

When You Become Eligible for Medicare



MIDDLETON PLACE, *Charleston*



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Introduction

This handbook is for participants in a state health insurance plan and their covered family members who are eligible for Medicare or who soon will be. It provides information about how the Medicare Supplemental Plan and the Standard Plan, health insurance offered through PEBA Insurance Benefits, work with Medicare. For more information about your health plan, refer to the Health Insurance chapter in your 2015 *Insurance Benefits Guide* (IBG), which is available on the PEBA Insurance Benefits website, www.eip.sc.gov, from your benefits administrator or from PEBA Insurance Benefits. You may also contact BlueCross BlueShield of South Carolina. Contact information is on the inside cover of this guide.

Please note: Catamaran is the pharmacy benefits manager for the State Health Plan (SHP). The SHP includes the Medicare Supplemental Plan, the Standard Plan and the Savings Plan. Call Catamaran at 855-901-PEBA (7322) for information about prescription drug coverage, including the SHP Medicare Prescription Drug Program.

The Retirement/Disability Retirement chapter in the IBG offers information on topics such as eligibility, enrollment and when coverage begins and ends. It also discusses how other insurance offered through PEBA Insurance Benefits is affected by retirement. **Please continue to refer to the Retirement/Disability Retirement chapter, as well as to the chapters on specific insurance programs.**

If you have questions or need additional information, contact PEBA Insurance Benefits through its website, www.eip.sc.gov, or call 803-734-0678 (Greater Columbia area) or 888-260-9430 (toll-free outside the Columbia area). If you wish to meet with a PEBA representative, please come to PEBA Insurance Benefits' office at 202 Arbor Lake Drive, Columbia.

When You or Someone You Cover Becomes Eligible for Medicare

About Medicare

Information in this section relates to Medicare *Part A*, *Part B* and *Part D*. To learn more:

- Read *Medicare & You 2015*
- Visit the Medicare website at www.medicare.gov
- Call Medicare at 800-633-4227 or 877-486-2048 (TTY)
- Call 800-868-9095 for contact information for the regional State Health Insurance Assistance Program (SHIP) offices in South Carolina. The program provides individual help with Medicare and Medicaid.

Medicare Part A

Part A is hospital insurance. Most people do not pay a premium for Part A because they or their spouse paid Medicare taxes while they were working. Part A helps cover inpatient care in hospitals, in critical access hospitals in rural areas and in skilled nursing facilities. Part A has an inpatient hospital deductible for each benefit period. For 2015, it is \$1,260. Part A also cov-

ers hospice care and some home health care. You must meet certain requirements to be eligible for Part A. If you are not eligible for free Part A coverage, you may buy it. Contact Medicare for more information.

Please note: If you or your spouse or child gains Medicare coverage, the family member who gains coverage may drop health coverage through PEBA Insurance Benefits **within 31 days** of the date Part A is effective. Attach a photocopy of the Medicare card to a Notice of Election form and give it to your benefits administrator (BA) within 31 days of the date you gain Part A. Coverage will be canceled on the date Part A coverage is effective.

Medicare Part B

Part B is medical insurance. Most people pay a premium through the Social Security Administration for Part B. It helps cover doctors' services, durable medical equipment and outpatient hospital care. It also covers some medical services that Part A does not cover, such as some services of physical and occupational therapists and home health care. Part B pays for these covered services and supplies when they are medically necessary. In 2015, the Part B deductible is \$147 a year.

It is important that Medicare-eligible retirees, spouses and children be covered by Medicare Part A and Part B. Medicare becomes your primary insurance, and your retiree group insurance becomes the secondary payer. **If you are not covered by Part A and Part B, you will be required to pay the portion of your health care costs that Part A and Part B would have paid.**

Note: Medicare's preventive benefits include a free yearly Wellness visit, in addition to the Welcome to Medicare preventive visit. For detailed information, see *Medicare & You 2015* or *Your Guide to Medicare's Preventive Services* or contact Medicare.

Medicare Part D

What Does the SHP Medicare Prescription Drug Program Mean to You?

