information.

If you have questions about how your HSA contributions were reported on your W-2 Form, contact your benefits office.

What happens to your HSA after you die

If the account owner's spouse is the beneficiary of the HSA, the account can be transferred to an HSA in the spouse's name. If the beneficiary is someone other than the spouse, the account will cease to be an HSA on the account owner's date of death. If the beneficiary is the account owner's estate, the fair market value of the account on the date of death will be taxable on the account owner's final return. For beneficiaries other than the spouse or the estate, the fair market value of the account is taxable to the beneficiary for the tax year in which the account owner died.

For more information, see Section VII of the Health Savings Account Custodial Agreement. A copy of the agreement is found at www.peba.sc.gov/moneyplus.html.

Closing your HSA

If you are no longer eligible to contribute to an HSA or would like to stop contributing you will need to submit a *MoneyPlus Enrollment Form*, found at www.peba.sc.gov/iforms.html, to your benefits administrator. Enter \$0 in Section A to stop contributions to the account.

If money remains in the account, you may continue to use it for qualified, unreimbursed medical expenses. Contact Optum to close the account.

Appeals

If your request for reimbursement, claim for benefits, or mid-plan-year election change for an account is denied in full or in part, you have the right to appeal the decision. Appeals are approved only if the extenuating circumstances and supporting documentation are within your employer's, your insurance provider's, and IRS' regulations governing the plan.

Send a written request within 30 days of the denial for review to WageWorks, Attn: Appeals Process, P.O. Box 14766, Lexington, KY 40512-4766. Please retain copies of claims and receipts for your records.

Your appeal must include:

- The name of your employer;
- The date of the services for which your request was denied;
- A copy of the denied request;
- A copy of the denial letter you received;
- Why you think your request should not

have been denied; and

- Any additional documents, information or comments you think may have a bearing on your appeal.

You will be notified of the results of this review within 30 business days from receipt of your appeal. In unusual cases, such as when an appeal requires additional documentation, the review may take longer. If your appeal is approved, additional processing time is required to modify your benefit elections.

If you are still dissatisfied after the decision is re-examined, you may ask PEBA to review the matter by making a written request to PEBA within 90 days of notice of WageWorks denial of your appeal. Send the request to:

Appeals Department
S.C. PEBA
202 Arbor Lake Drive
Columbia, SC 29223

A healthcare provider or benefits administrator may not appeal to PEBA on your behalf, even if the provider appealed the decision to the third-party claims processor. Only you, the member, or your authorized representative may initiate an appeal through PEBA. A provider or benefits administrator may not be an authorized representative.

PEBA will make every effort to process your appeal within 180 days of the date it receives your claim file from WageWorks, as outlined in the Plan. However, this time may be extended if additional material is requested or you ask for an extension. PEBA will send you periodic updates on the status of your review. When PEBA's review of your appeal is complete, you will receive a written determination in the mail.

If the denial is upheld by the PEBA Appeals Committee, you have 30 days to seek judicial

review at the Administrative Law Court, as provided by Sections 1-11-710 and 1-23-380 of the S.C. Code of Laws, as amended.

Contacting WageWorks

www.myFBMC.com

Customer Care Center
Monday – Friday, 7 a.m.-10 p.m., ET
800.342.8017 | 800.955.8771 (TDD)

Interactive voice response
24 hours a day, seven days a week
800.865.3262

Dispute line
Monday-Friday, 7 a.m.-10 p.m., ET
800.342.8017

Toll-free claims fax
888.800.5217



Retiree group insurance

Are you eligible for retiree group insurance?

Some of the insurance benefits you enjoy as an active employee may be available to you as a retiree through the group insurance programs PEBA sponsors. This chapter covers retiree group insurance eligibility and whether your employer may pay a portion of your retiree insurance premiums.

Your eligibility for retiree group insurance is based on the retirement service credit you earn while working for an employer that participates in the State Health Plan. If you are a member of one of the defined benefit retirement plans PEBA administers, your eligibility for retiree group insurance will depend on whether you have met the minimum statutory requirements for retirement eligibility established for the plan in which you are a member when you leave employment.

PEBA's defined benefit plans include the South Carolina Retirement System (SCRS), the Police Officers Retirement System (PORS), the General Assembly Retirement System (GARS), and the Judges and Solicitors Retirement System (JSRS). PEBA also administers a defined contribution plan, the State Optional Retirement Program (State ORP). If you are a State ORP participant, you would become eligible for retiree group insurance using the same requirements as an SCRS member.

Will your employer pay part of your retiree insurance premiums?

As an active employee, your employer must pay part of the cost of your health and dental insurance. When you retire, the amount your employer contributes to your retiree insurance premiums is based on several factors, including the type of employer from which you retired.

Employees of state agencies, higher education institutions, and public school districts that participate in the state insurance program may be eligible for a state contribution to their retiree insurance premiums based on when you began employment and on your number of years of earned service credit.

Retiree insurance eligibility guidelines are the same for local subdivision retirees as they are for state, higher education, and public school district retirees. However, the funding is different. Local subdivisions may or may not pay a portion of the cost of their retirees' insurance premiums. Each local subdivision develops its own policy for funding retiree insurance premiums for its eligible retirees. If you are a local subdivision employee, contact your benefits office for information about retiree insurance premiums.

Eligibility requirements for employees hired before May 2, 2008

- Your retirement eligibility, including disability retirement eligibility, is determined by the provisions of the applicable retirement system. For

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Retirees of state agencies, higher education institutions and public school districts¹ – Employees hired before May 2, 2008

Retirement status	Earned service credit with an employer participating in the State Health Plan ²	Responsibility for paying for premiums
Left employment <u>after</u> reaching retirement eligibility	5 years, but fewer than 10 years	You pay the full premium (employee and employer share)
	10 or more years	You pay the employee share of the premium only
Left employment <u>before</u> reaching retirement eligibility	Fewer than 20 years	Not eligible for retiree insurance coverage
	20 or more years	You pay the employee share of the premium only

Retirees of local subdivisions¹ – Employees hired before May 2, 2008

Retirement status	Earned service credit with an employer participating in the State Health Plan ²	Responsibility for paying for premiums
Left employment <u>after</u> reaching retirement eligibility	At least 5 years	Your portion of the premium, up to the full amount of the employee and employer share, is at your employer's discretion
Left employment <u>before</u> reaching retirement eligibility	Fewer than 20 years	Not eligible for retiree insurance coverage
	20 or more years	Your portion of the premium, up to the full amount of the employee and employer share, is at your employer's discretion

¹Your last employer prior to retirement must be a state agency, state institution of higher education, public school district, or local subdivision. Your last five years of employment must have been served consecutively in a full-time, permanent position with an employer that participates in the State Health Plan.

²Earned service credit is time earned and established in one of the defined benefit pension plans PEBA administers; time worked while participating in the State ORP; or time worked for an employer that participates in the State Health Plan, but not the retirement plans PEBA administers. Earned service credit does not include any purchased service credit not considered earned service in the retirement plans.

Continued from Page 162

participants in the State ORP, retirement eligibility is determined as if the participant was a member of SCRS. As a result, State ORP members who seek insurance coverage as a disability retiree will need disability approval from the Social Security Administration, but not from PEBA, because State ORP does not offer disability retirement annuities. For more information about retirement eligibility, please review the handbook for your retirement plan. Retirement handbooks are found at www.peba.sc.gov/rresources.html under Publications.

- If you are a Class Two member of SCRS who retires under the 55/25 early retirement provision, you must pay the full premium (employee and employer share) until you reach age 60 or the date you would have reached 28 years of service credit had you not retired, whichever occurs first.

Other retirees

If you are a member of the General Assembly, who leaves office or retires with at least eight years of credited service in GARS, you pay the full premium (employee and employer share).

If you are a former municipal and county council member, who served on the council for at least 12 years, and were covered under the Plan at the time of termination from the council, you pay the full premium (employee and employer share).

Eligibility requirements for employees hired on or after May 2, 2008

- Your retirement eligibility, including disability retirement eligibility, is determined by the provisions of the applicable retirement system. For participants in the State ORP, retirement eligibility is determined as if the participant were a member of SCRS. As a result, State ORP members who seek insurance coverage as a disability retiree will need disability approval from the Social Security Administration, but not from PEBA, because State ORP does not offer disability retirement annuities. For more information about retirement eligibility, please review the handbook for your retirement plan. Retirement handbooks are found at www.peba.sc.gov/rresources.html.
- If you are a Class Two member of SCRS who retires under the 55/25 early retirement provision, you must pay the full premium (employee and employer share) until you reach age 60 or the date you would have reached 28 years of service credit had you not retired, whichever occurs first.

Contact PEBA to confirm your eligibility

PEBA cannot confirm eligibility for retiree group insurance or funding of your retiree insurance premiums by telephone. If you plan to retire within 90 days, please complete and submit to PEBA a *Retiree Notice of Election* form and an

Continued on Page 166

Retirees of state agencies, higher education institutions and public school districts³ – Employees hired on or after May 2, 2008

Retirement status	Earned service credit with an employer participating in the State Health Plan ⁴	Responsibility for paying for premiums
Left employment <u>after</u> reaching retirement eligibility	5 years, but fewer than 15 years	You pay the full premium (employee and employer share)
	15 years, but fewer than 25 years	You pay the employee share of the premium and 50 percent of the employer share of the premium
	25 or more years	You pay the employee share of the premium only
Left employment <u>before</u> reaching retirement eligibility	Fewer than 20 years	Not eligible for retiree insurance coverage
	20 years, but fewer than 25 years	You pay the employee share of the premium and 50 percent of the employer share of the premium
	25 or more years	You pay the employee share of the premium only

Retirees of local subdivisions³ – Employees hired on or after May 2, 2008

Retirement status	Earned service credit with an employer participating in the State Health Plan ⁴	Responsibility for paying for premiums
Left employment <u>after</u> reaching retirement eligibility	At least 5 years	Your portion of the premium, up to the full amount of the employee and employer share, is at your employer's discretion
Left employment <u>before</u> reaching retirement eligibility	Less than 20 years	Not eligible for retiree insurance coverage
	At least 20 years	Your portion of the premium, up to the full amount of the employee and employer share, is at your employer's discretion

³Your last employer prior to retirement must be a state agency, state institution of higher education, public school district, or local subdivision. Your last five years of employment must have been served consecutively in a full-time, permanent position with an employer that participates in the State Health Plan.

⁴Earned service credit is time earned and established in one of the defined benefit pension plans PEBA administers; time worked while participating in the State ORP; or time worked for an employer that participates in the State Health Plan, but not the retirement plans PEBA administers. Earned service credit does not include any purchased service credit not considered earned service in the retirement plans.

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Employment Verification Record form. If you plan to retire in three to six months, please submit to PEBA a written request that includes your anticipated retirement date and a completed *Employment Verification Record* form. PEBA will send you written confirmation of your eligibility. PEBA does not confirm eligibility for retirement dates further out than six months.

PEBA determines whether you are eligible for retiree insurance benefits, considering the above eligibility requirements. You need to submit the necessary forms to enroll in coverage, however, because your coverage does not automatically continue when you retire.

Your retiree insurance coverage choices

If you are not eligible for Medicare

If you, your covered spouse, and your covered children are not eligible for Medicare, you may be covered under one of these plans:

- State Health Plan Standard Plan; or
- State Health Plan Savings Plan; or
- TRICARE Supplement Plan (for eligible members of the military community).

Your health insurance benefits, which are described in the **Health insurance** chapter, will be the same as if you were an active employee. Your premiums may change depending on whether you are a funded or a non-funded retiree (see eligibility requirements on Pages 162–165). Premiums are on Pages 180–186.

If you are considering the Savings Plan

If you are a retiree who is not eligible for Medicare, you may enroll in the Savings Plan, but contributions to a Health Savings Account (HSA) from your annuity payment are not deducted pretax. You may deduct your contributions to an HSA on your income tax return.

If you are age 65 or older and not eligible for Medicare

If, when you retire, you are age 65 or older and not eligible for Medicare, contact the Social

Continued on Page 168

Footnotes for summary of benefits chart on Page 165

⁵This chart is a summary of benefits. More information is available in this chapter and the **Health insurance** chapter.

⁶State Health Plan subscribers who use tobacco or cover dependents who use tobacco will pay a \$40-per-month premium for subscriber-only coverage and \$60 for other levels of coverage. See Page 187 in the Premiums chapter for more information.

⁷An out-of-network provider may bill you for more than the plan's allowed amount for services.

⁸If more than one family member is covered, no family member will receive benefits, other than preventive benefits, until the \$7,200 annual family deductible is met.

⁹The \$12 copayment is waived for routine Pap tests, routine mammograms, and well child care visits. Standard Plan subscribers who receive care at a BlueCross-affiliated PCMH provider will not be charged the \$12 copayment for a physician office visit. After Savings Plan and Standard Plan subscribers meet their deductible, they will pay 10 percent coinsurance, rather than 20 percent, for care at a Patient-Centered Medical Home. More information about Blue CareOnDemandSM is available on Page 39.

¹⁰\$95 copayment for out-patient facility services is waived for emergency room, physical therapy, speech therapy, occupational therapy, oncology, and dialysis services, routine mammograms and Pap tests, clinic visits, partial hospitalizations, intensive outpatient services, electro-convulsive therapy, and psychiatric medication management.

¹¹\$159 copayment for emergency care is waived if admitted.

¹²Prescription drugs are not covered at out-of-network pharmacies.

¹³See the MoneyPlus chapter on Page 142 for more information on these accounts, which can allow you to pay medical expenses or in some cases premiums with pretax dollars.

Health plans offered in 2017 for retirees and dependents not eligible for Medicare⁵

Plan ⁶	Savings Plan		Standard Plan	
	In-network	Out-of-network ⁷	In-network	Out-of-network ⁷
Availability	Coverage worldwide		Coverage worldwide	
Annual deductible	Single: \$3,600 Family: \$7,200 ⁸		Single: \$445 Family: \$890	
Coinsurance⁸	Plan pays 80% You pay 20%	Plan pays 60% You pay 40%	Plan pays 80% You pay 20%	Plan pays 60% You pay 40%
Coinsurance maximum	Single \$2,400 Family \$4,800 Excludes deductible	Single \$4,800 Family \$9,600 Excludes deductible	Single \$2,540 Family \$5,080 Excludes deductible and copayments	Single \$5,080 Family \$10,160 Excludes deductible and copayments
Physicians office visits and virtual visits through Blue CareOnDemand⁹	No copayment Plan pays 80% You pay 20%	No copayment Plan pays 60% You pay 40%	\$12 copayment Plan pays 80% You pay 20%	\$12 copayment Plan pays 60% You pay 40%
Hospitalization/emergency care^{10,11}	No copayments for outpatient facility services or emergency care		Outpatient facility services: \$95 copayment Emergency care: \$159 copayment Plan pays 80% You pay 20%	Outpatient facility services: \$95 copayment Emergency care: \$159 copayment Plan pays 60% You pay 40%
Chiropractic	\$500 limit per covered person		\$2,000 limit per covered person	
Prescription drugs¹²	Participating pharmacies and mail order: You pay the State Health Plan's allowed amount until your annual deductible is met. Afterward, the Plan will pay 80% of the allowed amount; you pay 20% in coinsurance. Drug costs are applied to your coinsurance maximum. When the maximum is reached, the Plan will pay 100% of the allowed amount, and you may obtain the medication at no cost.		Participating pharmacies only (up to 30-day supply) Tier 1 (generic-lowest cost alternative): \$9 Tier 2 (brand-higher cost alternative): \$38 Tier 3 (brand-highest cost alternative): \$63 Mail order and retail maintenance network pharmacies (up to 90-day supply) Tier 1: \$22 Tier 2: \$95 Tier 3: \$158 Copoly maximum: \$2,500	
Prescription drug deductible per year			No annual deductible	
Lifetime maximum	None		None	
Tax-favored medical accounts¹³	Health Savings Account Limited-use Medical Spending Account		Medical Spending Account	

Footnotes available on previous page.

Security Administration (SSA). The SSA will send you a letter of denial of Medicare coverage. Give a copy of the letter to your benefits administrator. You may enroll in health insurance as a retiree within 31 days of loss of active coverage, within 31 days of a special eligibility situation, or during an annual open enrollment period. You also may enroll your eligible family members.

If you are eligible for Medicare

If you, your covered spouse, or your covered children are eligible for Medicare, you may be covered under one of these plans:

- State Health Plan Standard Plan; or
- State Health Plan Medicare Supplemental Plan.