When you become eligible for Medicare, you automatically will be enrolled in the State Health Plan Medicare Prescription Drug Program, a group-based, Medicare Part D Prescription Drug Plan. Catamaran, the SHP's pharmacy benefits manager, will send you a packet of information that will include a letter about how you can opt out of the Medicare drug program and remain covered by the State Health Plan Prescription Drug Program. The pharmacy benefits manager is required to give you 21 days to opt out.

Most subscribers covered by the Medicare Supplemental Plan or the Standard Plan will be bet-

IMPORTANT MEDICARE NOTE

If you or someone you cover becomes eligible for Medicare before age 65, you must notify PEBA Insurance Benefits within 31 days of eligibility. If you do not notify PEBA Insurance Benefits of your Medicare eligibility, and PEBA Insurance Benefits continues to pay benefits as if it were your primary insurance, when PEBA Insurance Benefits discovers you or your covered family member is eligible for Medicare, PEBA Insurance Benefits will:

- Begin paying benefits as if you were covered by Medicare
- Seek reimbursement for overpaid claims back to the date you or your family member(s) became eligible for Medicare.

When you become eligible for Medicare, it is strongly advised you enroll in Medicare Part A AND Part B if you are covered as a retiree or as a spouse or child of a retiree. Medicare becomes your primary insurance. If you are not covered by Part A and Part B, you will be required to pay the portion of your health care costs that Parts A and B would have paid.

ter served if they remain covered by the Medicare Part D plan sponsored by PEBA Insurance Benefits. Because you have this coverage, your drug benefits will continue to be paid through your health insurance. PEBA charges no additional premium for drug coverage.

This section highlights some aspects of the SHP Medicare Prescription Drug Program. Catamaran will send you detailed information about the plan's coverage and benefits.

You may have heard that if you do not sign up for Part D when you are first eligible — then later do so — you will have to pay higher premiums for Part D. For PEBA Insurance Benefits subscribers, this is not true. According to Medicare rules, Medicare recipients who have “creditable coverage” (drug coverage that is as good as, or better than, Part D) and who later sign up for Part D, will not be penalized by higher Part D premiums. Subscribers to the health plans offered through PEBA Insurance Benefits have creditable coverage.

When you turn 65 and become eligible for Medicare, you will receive a Notice of Creditable Coverage from PEBA Insurance Benefits. (If you become eligible for Medicare before age 65, the letter will not be sent to you. You must notify PEBA Insurance Benefits of your Medicare eligibility.) Please save your Notice of Creditable Coverage from PEBA Insurance Benefits in case you need to prove you had this coverage when you became eligible for Part D. **Please note:** if a member joins a plan that does not provide creditable coverage and then joins a Medicare plan, he will have to pay a late enrollment penalty.

Most people should not respond to information they may get from Medicare or advertisements from companies asking them to buy Part D prescription drug plans. If you enroll in a Medicare Part D prescription drug plan other than the one offered through PEBA, you will not be eligible for drug benefits through the State Health Plan. Your health insurance premium will remain the same.

Medication Therapy Management

Catamaran’s Medication Therapy Management (MTM) program helps ensure SHP Medicare Prescription Drug Program members receive the most effective medications while reducing side effects and out-of-pocket costs. To participate, a member must have two or more of these diseases: asthma, COPD, depression, diabetes, high cholesterol, heart failure, HIV, high blood pressure, osteoporosis and rheumatoid arthritis; have filled four or more Part D maintenance or chronic condition drug prescriptions; and be likely to spend \$3,017 or more yearly on drugs.

Medicare requires that members who qualify automatically be enrolled in the program. However, they may opt out at any time.

Eligible members will receive a letter and will be contacted by a specially trained pharmacist to review their medications and answer questions. After the consultation, members will receive material about their medications. MTM pharmacists work closely with members and their doctors to solve drug-related problems.

For more information, call MTM at 866-352-5305, Monday-Friday, 9 a.m. – 9 p.m. ET.

No Pay-the-Difference Policy

Under the SHP Medicare Prescription Drug Program, a brand-name drug will be covered for

the appropriate copayment, even if a generic drug is available. There is no “pay-the-difference” under the SHP **Medicare** prescription drug plan.

Out-of-Network Coverage

You must use a network pharmacy, either a local retail pharmacy or Catamaran Home Delivery, to fill prescriptions.

Low-Income Subsidies

Some people with limited income and resources may be able to get “Extra Help” to pay the costs, such as copayments, related to a Medicare prescription drug plan. For more information, including resource limits, see *Understanding The Extra Help With Your Medicare Prescription Drug Plan*, which is available at www.socialsecurity.gov. You also may call the State Health Insurance Assistance Program (SHIP) at 803-734-9900 (Greater Columbia area) or 800-868-9095 (toll free).

IRMAA (Income-Related Monthly Adjustment Amounts)

High-income earners enrolled in a Medicare Part D plan may be required to pay a monthly fee to the Social Security Administration (SSA). For information about income thresholds and amounts of the fees, go to www.socialsecurity.gov/n/ssa-44.pdf. If you will pay an IRMAA fee, you should determine if the additional benefits of the Medicare Part D plan are worth the additional fee you will pay to the SSA.

For More Information

For detailed information about the State Health Plan Medicare Prescription Drug Program, see the *Evidence of Coverage* book, which Catamaran sent to you.

If you have questions about your prescription drug benefit, call Catamaran at 855-901-PEBA (7322).

Please remember: Medicare Part D does not affect your need to be covered by Medicare Part B (medical insurance). As a retiree covered under PEBA Insurance Benefits, you must be covered by Part A, and it is strongly advised that you enroll in Part B when you become eligible for Medicare. **If you are not covered by Parts A and B of Medicare, you will be required to pay the portion of your health care costs that Parts A and B would have paid.**

Medicare Before Age 65: Disability Retirees

If you or your eligible spouse or child becomes eligible for Medicare before age 65 due to disability, including end-stage renal disease (ESRD), you must notify PEBA Insurance Benefits within 31 days of Medicare eligibility by sending PEBA Insurance Benefits a copy of your Medicare card.

Because Medicare is primary (pays first) over your retiree health insurance (except during the 30-month end-stage renal disease [ESRD] coordination of benefits period), when you become eligible for Medicare, you must enroll in Medicare Part A, and it is strongly advised that you enroll in Part B. **If you are not covered by Parts A and B, you will be required to pay the portion of your health care costs that Parts A and B would have paid.**

A chart showing how the Medicare Supplemental Plan and the Standard Plan pay with Medicare is on page 9. To enroll in the Medicare Supplemental Plan, you must complete a Retiree Notice of Election (RNOE) form. Send it to PEBA Insurance Benefits if you worked for a state agency, a college or university or a public school district. If you worked for a local subdivision, send it to the benefits administrator in your former employer's personnel office. Coverage will begin the first of the month after PEBA Insurance Benefits is notified you are covered by Medicare.

End-stage Renal Disease

If you have end-stage renal disease you will become eligible for Medicare three months after beginning dialysis. At this point, a 30-month "coordination period" begins. During this period, your health coverage through PEBA Insurance Benefits is primary, which means it pays your medical claims first. After 30 months, Medicare becomes your primary coverage. Please notify PEBA Insurance Benefits within 31 days of the end of the coordination period. If you are covered as a retiree, you will then have the option of changing to the Medicare Supplemental Plan. (The Medicare Supplemental Plan is not available to active employees or their covered family members.) A chart showing how the Medicare Supplemental Plan and the Standard Plan pay with Medicare is on page 9.

The coordination period applies whether you are an active employee, a retiree, a survivor or a covered spouse or child and whether you were already eligible for Medicare for another reason, such as age. If you were covered by the Medicare Supplemental Plan, your claims will be processed under the Standard Plan for the 30-month coordination period.

Medicare At 65 if You Are Retired

At age 65, Medicare is primary (pays first) over your retiree health insurance. You must be covered by Medicare Part A, and it is strongly advised that you be covered by Part B. **If you are not covered by Medicare Part A and Part B, you will be required to pay the portion of your health care costs Parts A and B would have paid.**

Medicare's Initial Enrollment Period starts three months before your 65th birthday, includes the month of your birthday and extends three months past the month you turn 65. If you are not receiving Social Security benefits, you should ask about enrolling in Medicare three months before you turn age 65 so your Medicare coverage can start the month you turn 65.

If you are receiving Social Security benefits, you should be notified of Medicare eligibility by the Social Security Administration three months before you reach age 65. Medicare Part A starts automatically. It is strongly advised that you enroll in Part B. If you are not notified, contact your local Social Security office immediately.