You and your Medicare-eligible dependents will automatically be enrolled in Express Scripts Medicare®, the State Health Plan's Medicare Part D program. For more information about the program, including how to opt out of the program, see PEBA's *Insurance Coverage for the Medicare-eligible Member handbook*, available at www.peba.sc.gov/assets/medicarehandbook.pdf.

To learn more about how health insurance offered through PEBA works with Medicare:

- Read PEBA's *Insurance Coverage for the Medicare-eligible Member handbook*; or
- Call PEBA at 803.737.6800 or 888.260.9430.

To learn more about Medicare:

- Read *Medicare and You 2017*; www.medicare.gov/pubs/pdf/10050-Medicare-and-You.pdf;
- Visit www.medicare.gov;
- Call Medicare at 800.633.4227 or

Dental benefits

If you retire from a participating employer, you can continue your State Dental Plan and Dental Plus coverage if you meet the eligibility requirements listed on Pages 162–166. Your coverage does not automatically continue when you retire. To maintain continuous coverage, you will need to complete and submit to PEBA a *Retiree Notice of Election* form and an *Employment Verification Record* form. You need to submit these forms to PEBA within 31 days of your retirement date, the date your Teacher and Employee Retention Incentive (TERI) participation ends, or the date of your approval for disability benefits.

If you do not enroll within 31 days of your date of retirement, you may enroll during the next open enrollment period in an odd-numbered year (October 2017). Coverage will be effective the following January 1. You also may enroll within 31 days of a special eligibility situation. Information about State Dental Plan and Dental Plus benefits is on Pages 93–96.

Vision care

State Vision Plan

If you retire from a participating employer, you can continue your State Vision Plan coverage if you meet the eligibility requirements listed on Pages 162–166. Your coverage does not automatically continue when you retire. To maintain continuous coverage, you will need to complete and submit to PEBA a *Retiree Notice of Election* form and an *Employment Verification Record* form. You need to submit these forms to PEBA within 31 days of your retirement date, the date your TERI participation ends, or the date of your approval for disability benefits.

If you do not enroll within 31 days of your date of retirement, you may enroll during the next open enrollment period, which occurs yearly in October. Coverage will be effective the following January 1. Information about vision care benefits is on Pages 104–110.

Vision Care Discount Program

This discount program is available at no cost to retirees, as well as to full-time and part-time employees, covered family members, survivors, and COBRA subscribers. More information about the Vision Care Discount Program is on Page 110.

When to enroll in retiree insurance coverage

Your insurance does not automatically continue when you retire. To enroll in retiree insurance, you will need to complete a *Retiree Notice of Election* form and an *Employment Verification Record* form. Please submit these forms at least 30 days before your retirement date. This will provide PEBA with enough time to process your enrollment so your insurance coverage as a retiree starts the day your coverage as an active employee ends.

Leaving covered employment at retirement

Service retirement

You may enroll in retiree insurance within 31 days of your retirement. If you do not enroll within 31 days of your retirement, you may enroll within 31 days of a special eligibility situation (defined on Pages 21-27), or during an annual open enrollment period.

Ending Teacher and Employee Retention Incentive program participation

Your benefits as an active employee continue while you participate in the TERI program in a full-time position. When your TERI participation ends, however, you need to apply for continuation of your insurance as a retiree, if you are eligible for retiree group insurance. The eligibility requirements are listed on Pages 162–166. You need to apply within 31 days of the date your employment ends to continue coverage without disruption and must submit an *Employment Verification Record* form.

Disability retirement

If you are approved for disability retirement benefits through one of the defined benefit retirement plans PEBA administers (SCRS, PORS, GARS, or JSRS), you may apply for retiree group insurance within 31 days of the date on the letter from PEBA approving your disability benefits.

If you are approved for disability by the Social Security Administration, but are not otherwise eligible for coverage as a retiree through PEBA, your coverage under PEBA cannot begin earlier than the first day of the month that occurs after your Social Security disability approval.

State ORP participants and employees of local subdivisions who do not participate in a PEBA-administered retirement plan may meet the disability retirement eligibility requirements for retiree group insurance through disability approval by the Social Security Administration. You may apply within 31 days of the date on the letter from the Social Security Administration approving your disability benefits. Your retiree insurance coverage would be effective the first of the month after you leave active

employment.

Leaving covered employment before retirement

If you leave employment with an employer that participates in the State Health Plan prior to reaching eligibility for retirement but meet one of the eligibility requirements for retiree group insurance, you may apply for retiree insurance coverage in the following situations:

- If you are an SCRS member and you kept your contributions in your SCRS account, you may enroll within 31 days of your 60th birthday, which is when you become eligible to apply for a deferred retirement annuity, within 31 days of a special eligibility situation, or during an annual open enrollment period.
- If you are a PORS member and kept your contributions in your PORS account, you may enroll within 31 days of your 55th birthday, which is when you become eligible to apply for a deferred retirement annuity, within 31 days of a special eligibility situation, or during an annual open enrollment period.

To apply, please complete and submit to PEBA a *Retiree Notice of Election* form and an *Employment Verification Record*, needed for employment covered under SCRS as well as non-SCRS employment.

Within 31 days of a special eligibility situation

A special eligibility situation is created by certain events, such as marriage, birth of a child, or loss of other insurance coverage. A special eligibility situation allows you to enroll in an insurance plan or to make enrollment changes. You have 31 days from the date of the event to enroll or

make changes. More information about special eligibility situations is on Pages 21–27. You can use PEBA's secure, online insurance benefits enrollment website, MyBenefits.sc.gov, to make changes during open enrollment, which occurs in October.

During an open enrollment period

If you, your spouse, and children do not enroll within 31 days of your retirement, within 31 days of approval for disability benefits, or within 31 days of a special eligibility situation, you may enroll during an open enrollment period, which is held in October. Dental coverage may be added or dropped only during an open enrollment period in an odd-numbered year. Your coverage will take effect the following January 1. You can use PEBA's secure, online insurance benefits enrollment website, MyBenefits.sc.gov, to make changes, but not to enroll in coverage.

How to enroll in retiree insurance coverage

To continue your insurance coverage when you retire, you need to complete and submit to PEBA a *Retiree Notice of Election* form and an *Employment Verification Record*. You can obtain these forms at www.peba.sc.gov/iforms.html, where the retiree insurance packet is found under Other forms. You may also get copies from your employer, or may contact PEBA at 803.737.6800 or 888.260.9430 for a retiree insurance enrollment packet.

In addition to asking your benefits administrator for help in completing the forms, you may also choose to meet with a PEBA representative at PEBA's office at 202 Arbor Lake Drive, Columbia. PEBA's office is open

Monday through Friday, 8:30 a.m. to 5 p.m. You will not need an appointment.

You may enroll yourself and any eligible family members. As a retiree, you do not have to cover the same eligible family members you covered as an active employee.

You may be required to submit the appropriate documents to show that the family members you wish to cover are eligible for coverage. More information about documents needed at enrollment is on Page 17.

After PEBA processes your retiree insurance enrollment, PEBA will send you a letter confirming the coverage selected and the premiums due each month. You have 31 days from the date your retiree insurance becomes effective to make any corrections or changes to your coverage. Otherwise, you will have to wait until the next open enrollment period, which occurs every year in October, or until a special eligibility situation to make changes. If you do not enroll in dental coverage within 31 days of eligibility, your next opportunity to add, drop, or change dental coverage will be during open enrollment in October of an odd-numbered year.

Retiree premiums and premium payment

State agency, higher education and school district retirees

PEBA deducts your health, TRICARE Supplement Plan, dental, and vision premiums from your monthly annuity payment.

When you retire, your insurance premiums may be due before your retirement paperwork has been finalized. If this happens, PEBA will send you a monthly bill for your insurance premiums

until you receive your first annuity payment. If you do not pay the bill, the total premiums due will be deducted from your first annuity payment.

Your annuity is paid on the last business day of each month and your insurance premiums are paid at the beginning of the month. For example, your insurance premiums for April are deducted from your March annuity payment. Depending on when your retirement paperwork is processed, more than one month's premium may be deducted from your first annuity payment. If at any time the total premiums due add up to an amount greater than the amount of your annuity payment, PEBA will bill you for the full amount.

Local subdivision retirees

You pay your health, dental, and vision premiums to your former employer. Your employer sends them to PEBA. Contact your benefits office for information about your insurance premiums in retirement.

Failure to pay premiums

Health, dental, and vision premiums are due by the 10th of each month. If you do not pay the entire bill, including the tobacco-user premium, if it applies, PEBA will cancel all of your coverage, including coverage for which you may not pay a premium, such as the State Dental Plan.