If you decide not to receive Social Security benefits until you reach **your** full Social Security retirement age, you must still be covered by Medicare Part A and Part B. We recommend you contact the Social Security Administration within three months of your 65th birthday to enroll. The Social Security Administration will bill you quarterly for the premium for Part B.

If You Are an Active Employee at Age 65

If you are actively working and/or covered under a state health insurance plan for active employees, you may delay enrollment in Part B because your insurance as an

active employee remains primary. If you are an active employee but your spouse is eligible for Medicare, your spouse should enroll in Part A but may delay enrollment in Part B until you retire and your active coverage ends.

Please note: If you or your spouse defer Part B coverage and later elect to enroll in Part B while you are still actively at work, a gain of Part B is not a special eligibility situation that would permit you to drop health coverage with PEBA. You must wait until open enrollment, which occurs yearly in October, or until within 31 days of a special eligibility situation, to drop your health coverage.

Please note: If you are an active employee, you cover your spouse under a state health insurance plan for active employees and your spouse is eligible for Medicare due to disability, your spouse may delay enrollment in Part B because your insurance as an active employee remains primary. If your spouse's eligibility is due to end-stage renal disease, contact PEBA Insurance Benefits.

When You Leave Active Employment After Age 65

Social Security has a special enrollment rule for employees ending active employment after age 65. You should contact the Social Security Administration at least 90 days before you retire to ensure that you or your covered spouse or child's Medicare Part A and Part B coverage begins on the same date as your retiree coverage.

Please check with the Social Security Administration to make sure you are covered by Medicare Part A. **It is strongly advised that you be covered by Part B because Medicare becomes your primary coverage.**

A chart showing how the Medicare Supplemental Plan and the Standard Plan pay with Medicare is on page 9. You may enroll in the Medicare Supplemental Plan within 31 days of the date your active coverage ends. To do so, complete a Retiree Notice of Election (RNOE) form and send it to PEBA Insurance Benefits if you are retiring from a state agency, a college or university or a public school district. If you are retiring from a local subdivision, give the RNOE to your benefits administrator.

If Your Spouse or Child is Eligible for Medicare

If you are a retiree and your spouse or child is eligible for Medicare and you are not, they can enroll in the Medicare Supplemental Plan. Family members who are not eligible for Medicare will be covered under the Standard Plan provisions.

Sign up for Parts A and B of Medicare

You must be covered by both Part A and Part B of Medicare to receive full benefits with any state-offered retiree group health plan. If you are not covered by both parts of Medicare, you will be required to pay the portion of your health care costs Parts A and B would have paid.

How Turning Down Part B Affects Medicare Coverage

Unless you are covered as an active employee at the time, if you turn down Medicare Part B when you are first eligible, you must wait until Medicare's General Enrollment Period. This period is from Jan. 1 to March 31 of each year, and coverage begins on July 1. Your Medicare

premium will be 10 percent higher for each year you were not covered by Part B after you were first eligible. Contact Medicare for enrollment details and for premium information that applies specifically to you.

If you Are Retired, 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 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 or within 31 days of a special eligibility situation or during open enrollment. You may also enroll your eligible family members.

Working in a Benefits-Eligible Job After Retirement

If you or your spouse or child is covered under the retiree group insurance program and you return to work in a benefits-eligible job for an employer participating in the state insurance program, you will need to make decisions about your coverage.

If you continued or converted your life insurance when you retired, please see the Life Insurance chapter of the 2015 IBG or contact your BA.

If You or a Member of Your Family is Covered by Medicare

Medicare cannot be the primary insurance and coverage through PEBA Insurance Benefits cannot be secondary insurance for you, or for anyone you cover, while you are employed, according to federal law. To comply with this requirement, you must suspend your retiree group coverage and enroll as an active employee with Medicare as the secondary payer, or refuse all PEBA Insurance Benefits-sponsored health coverage for yourself, your spouse and your children and have Medicare coverage only. (You may keep your dental and vision coverage.)

If you are a new **full-time permanent or nonpermanent employee** you are eligible to enroll in health, dental and vision coverage as an active employee.