Other insurance programs PEBA offers

Life insurance

If you are eligible for retiree group insurance when you retire, you may choose to continue or convert your life insurance through Securian,

the company that underwrites PEBA's life insurance program. To do so, please complete the *Retiree Life Continuation Election* form or the *Conversion of Group Life Insurance Enrollment* form, which is available on request from Securian, as well as the PEBA Coverage

Verification Notice of Group Life Insurance form.

If you retired before January 1, 1999, and you continued your coverage, your coverage will end after 11:59 p.m. on December 31 after the date you turn 70.

These forms are available at www.peba.sc.gov/ifor.ms.html or from your benefits administrator. The continuation and conversion application period is time-sensitive. If Securian

does not receive the appropriate form(s) within 31 days of the date your coverage as an active employee ends, you will forfeit your right to continue or convert your life insurance. If you need help completing these forms, contact your benefits administrator or PEBA. If you have questions about life insurance coverage issues, such as billing or claims, call Securian at 866.365.2374.

Retiree life insurance coverage does not include Accidental Death and Dismemberment benefits.

\$3,000 Basic Life Insurance

This term life insurance, offered at no charge to you as an active employee, ends with retirement or when you leave your job for another reason. You may convert your Basic Life Insurance to an individual whole life policy, which is a permanent form of life insurance.

Dependent Life Insurance

Any Dependent Life Insurance coverage you have ends when you leave active employment. You may convert the coverage for your spouse or child to an individual whole life policy.

Optional Life Insurance

You can continue or convert your Optional Life Insurance through Securian.

You can continue your term life insurance or you can convert your life insurance coverage to a whole life policy, a permanent form of life insurance, within 31 days of the date your coverage ends. Your coverage can be continued in \$10,000 increments up to the final amount of coverage in force on the day before you left covered employment and lost active employee coverage.

Continuation

As a retiree, you may continue your Optional Life coverage at the same rates you paid while you were an employee. The minimum amount that can be continued is \$10,000. You cannot increase your coverage, but you can decrease it. Rates are based on your age and will increase when your age category changes. Your coverage will reduce to 65 percent at age 70 and then end after 11:59 p.m. on December 31 after the date you turn age 75 if you continued coverage and retired on or after January 1, 1999. When your coverage either reduces or ends, you can convert the amount of reduced or lost coverage within 31 days, as described in the Conversion section below. Continued coverage is term life insurance.

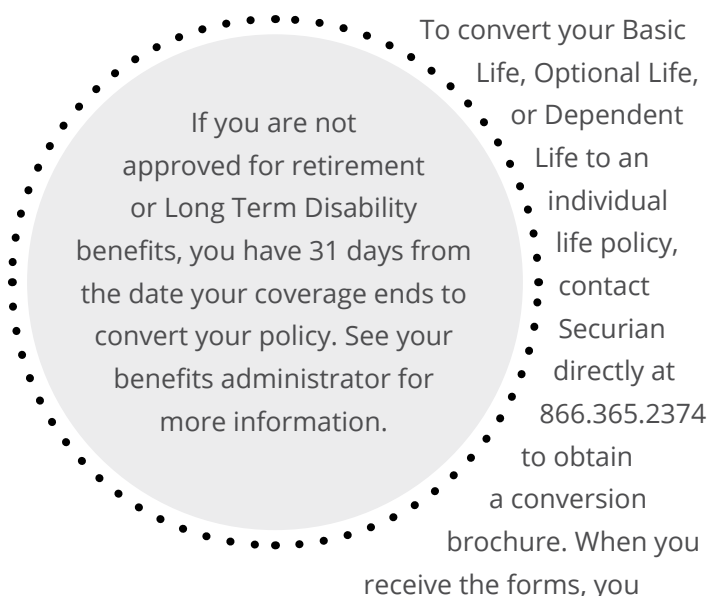
To continue your coverage, you and your benefits administrator (or a PEBA Insurance Benefits representative) need to complete the *Retiree Life Continuation Election* form and

PEBA's *Coverage Verification Notice of Group Life Insurance* form. Submit both documents to Securian at the address or fax number on the continuation form. Securian must receive your completed forms within 31 days of your loss of coverage.

Term life insurance provides coverage for a specific time period. It has no cash value.

Conversion

Within 31 days of loss of coverage, you may convert your Basic Life, Optional Life, or Dependent Life coverage to an individual whole life policy.



must complete a *Conversion of Group Life Insurance Enrollment* form and send it with PEBA's *Coverage Verification Notice of Group Life Insurance* form and the first premium within 31 days of loss of coverage, or you will forfeit your right to convert your life insurance.

Continuation and conversion

You may also split your coverage between term life insurance (continuation) and individual whole life insurance (conversion).

If you participate in the TERI program, you can

continue your benefits as an active employee, if you are eligible. When the TERI period ends, you must file for retiree benefits within 31 days, as explained above.

If you return to work as a full-time, permanent employee with a participating employer, you must choose whether to enroll in Optional Life Insurance coverage as an active employee or to continue your retiree coverage. If you refuse to enroll as an active employee, you also refuse the \$3,000 Basic Life benefit, Optional, and Dependent Life coverage. Your active group coverage will become effective only if you discontinue the retiree continuation coverage.

MoneyPlus

MoneyPlus is not available in retirement. When you retire, however, you may be able to continue your Medical Spending Account (MSA) on an after-tax basis through COBRA. See Pages 154–155 for more information. If you wish to continue your account, contact your benefits administrator within 31 days of your last day at work and fill out the appropriate forms.

If you do not wish to continue your MSA, you have 90 days from your last day at work to submit claims for eligible expenses incurred before you left employment.

You cannot continue contributing to your Dependent Care Spending Account after you retire. You can request reimbursement for eligible expenses incurred while you were employed until you exhaust your account or the plan year ends.

The Pretax Group Insurance Premium Feature, which allows you to pay health, TRICARE Supplement Plan, dental, vision, and some life insurance premiums before taxes, is not available in retirement.

Long term disability

Disability insurance protects an employee and their family from loss of income due to an injury or an extended illness that prevents the employee from working. When you leave active employment and retire, your Basic Long Term Disability and Supplemental Long Term Disability insurance both end. Neither policy may be continued or converted to individual coverage.

When your coverage as a retiree begins

Your retiree coverage will begin the day after your active coverage ends. If you are enrolling due to a special eligibility situation, your effective date will be either the date of the event or the first of the month after the event, depending on the type of event. More information about special eligibility situations is on Pages 21–27. If you enroll during an annual open enrollment period, your coverage will be effective the following January 1.

Your benefits administrator helps you enroll in or change your insurance coverage. If you worked for a state agency, higher education institution, or school district, PEBA is your benefits administrator after you retire. If you worked for a local subdivision, your benefits administrator is your former employer after you retire.

Information you will receive

After you enroll, PEBA will send you a letter confirming you have retiree group insurance coverage. Because your coverage as an active employee is ending, federal law requires that PEBA also send you:

- A *Certificate of Creditable Coverage*, which

gives the dates of your active coverage, the names of the individuals covered, and the types of coverage; and

- A Qualifying Event Notice, which tells you that you may continue your coverage under COBRA.

Typically, these letters require no action on your part.

If you are eligible for Medicare, you will be automatically enrolled in Express Scripts Medicare, the State Health Plan's Medicare Part D prescription drug program. Express Scripts, the State Health Plan's pharmacy benefits manager, will send you an information packet that includes a letter telling you that you can opt out of the Medicare drug program and remain enrolled in the State Health Plan drug program for members who are not eligible for Medicare. The pharmacy benefits manager is required to give you 21 days to opt out.

Your insurance identification cards in retirement

You may keep and use your same insurance identification cards if you do not change plans when you retire. Your Benefits Identification Number will not change, and your health and dental cards will still be valid. You will receive a new card if you enroll in a dental plan or the State Vision Plan for the first time.

If you or your covered dependents enroll in Express Scripts Medicare, each member will receive one prescription drug card issued in his own name. Covered family members who are not enrolled in the Medicare drug program will receive cards showing they are enrolled in the "State Health Plan Prescription Drug Program." Two cards are issued in the subscriber's name.

If your card is lost, stolen, or damaged, you may request a new card from these vendors:

- State Health Plan: BlueCross BlueShield of South Carolina
- State Health Plan prescription drug program: Express Scripts
- TRICARE Supplement Plan: Selman & Company
- Dental Plus: BlueCross BlueShield of South Carolina
- State Vision Plan: EyeMed

Contact information is available at the end of this guide.

Changing coverage

An open enrollment period is held every October. Eligible employees, retirees, survivors, and COBRA subscribers may enroll in or drop their own health coverage and add or drop their eligible spouse and children without regard to special eligibility situations. Eligible subscribers also may change health plans. This includes changing to or from the Medicare Supplemental Plan if the subscriber is retired and enrolled in Medicare. Eligible members of the military community may change to or from the TRICARE Supplement Plan if they are not eligible for Medicare. Eligible subscribers also can enroll in the State Vision Plan. During open enrollment periods held in odd-numbered years, eligible subscribers may add or drop the State Dental Plan and Dental Plus.

More information about open enrollment is found on Page 20 in the General Information chapter.

Dropping a covered spouse or child

If a covered spouse or child becomes ineligible,

you need to drop him from your health, dental, vision, and life coverage. This may occur because of divorce or separation, a covered dependent gains coverage under the State Health Plan, or a child turns 26. To drop a spouse or child from your coverage, complete and submit to PEBA a *Retiree Notice of Election* form and provide documentation within 31 days of the date your spouse or child becomes ineligible.

When your child becomes ineligible for coverage because of age, PEBA will automatically drop them from coverage. If they are your last covered child, your level of coverage will change.

Returning to work in a benefits-eligible job

If you return to work for a participating employer and are eligible for enrollment in the State Health Plan, and you, your spouse, or your children are covered under retiree group insurance, you will need to make decisions about your coverage.

If you or any of your covered family members are not eligible for Medicare, you can decide whether to return to coverage under active group employee benefits or to continue your retiree group benefits. You cannot be covered under both.

If you leave work and return to retiree group coverage before age 65, be sure to contact the SSA within 60 days of turning 65 to enroll in Medicare Part A and Part B when you become eligible.

If you or any of your covered family members are eligible for Medicare, you cannot remain on retiree group coverage while employed.

All employees who are eligible for enrollment in the State Health Plan (the Savings Plan and the Standard Plan), are also eligible for these programs:

- State Dental Plan and Dental Plus;
- State Vision Plan;
- Basic, Optional, and Dependent Life insurance (with the exception of part-time teachers eligible for the State Health Plan according to S.C. Code § 59-25-45);
- Basic and Supplemental Long Term Disability insurance (with the exception of part-time teachers eligible for the State Health Plan according to S.C. Code § 59-25-45);
- MoneyPlus Pretax Group Insurance Premium Feature;
- MoneyPlus Medical Spending Account, Limited-use Medical Spending Account, and Dependent Care Account; and
- Health Savings Account (for employees enrolled in the Savings Plan).

If no one in your family, including yourself, is eligible for Medicare and you prefer to continue your retiree group insurance benefits, you must complete and sign an *Active Group Benefits Refusal* form, found at <http://www.peba.sc.gov/iforms.html> under Notice of Election.

Retirees who continued life insurance

Retirees hired in a benefits-eligible job

If you continued your Optional Life coverage as a retiree, you may keep the policy if you decide to continue your retiree group benefits. You must cancel the policy, however, if you choose active benefits. You may then enroll in Optional Life as an active employee. Contact Securian

within 31 days of returning to work to cancel your continued coverage if you decide to enroll in active coverage.

If you are considered a new hire, see the **Life Insurance** chapter, which begins on Page 112.

If you or a member of your family is covered by Medicare

Medicare cannot be the primary insurance for you or any of your covered family members while you are employed in a benefits-eligible job, according to federal law. To comply with this regulation, you are required to suspend your retiree group coverage and enroll as an active employee with Medicare as the secondary payer, or refuse all PEBA-sponsored health coverage for yourself and your eligible family members and have Medicare coverage only.

If you enroll in active group coverage, you must notify the SSA because Medicare will pay after or secondary to your active group coverage. You may remain enrolled in Medicare Part B and continue paying the premium, and Medicare will be the secondary payer. You may also delay or drop Medicare Part B without a penalty while you have active group coverage. Contact the SSA for additional information.

When you stop working and your active group coverage ends, you may re-enroll in retiree group coverage within 31 days of the date you leave active employment. You must also notify the SSA that you are no longer covered under an active group so that you can re-enroll in Medicare Part B, if you dropped it earlier.

If your new position does not make you eligible for benefits, your retiree group coverage continues and Medicare remains the primary payer.

When your retiree insurance coverage ends

Your coverage will end:

- If you do not pay the required premium when it is due.
- The date it ends for all employees and retirees.
- The day after your death.

Coverage of your family members will end:

- The date your coverage ends.
- The date coverage for spouses or children is no longer offered.
- The last day of the month your spouse or child is no longer eligible for coverage. If your spouse or child's coverage ends, they may be eligible for continuation of coverage under COBRA (see Pages 29–31).

If you are dropping a spouse or child from your coverage, you must complete a *Retiree Notice of Election* form within 31 days of the date the spouse or child is no longer eligible for coverage.

Death of a retiree

If a retiree dies, a surviving family member should contact PEBA to report the death and end the retiree's insurance coverage. If the deceased retired from employment with a local subdivision, contact the benefits administrator who works in the personnel office of his former employer.

Survivors of a retiree

Spouses or children who are covered as dependents under the State Health Plan, State Dental Plan, or the State Vision Plan are classified as survivors when a covered

employee or retiree dies. Survivors of funded retirees of a state agency, a higher education institution, or a school district may be eligible for a one-year waiver of health insurance premiums. Survivors of non-funded retirees may continue their coverage; however, they must pay the full premium.

Participating local subdivisions are not required to but may waive the premiums of survivors of retirees. A survivor may continue coverage at the full rate for as long as they are eligible. If you are a retiree of a participating local subdivision, check with your benefits administrator to see whether the waiver applies.

To continue coverage, a *Survivor Notice of Election* form must be completed within 31 days of the subscriber's date of death. A new Benefits Identification Number will be created, and new identification cards will be issued by vendors for the programs in which the survivors are enrolled.

After the first year, a survivor who qualifies for the waiver must pay the full premium to continue coverage. At the end of the waiver, health coverage can be canceled or continued for all covered family members. If coverage is continued, no covered family members can be dropped until an annual open enrollment period or within 31 days of a special eligibility situation.

If you and your spouse are both covered as subscribers through employment, or are funded retirees at the time of death, your surviving spouse is not eligible for the premium waiver.

Vision premiums are not waived. Dental premiums are not typically waived; dental premiums are only waived for survivors of an

active or retired employee who was killed in the line of duty after December 31, 2001, while working for a state agency or public school district. However, survivors, including survivors of a subscriber enrolled in the TRICARE Supplement Plan, dental, or vision coverage, can continue coverage by paying the full premium.

As a surviving spouse, you can continue coverage until you remarry. If you are a child, you can continue coverage until you are no longer eligible. If you are no longer eligible for coverage as a survivor, you may be eligible to continue coverage under COBRA. If your spouse retired from a state agency, a higher education institution, or a school district, contact PEBA for more information. If your spouse retired from a local subdivision, contact the personnel office at the local subdivision to speak with the benefits administrator.

A surviving spouse or child of a military retiree should contact Selman & Company about TRICARE coverage.

As long as a survivor remains covered by health, dental, or vision insurance, they can add health and vision coverage at open enrollment or within 31 days of a special eligibility situation. Dental coverage can be added or dropped but only during an open enrollment period in an odd-numbered year or within 31 days of a special eligibility situation. If a survivor has health, dental, and vision coverage, and drops all three, they are no longer eligible for survivor coverage and cannot re-enroll, not even during an annual open enrollment period.

If a surviving spouse becomes an active employee of a participating employer, they can switch to active coverage. When the surviving spouse leaves active employment, they can go back to survivor coverage within 31 days of

the date their coverage ends if they have not remarried.

Until you become eligible for Medicare, your health insurance pays claims the same way it did when you were an active employee. For more information, see the **Health Insurance** chapter and the chart on Page 167.