These benefits are available to you only if you are covered as a full-time permanent employee:

- MoneyPlus benefits (You must have completed one year of continuous state-covered service by Jan. 1 after open enrollment, which occurs yearly in October, to qualify for a Medical Spending Account.)
- Basic Long Term Disability, if you are enrolled in the State Health Plan
- Supplemental Long Term Disability coverage
- \$3,000 Basic Life Insurance, if you are enrolled in the State Health Plan
- Optional Life Insurance
- Dependent Life Insurance.

If you enroll in active group coverage, you must notify the Medicare coordination of benefits contractor at 855-798-2627. Medicare will pay after your active group coverage.

You may remain covered by Medicare Part B and continue paying the premium, and Medicare will be the secondary payer. You may also delay or drop Part B without a penalty while you have active group coverage. For more information, contact the Social Security Administration (SSA) at 800-772-1213.

When you stop working and your active group coverage ends, you may re-enroll in retiree group coverage within 31 days of your active termination date. You also may enroll during open enrollment or within 31 days of a special eligibility situation. In addition, you must 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 job does not make you eligible for benefits, your retiree group coverage continues, and Medicare remains the primary payer.

How Medicare Affects COBRA Coverage

If you or your eligible spouse or child has continued coverage under COBRA and becomes eligible for Medicare Part A, Part B or both, please notify PEBA Insurance Benefits. Your continued coverage will end.

A subscriber or eligible spouse or child who is covered by Medicare and then becomes eligible for continued coverage under COBRA can generally use the continued coverage as secondary insurance. Medicare will be his primary coverage.

For more information about continued coverage under COBRA, see pages 31-33 of the 2015 *Insurance Benefits Guide* or contact your benefits office.

Your Health Insurance Options With Medicare

When you and/or your eligible spouse or children are covered under retiree group health insurance and become eligible for Medicare, Medicare becomes the primary payer, and your health insurance options change. Plans available to you and your eligible family members are:

- The Medicare Supplemental Plan
- The Standard Plan

You will automatically be enrolled in the Medicare Supplemental Plan:

- **If you become eligible for Medicare due to age and you are covered by the Standard Plan or the Savings Plan unless you respond to the notification letter from PEBA Insurance Benefits by choosing the Standard Plan.** Coverage changes must be made within 31 days of the date you become eligible for Medicare.

You **have the option** to change to the Medicare Supplemental Plan:

- If you or someone you cover becomes eligible for Medicare due to a disability
- At the end of the end-stage renal disease coordination period if you are covered as a retiree
- When you leave active employment after age 65.

For more information about your health insurance choices when you become eligible for Medicare, see the comparison table on pages 24-25.

When you become eligible for Medicare before age 65, you **MUST** notify PEBA Insurance Benefits within 31 days.

To make a change, attach a copy of your Medicare card to your Notice of Election form and give it to your BA with 31 days of Medicare eligibility. For more information, See pages 4-6.

How PEBA Insurance Benefits Health Plans Pay with Medicare

Medicare Supplemental Plan	Standard Plan (carve-out method)																																												
<p>Medicare is primary. The hospital bill for a January admission is \$7,500. If you are covered by the Medicare Supplemental Plan and Medicare, your Medicare claim will be processed like this:</p> <table> <tr> <td>\$7,500</td> <td>Medicare-approved amount</td> </tr> <tr> <td><u>-1,260</u></td> <td>Part A deductible for 2015</td> </tr> <tr> <td>\$6,240</td> <td>Medicare payment</td> </tr> <tr> <td> </td> <td></td> </tr> <tr> <td>\$1,260</td> <td>Remaining bill</td> </tr> </table> <p>Next, the Medicare Supplemental Plan benefits are applied:</p> <table> <tr> <td>\$1,260</td> <td>Remaining bill</td> </tr> <tr> <td><u>-\$1,260</u></td> <td>Medicare Supplemental Plan pays Medicare Part A deductible</td> </tr> <tr> <td>\$ 0</td> <td>You pay nothing.</td> </tr> </table>	\$7,500	Medicare-approved amount	<u>-1,260</u>	Part A deductible for 2015	\$6,240	Medicare payment	 		\$1,260	Remaining bill	\$1,260	Remaining bill	<u>-\$1,260</u>	Medicare Supplemental Plan pays Medicare Part A deductible	\$ 0	You pay nothing.	<p>Medicare is primary. The hospital bill for a January admission is \$7,500. If you are covered by the Standard Plan and Medicare, your Medicare claim will be processed like this:</p> <table> <tr> <td>\$7,500</td> <td>Medicare-approved amount</td> </tr> <tr> <td><u>- 1,260</u></td> <td>Part A deductible for 2015</td> </tr> <tr> <td>\$6,240</td> <td>Medicare payment</td> </tr> <tr> <td> </td> <td></td> </tr> <tr> <td>\$1,260</td> <td>Remaining bill</td> </tr> </table> <p>Next, Standard Plan benefits are applied to the Medicare-approved amount:</p> <table> <tr> <td>\$7,500</td> <td>SHP allowed amount</td> </tr> <tr> <td><u>- 445</u></td> <td>Standard Plan deductible for 2015</td> </tr> <tr> <td>\$7,055</td> <td>Standard Plan's allowance after deductible</td> </tr> <tr> <td><u>x 80%</u></td> <td>Standard Plan coinsurance</td> </tr> <tr> <td>\$5,644</td> <td>Standard Plan payment in the absence of Medicare</td> </tr> <tr> <td><u>- 6,240</u></td> <td>Medicare payment is "carved out" of the Standard Plan payment.</td> </tr> <tr> <td>\$ 0</td> <td>Standard Plan pays nothing.</td> </tr> <tr> <td> </td> <td></td> </tr> <tr> <td>\$1,260</td> <td>Remaining bill – amount you pay.</td> </tr> </table>	\$7,500	Medicare-approved amount	<u>- 1,260</u>	Part A deductible for 2015	\$6,240	Medicare payment	 		\$1,260	Remaining bill	\$7,500	SHP allowed amount	<u>- 445</u>	Standard Plan deductible for 2015	\$7,055	Standard Plan's allowance after deductible	<u>x 80%</u>	Standard Plan coinsurance	\$5,644	Standard Plan payment in the absence of Medicare	<u>- 6,240</u>	Medicare payment is "carved out" of the Standard Plan payment.	\$ 0	Standard Plan pays nothing.	 		\$1,260	Remaining bill – amount you pay.
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If you or your covered spouse or child is covered by the Medicare Supplemental Plan, the claims of covered family members without Medicare are paid through the Standard Plan provisions.

How the Medicare Supplemental Plan Pays with Medicare

If a provider accepts Medicare assignment, the provider accepts Medicare's payment plus the Medicare Supplemental Plan's payment as payment in full for covered services. If the provider does not accept Medicare assignment, the provider may charge more than what Medicare and the Medicare Supplemental Plan pay combined. You pay the difference.

How the Standard Plan Pays with Medicare: The Carve-out Method

When a retired subscriber is covered by Medicare, Medicare pays first, and the Standard Plan pays second. If your provider accepts the amount Medicare allows as payment in full, the Standard Plan will pay the lesser of:

1. The amount Medicare allows, minus what Medicare reported paying or

2. The amount the State Health Plan (SHP) would pay in the absence of Medicare, minus what Medicare reported paying.

If your provider does not accept the amount Medicare allows as payment in full, the Standard Plan pays the difference between the amount the SHP allows and the amount Medicare reported paying. The Standard Plan will never pay more than the SHP allows. If the Medicare payment is more than the amount the SHP allows, the Standard Plan pays nothing.

As shown in the example, under the carve-out method, you pay the Standard Plan deductible and coinsurance or the remainder of the bill, whichever is less. In this example, the \$445 deductible and your 20 percent coinsurance is \$1,856. However, the remainder of the bill is \$1,260, so you pay the lesser amount, \$1,260.

Once you reach your \$2,540 coinsurance maximum, all claims will be calculated at 100 percent of the allowed amount based on the carve-out method of claims payment. All of your Medicare deductibles and your Medicare Part B 20 percent coinsurance should be paid in full for the rest of the calendar year after you reach your \$2,540 coinsurance maximum.

Your Prescription Drug Coverage with Medicare

When you become eligible for Medicare, you will automatically be enrolled in the SHP Medicare Prescription Drug program, whether you are covered by the **Medicare Supplemental Plan** or the **Standard Plan**. For more information, see page 2-4.