Premiums

2017 monthly premiums for active employees^{1,2}

	Employee	Employee/spouse	Employee/children	Full family
Savings Plan	\$9.70	\$77.40	\$20.48	\$113.00
Standard Plan	\$97.68	\$253.36	\$143.86	\$306.56
TRICARE Supplement	\$62.50	\$121.50	\$121.50	\$162.50
Dental	\$0.00	\$7.64	\$13.72	\$21.34
Dental Plus³	\$25.96	\$52.46	\$60.50	\$78.60
Vision	\$7.00	\$14.00	\$14.98	\$21.98

2017 monthly premiums for funded retirees^{1,2}

Retiree eligible for Medicare/spouse eligible for Medicare

	Retiree	Retiree/spouse	Retiree/children	Full family
Savings Plan	N/A	N/A	N/A	N/A
Standard Plan	\$79.68	\$217.36	\$125.86	\$270.56
Medicare Supplement⁴	\$97.68	\$253.36	\$143.86	\$306.56
TRICARE Supplement	N/A	N/A	N/A	N/A
Dental	\$0.00	\$7.64	\$13.72	\$21.34
Dental Plus³	\$25.96	\$52.46	\$60.50	\$78.60
Vision	\$7.00	\$14.00	\$14.98	\$21.98

Retiree eligible for Medicare/spouse not eligible for Medicare

	Retiree/spouse	Full family
Savings Plan	N/A	N/A
Standard Plan	\$235.36	\$281.54
Medicare Supplement⁴	\$253.36	\$299.54
TRICARE Supplement	N/A	N/A
Dental	\$7.64	\$21.34
Dental Plus³	\$52.46	\$78.60
Vision	\$14.00	\$21.98

Retiree not eligible for Medicare/spouse eligible for Medicare

	Retiree/spouse	Full family
Savings Plan	\$77.40	\$113.00
Standard Plan	\$235.36	\$281.54
Medicare Supplement⁴	\$253.36	\$299.54
TRICARE Supplement	N/A	N/A
Dental	\$7.64	\$21.34
Dental Plus³	\$52.46	\$78.60
Vision	\$14.00	\$21.98

Footnotes listed on Page 186

Retiree not eligible for Medicare/spouse not eligible for Medicare

	Retiree	Retiree/spouse	Retiree/children	Full family
Savings Plan	\$9.70	\$77.40	\$20.48	\$113.00
Standard Plan	\$97.68	\$253.36	\$143.86	\$306.56
Medicare Supplement⁴	N/A	N/A	N/A	N/A
TRICARE Supplement	\$62.50	\$121.50	\$121.50	\$162.50
Dental	\$0.00	\$7.64	\$13.72	\$21.34
Dental Plus³	\$25.96	\$52.46	\$60.50	\$78.60
Vision	\$7.00	\$14.00	\$14.98	\$21.98

Retiree not eligible for Medicare/spouse not eligible for Medicare/one or more children eligible for Medicare

	Retiree/children	Full family
Savings Plan	\$20.48	\$113.00
Standard Plan	\$143.86	\$306.56
Medicare Supplement⁴	\$161.86	\$324.56
TRICARE Supplement	N/A	N/A
Dental	\$13.72	\$21.34
Dental Plus³	\$60.50	\$78.60
Vision	\$14.98	\$21.98

2017 monthly premiums for non-funded retirees^{1,2}

Retiree eligible for Medicare/spouse eligible for Medicare

	Retiree	Retiree/spouse	Retiree/children	Full family
Savings Plan	N/A	N/A	N/A	N/A
Standard Plan	\$442.66	\$936.34	\$682.96	\$1,170.74
Medicare Supplement⁴	\$460.66	\$972.34	\$700.96	\$1,206.74
TRICARE Supplement	N/A	N/A	N/A	N/A
Dental	\$13.48	\$21.12	\$27.20	\$34.82
Dental Plus³	\$25.96	\$52.46	\$60.50	\$78.60
Vision	\$7.00	\$14.00	\$14.98	\$21.98

Footnotes listed on Page 186

Retiree eligible for Medicare/spouse not eligible for Medicare

	Retiree/spouse	Full family
Savings Plan	N/A	N/A
Standard Plan	\$954.34	\$1,181.72
Medicare Supplement⁴	\$972.34	\$1,199.72
TRICARE Supplement	N/A	N/A
Dental	\$21.12	\$34.82
Dental Plus³	\$52.46	\$78.60
Vision	\$14.00	\$21.98

Retiree not eligible for Medicare/spouse eligible for Medicare

	Retiree/spouse	Full family
Savings Plan	\$796.38	\$1,013.18
Standard Plan	\$954.34	\$1,181.72
Medicare Supplement⁴	\$972.34	\$1,199.72
TRICARE Supplement	N/A	N/A
Dental	\$21.12	\$34.82
Dental Plus³	\$52.46	\$78.60
Vision	\$14.00	\$21.98

Retiree not eligible for Medicare/spouse not eligible for Medicare

	Retiree	Retiree/spouse	Retiree/children	Full family
Savings Plan	\$372.68	\$796.38	\$577.58	\$1,013.18
Standard Plan	\$460.66	\$972.34	\$700.96	\$1,206.74
Medicare Supplement⁴	N/A	N/A	N/A	N/A
TRICARE Supplement	\$62.50	\$121.50	\$121.50	\$162.50
Dental	\$13.48	\$21.12	\$27.20	\$34.82
Dental Plus³	\$25.96	\$52.46	\$60.50	\$78.60
Vision	\$7.00	\$14.00	\$14.98	\$21.98

Retiree not eligible for Medicare/spouse not eligible for Medicare/one or more children eligible for Medicare

	Retiree/children	Full family
Savings Plan	\$577.58	\$1,013.18
Standard Plan	\$700.96	\$1,206.74
Medicare Supplement⁴	\$718.96	\$1,224.74
TRICARE Supplement	N/A	N/A
Dental	\$27.20	\$34.82
Dental Plus³	\$60.50	\$78.60
Vision	\$14.98	\$21.98

Footnotes listed on Page 186

2017 monthly premiums for non-funded survivors^{1,2}

Spouse eligible for Medicare/children eligible for Medicare

	Spouse	Spouse/children	Children only
Savings Plan	N/A	N/A	N/A
Standard Plan	\$442.66	\$682.96	\$240.30
Medicare Supplement⁴	\$460.66	\$718.96	\$258.30 ⁵
TRICARE Supplement	N/A	N/A	N/A
Dental	\$13.48	\$27.20	\$13.72
Dental Plus³	\$25.96	\$60.50	\$34.54
Vision	\$7.00	\$14.98	\$7.98

Spouse eligible for Medicare/children not eligible for Medicare

	Spouse	Spouse/children	Children only
Savings Plan	N/A	N/A	\$204.90
Standard Plan	\$442.66	\$682.96	\$240.30
Medicare Supplement⁴	\$460.66	\$700.96	N/A
TRICARE Supplement	N/A	N/A	N/A
Dental	\$13.48	\$27.20	\$13.72
Dental Plus³	\$25.96	\$60.50	\$34.54
Vision	\$7.00	\$14.98	\$7.98

Spouse not eligible for Medicare/children eligible for Medicare

	Spouse	Spouse/children	Children only
Savings Plan	\$372.68	\$577.58	N/A
Standard Plan	\$460.66	\$700.96	\$240.30
Medicare Supplement⁴	N/A	\$718.96 ⁸	\$258.30 ⁵
TRICARE Supplement	N/A	N/A	N/A
Dental	\$13.48	\$27.20	\$13.72
Dental Plus³	\$25.96	\$60.50	\$34.54
Vision	\$7.00	\$14.98	\$7.98

Spouse not eligible for Medicare/children not eligible for Medicare

	Spouse	Spouse/children	Children only
Savings Plan	\$372.68	\$577.58	\$204.90
Standard Plan	\$460.66	\$700.96	\$240.30
Medicare Supplement⁴	N/A	N/A	N/A
TRICARE Supplement	\$62.50	\$121.50	\$61.00
Dental	\$13.48	\$27.20	\$13.72
Dental Plus³	\$25.96	\$60.50	\$34.54
Vision	\$7.00	\$14.98	\$7.98

Footnotes listed on Page 186

2017 monthly premiums for COBRA^{1,2}

18 and 36 months

	Subscriber	Subscriber/ spouse	Subscriber/ children	Full family	Children only
Savings Plan	\$380.14	\$812.32	\$589.14	\$1,033.44	\$209.00
Standard Plan	\$469.88	\$991.80	\$714.98	\$1,230.88	\$245.10
Medicare Supplement⁴	\$469.88	\$991.80	\$714.98	\$1,230.88	\$245.10
Dental	\$13.76	\$21.54	\$27.74	\$35.52	\$14.00
Dental Plus³	\$26.48	\$53.52	\$61.72	\$80.18	\$35.24
Vision	\$7.14	\$14.28	\$15.28	\$22.42	\$8.14

29 months

	Subscriber	Subscriber/ spouse	Subscriber/ children	Full family	Children only
Savings Plan	\$559.02	\$1,194.58	\$866.38	\$1,519.78	\$307.36
Standard Plan	\$691.00	\$1,458.52	\$1,051.44	\$1,810.12	\$360.44
Medicare Supplement⁴	\$691.00	\$1,458.52	\$1,051.44	\$1,810.12	\$360.44
Dental	\$13.76	\$21.54	\$27.74	\$35.52	\$14.00
Dental Plus³	\$26.48	\$53.52	\$61.72	\$80.18	\$35.24
Vision	\$7.14	\$14.28	\$15.28	\$22.42	\$8.14

2017 monthly premiums for permanent, part-time teachers²

Category I: 15-19 hours

	Employee	Employee/spouse	Employee/children	Full family
Savings Plan	\$191.18	\$436.88	\$299.02	\$563.08
Standard Plan	\$279.16	\$612.84	\$422.40	\$756.64
TRICARE Supplement	\$62.50	\$121.50	\$121.50	\$162.50
Dental	\$6.74	\$14.38	\$20.46	\$28.08
Dental Plus³	\$25.96	\$52.46	\$60.50	\$78.60
Vision	\$7.00	\$14.00	\$14.98	\$21.98

Footnotes listed on Page 186

Category II: 20-24 hours

	Employee	Employee/spouse	Employee/children	Full family
Savings Plan	\$129.48	\$314.66	\$204.32	\$410.06
Standard Plan	\$217.46	\$490.62	\$327.70	\$603.62
TRICARE Supplement	\$62.50	\$121.50	\$121.50	\$162.50
Dental	\$4.44	\$12.08	\$18.16	\$25.78
Dental Plus³	\$25.96	\$52.46	\$60.50	\$78.60
Vision	\$7.00	\$14.00	\$14.98	\$21.98

Category III: 25-29 hours

	Employee	Employee/spouse	Employee/children	Full family
Savings Plan	\$71.40	\$199.62	\$115.18	\$266.02
Standard Plan	\$159.38	\$375.58	\$238.56	\$459.58
TRICARE Supplement	\$62.50	\$121.50	\$121.50	\$162.50
Dental	\$2.30	\$9.94	\$16.02	\$23.64
Dental Plus³	\$25.96	\$52.46	\$60.50	\$78.60
Vision	\$7.00	\$14.00	\$14.98	\$21.98

2017 monthly life insurance premiums and sample rate calculations

Optional Term Life and AD&D, Dependent Life - Spouse and AD&D

Rates shown per \$10,000 of coverage

Age	Monthly rate
Under 35	\$0.52
35-39	\$0.68
40-44	\$0.76
45-49	\$1.08
50-54	\$1.70
55-59	\$2.96
60-64	\$5.48
65-69	\$11.60
70-74	\$20.02
75-79	\$32.56
80 and over	\$54.42

Employee, age 44, with \$100,000 in coverage	
Coverage amount	\$100,000
	÷ \$10,000
Coverage units	= 10
Monthly rate	× \$0.76
Monthly cost	= \$7.60
Employee, age 70, with \$100,000 in original coverage election	
Original coverage amount	\$100,000
Reduction	× 65%
Reduced coverage amount	\$65,000
	÷ \$10,000
Coverage units	= 6.5
Monthly rate	× \$20.02
Monthly cost	\$130.13

Dependent Life - Child

\$1.10 per month for \$15,000 of coverage; one premium provides coverage for all eligible children.

Footnotes listed on Page 186

2017 monthly employer contributions¹

Active employees

	Employee	Employee/spouse	Employee/children	Full family
Health	\$362.98	\$718.98	\$557.10	\$900.18
Dental	\$13.48	\$13.48	\$13.48	\$13.48
Life	\$0.28	\$0.28	\$0.28	\$0.28
Long term disability	\$3.22	\$3.22	\$3.22	\$3.22

Permanent, part-time teachers (Category I: 15-19 hours)

	Employee	Employee/spouse	Employee/children	Full family
Health	\$181.50	\$359.50	\$278.56	\$450.10
Dental	\$6.74	\$6.74	\$6.74	\$6.74

Permanent, part-time teachers (Category II: 20-24 hours)

	Employee	Employee/spouse	Employee/children	Full family
Health	\$243.20	\$481.72	\$373.26	\$603.12
Dental	\$9.04	\$9.04	\$9.04	\$9.04

Permanent, part-time teachers (Category III: 25-29 hours)

	Employee	Employee/spouse	Employee/children	Full family
Health	\$301.28	\$596.76	\$462.40	\$747.16
Dental	\$11.18	\$11.18	\$11.18	\$11.18

Footnotes for comparison and premium charts on Pages 180-186:

¹Premiums for local subdivisions may vary. To verify your rates, contact your benefits office.

²State Health Plan subscribers who use tobacco or cover dependents who use tobacco will pay a \$40-per-month premium for subscriber-only coverage. The premium is \$60 for other levels of coverage. The tobacco-use premium does not apply to TRICARE Supplement subscribers.

³If you enroll in Dental Plus, you must also be enrolled in the State Dental Plan. You will pay the combined premiums for both plans.

⁴If the Medicare Supplemental Plan is elected, claims for covered subscribers not eligible for Medicare will be based on the Standard Plan provisions.

⁵This premium applies only if one or more children are eligible for Medicare.

Tobacco-use premium

If you are a State Health Plan subscriber with single coverage and you use tobacco, you will pay an additional \$40 monthly premium. If you have subscriber/spouse, subscriber/children or full-family coverage and you or anyone you cover uses tobacco, the additional premium will be \$60 monthly.

The premium is automatic for all State Health Plan subscribers unless the subscriber certifies no one he covers uses tobacco or covered individuals who use tobacco have completed the Quit for Life® smoking cessation program. For information about Quit for Life, see Page 59.

To certify no one covered by his health insurance uses tobacco and no one has used it during the past six months, or all covered individuals who use tobacco have completed the smoking cessation program, the subscriber must complete a *Certification Regarding Tobacco Use* form. If you have not certified or need to change your certification, go to www.peba.sc.gov/iforms.html to find the form under Health insurance. Give the completed form to your benefits administrator who will send it to PEBA. The certification will be effective the first of the month after PEBA receives the form.

Subscribers need to pay all premiums, including the tobacco-use premium, if it applies, when they are due. If premiums are not paid, coverage for all plans will be canceled effective the last day of the month in which the premiums were paid in full.



Appendix

Terms to know

Here are definitions of some terms used in the *Insurance Benefits Guide*. For more information, refer to the pages listed or contact your benefits administrator.

Allowed amount The most a plan allows paying a provider for a covered service, procedure or supply.

Authorized representative An individual with whom a health plan has permission to discuss a covered person's Protected Health Information. An authorized representative can be named by completing an *Authorized Representative Form*, which is available on PEBA's website, www.peba.sc.gov, under "HIPAA."

Balance bill The difference between what a health plan pays for a service and the provider's actual charge. State Health Plan network providers may not balance bill members. See also Out-of-network differential.

Change in status An event, such as marriage, divorce or birth of a child that makes it possible to change a Medical Spending Account or a Dependent Care Spending Account. For more information, see Pages 22–25.

Coinsurance A percentage of the cost of health care a member pays after his deductible has been met. Under the State Health Plan, the coinsurance rate is different for network services, services at a BlueCross BlueShield of South Carolina-affiliated Patient-Centered Medical Home, out-of-network services, infertility treatment and fertility drugs.

Coinsurance maximum The amount of coinsurance a member is required to pay each year before he is no longer required to pay coinsurance.

Coordination of benefits A system to determine how claims are handled when a person is covered under more than one insurance plan. For information about how health claims are coordinated, see Pages 44–45. For information about how dental claims are coordinated, see Page 101.

Copayment A fixed amount a subscriber must pay for a drug or service. Savings Plan members do not pay copayments. Standard Plan members pay prescription drug copayments and copayments for office visits, emergency care and outpatient facility services. For more information, see Pages 40–41.

Coverage review A blanket term for the different types of processes the State Health Plan uses to ensure the safe and effective use of prescription drugs and to encourage the use of lower-cost alternatives when possible.

Deductible Generally, the amount a member must pay yearly for covered health care before the plan begins to pay a portion of the cost of his care. The deductible may not apply to all services.

Drug quantity management A type of coverage review the State Health Plan uses to make sure prescriptions are filled at levels the U.S. Food and Drug Administration considers safe.

Exclusion A condition for which, or a circumstance under which, an insurance plan will not pay benefits.

Formulary A pharmacy network's list of preferred drugs, including new drugs and generics. Physicians and pharmacists continually review and compare the medications on a pharmacy networks formulary. As a result, some safe and effective drugs become "preferred" and others may

become “non-preferred.” The formulary guides the copayment you make for a prescription drug.

Individual whole life insurance A permanent form of life insurance.

Local subdivision A local subdivision is any participating group other than a state agency, a higher education institution or a public school district. Examples include: counties, municipalities, councils on aging, commissions on alcohol and other drug abuse, special purpose districts, community action agencies, disabilities and special needs boards, recreation districts, hospital districts and councils of government. The General Assembly passed legislation extending voluntary participation in the state insurance program to certain local subdivisions. For a local subdivision to be eligible to participate in the state insurance program, it must fall within one of the categories established by statute (Section 1-11-720 of the S.C. Code of Laws, as amended).

Member A person covered by a health, dental or vision plan.

National Preferred Formulary The standard formulary, or list of preferred medications, used by Express Scripts, the State Health Plan’s pharmacy benefits manager. Preferred medications are those determined to be safe and effective but may cost less than alternatives.

Network A group of providers, facilities or suppliers under contract to provide care for people covered by a health, dental or vision plan.

Out-of-network differential A State Health Plan member pays 40 percent coinsurance, rather than 20 percent, when he uses a provider that is not in the network. For more

information, see Page 49.

Outpatient facility services Services provided in a hospital for patients who do not stay overnight or services provided in a freestanding medical center.

Pay-the-difference policy If a member buys a brand-name drug when a generic drug is available, he will be charged the generic copayment plus the difference between the allowed amounts for the generic drug and the brand-name drug. Only the copayment for the generic drug will apply toward his prescription drug copayment maximum. For more information and charts illustrating the policy, see Pages 68-69.

Please note: The pay-the-difference policy does not apply to Express Scripts Medicare®, the State Health Plan’s Medicare Part D program.

Plan of Benefits A document establishing eligibility requirements and benefits offered to individuals covered by the State Health Plan.

Preauthorization To require preauthorization is to require that a member get permission from the plan before he receives a particular service, supply or piece of equipment. For example, Medi-Call preauthorizes some services for State Health Plan members. The term prior authorization is used by the State Health Plan pharmacy benefits program.

Prior authorization A type of coverage review that may be needed when a medication is prescribed for which there is an effective and safe, lower-cost alternative.

Premium The amount a covered person pays for insurance coverage.

Qualifying event A change in a person’s life, such a reduction in working hours, job loss or loss of eligibility for insurance coverage,

that makes him eligible to enroll in continued coverage provided under COBRA.

Special eligibility situation An event that allows an eligible employee, retiree, survivor or COBRA subscriber to enroll in or drop coverage for himself and/or for eligible family members outside an open enrollment period. The coverage change must be made within 31 days of the event.

Step therapy A type of coverage review the State Health Plan uses to encourage use of low-cost prescription drugs of equal effectiveness and safety before trying more expensive alternatives.

Subrogation A claim is subrogated when someone else is responsible for a member's injury. To the extent provided by South Carolina law, health plans offered through PEBA have the right to recover payment in full for benefits provided to a covered person under the terms of the plan when the injury or illness occurs through the act or omission of another person, firm, corporation or organization. If a covered person receives payment for such medical expenses from another who caused the injury or illness, the covered person agrees to reimburse the plan in full for any medical expenses paid by the plan.

Subscriber An individual, such as an employee or a retiree, who is covered by an insurance plan. Because the individual is eligible and covered, members of his family also may be eligible to enroll in the plan.

Term life insurance Life insurance coverage that is provided for a specific period of time. It has no cash value. All life insurance offered through PEBA is term life.

Third-party claims processor (claims processor) A company, such as BlueCross

BlueShield of South Carolina, that is under contract to PEBA to process claims for members.

Vendor A company under contract to PEBA.



Contact information

S.C. PEBA

202 Arbor Lake Drive | Columbia, SC 29223
8:30 a.m.-5 p.m., Monday-Friday

- Customer Contact Center: 803.737.6800 or 888.260.9430
- Retiree billing: 803.734.1696
- www.peba.sc.gov

2017 insurance vendors

BlueCross BlueShield of South Carolina State Health Plan Standard Plan, Savings Plan, Medicare Supplemental Plan

P.O. Box 100605 | Columbia, SC 29260-0605

- Customer Service: 803.736.1576 or 800.868.2520
- BlueCard Program: 800.810.BLUE (2583)
- StateSC.SouthCarolinaBlues.com

Medi-Call (medical preauthorization)

AX-650 | I-20 at Alpine Road
Columbia, SC 29219

- 803.699.3337 or 800.925.9724
- Fax: 803.264.0183

Companion Benefit Alternatives (behavioral health)

P.O. Box 100185, AX-315 | Columbia, SC 29202

- Mental health and substance abuse
Customer Service: 803.736.1576 or 800.868.2520
- Mental health precertification/case management: 800.868.1032
- Mental health fax: 803.714.6456
- Tobacco cessation: 866.784.8454
- www.CompanionBenefitAlternatives.com

Health/wellness management

- 855.838.5897, option 2
- Fax: 803.264.4204

National Imaging Associates (advanced radiology preauthorization)

- 866.500.7664
- www.RadMD.com

State Dental Plan, Dental Plus

P.O. Box 100300 | Columbia, SC 29202-3300

- Customer Service: 888.214.6230 or 803.264.7323
- Fax: 803.264.7739
- StateSC.SouthCarolinaBlues.com

Express Scripts

State Health Plan Prescription Drug Program, Express Scripts Medicare®

Claims:

Attn: Commercial Claims

P.O. Box 2872 | Clinton, IA 52733-2872

Medicare members:

Attn: Medicare Part D

P.O. 14718 | Lexington, KY 40512-4718

- Prescription Drug Program Customer Service: 855.612.3128
- Express Scripts Medicare®: 855.612.3128
- www.Express-Scripts.com

EyeMed

State Vision Plan (Group No.: 9925991)

Claims:

OON Claims

P.O. Box 8504 | Mason, OH 45040-7111

- Customer Care Center: 877.735.9314
- www.EyeMed.com

Securian

**Basic Life, Optional Life, Dependent Life
(Policy No.: 34407)**

Group Administration Department
400 Robert Street North | St. Paul, MN 55101

- **Customer Service:** 866.486.5298
- **Evidence of insurability:** 800.872.2214
- **Claims:** 888.658.0193
- **Continuation or conversion:** 866.365.2374
- **Fax:** 651.665.4827

Selman & Company

GEA TRICARE Supplement Plan

6110 Parkland Boulevard | Cleveland, OH 44124

- **Customer Service:** 866.637.9911, option 1
- **Claims fax:** 800.310.5514
- www.selmantricareresource.com/SC

The Standard Insurance Company

Long Term Disability (Group No.: 621144)

P.O. Box 2800 | Portland, OR 97208-2800

- **Customer Service:** 800.628.9696
- **Fax:** 800.437.0961
- **Medical evidence of good health:**
800.843.7979
- www.standard.com/mybenefits/southcarolina

WageWorks

MoneyPlus

P.O. Box 14766 | Lexington, KY 40512-4766

- **Customer Care Center:** 800.342.8017
- **Automated information:** 800.865.3262
- **Claims fax:** 888.800.5217
- www.myFBMC.com

Other helpful contacts

Medicare

- 800.633.4227
- TTY: 877.486.2048
- www.medicare.gov

Social Security Administration

- 800.772.1213
- TTY: 800.325.0778
- www.socialsecurity.gov



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Making decisions about your benefits can be complicated and difficult. You have to think about how much coverage you will need and how much you will end up paying, all while learning new concepts.

This is why PEBA has created *Navigating Your Benefits*, a multimedia campaign to give you common-language explanations on unfamiliar benefits concepts to help you with the world of insurance and retirement benefits.

Start finding your way by visiting www.peba.sc.gov/nyb.html.

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