Health Insurance Coverage Overseas

The **Standard Plan** offers access to doctors and hospitals outside the United States through the BlueCard Worldwide program. The **Medicare Supplemental Plan**, which follows Medicare, does not.

If you move abroad, you can switch to the Standard Plan. Please provide your benefits administrator with proof of residency and travel documents showing your date of departure. If you will have dual residency, you will have to decide whether the Standard Plan or the Medicare Supplemental Plan best suits your needs. You cannot change plans except during open enrollment, which occurs yearly in October.

Prescription Drug Coverage

If you are enrolled in the SHP Prescription Drug Program, you have limited prescription drug coverage outside the U.S.

If you are traveling abroad, you may wish to buy travel health insurance for coverage during the trip. Such policies are available through most travel agencies.

If You Are Eligible for Medicare and Are Considering the Savings Plan

If you are a retiree and you are considering enrolling in the **Savings Plan**, please call PEBA Insurance Benefits or BCBSSC for information about how the Savings Plan would coordinate with Medicare or with other coverage. If you are retired and are covered under Medicare, you cannot contribute to a Health Savings Account, which is typically associated with the Savings Plan.

Your Insurance Cards When You Become Eligible for Medicare

Keep your identification cards if you do not change plans when you become eligible for Medicare. Your Benefits ID Number will not change, and your health and dental cards will still be valid. You will receive a new card if you enroll in the State Health Plan, a dental plan or the State Vision Plan for the first time.

If you or your dependents are covered under the State Health Plan Medicare Prescription Drug Program, each member will receive two copies of a prescription drug card issued in his own name with “Medicare RX” on it. Family members who are not covered under the Medicare drug program will receive cards, issued in the subscriber’s name, showing they are covered under the State Health Plan Prescription Drug Program.

Please note: Your health insurance card will come from BCBSSC. Your pharmacy benefits card will come from Catamaran. **These cards are not interchangeable.** You must use the BCBSSC card for medical services and the Catamaran card to fill prescriptions.

Medicare Assignment: How Medicare Shares the Cost of Your Care

When you choose a provider, you may wish to determine if:

- He accepts assignment
- He may accept assignment on an individual claim or
- He has opted out of Medicare.

Medicare *assignment* is a yearly agreement between Medicare and individual providers. After you meet your deductible and pay your coinsurance, if it applies, some doctors and suppliers, called “participating providers,” will accept the Medicare-approved amount as payment in full for services payable under Medicare Part B. This is called “accepting assignment.” A provider who accepts assignment also submits his claims directly to Medicare, so you don’t have to pay the full amount up front and wait for reimbursement.

A provider also may choose whether to accept assignment on each individual claim. Before you receive services from a physician, ask if he accepts assignment. If a doctor does not accept assignment, you may pay more for his services. Contact Medicare if you need more information.

If a doctor decides to accept assignment from Medicare, he cannot drop out in the middle of the year. Independent laboratories and doctors who perform diagnostic laboratory services and non-physician practitioners must accept assignment.

For a list of physicians, suppliers of medical equipment and other providers who accept assignment, visit www.medicare.gov. For more information, call 800-633-4227. TTY/TDD users should call 877-486-2048.

Opting Out: If a Provider Does not Accept Medicare

Some providers choose not to accept any payment from Medicare. If a provider has made this decision, Medicare covers none of that provider’s services, and no Medicare payment can be made to him. **If Medicare doesn’t pay anything, neither will the Medicare Supplemental Plan.**

If you are covered under the Standard Plan and your physician has opted out of Medicare, call Customer Service at 803-734-0678 (Greater Columbia area) or 888-260-9430 (toll-free outside the Columbia area) for information about how the Standard Plan will pay.

A provider who opts out of Medicare signs a two-year contract. The contract can be renewed.

The Medicare Supplemental Plan

If you are a retiree covered by the Standard Plan or the Savings Plan and become eligible for Medicare **due to your age**, you will receive a letter from PEBA Insurance Benefits stating that you will be enrolled automatically in the Medicare Supplemental Plan. If you prefer another health plan, you must inform PEBA Insurance Benefits by responding to the letter within 31 days of Medicare eligibility.

If you are covered by a health plan offered through PEBA Insurance Benefits, you may change to the Medicare Supplemental Plan within 31 days of Medicare eligibility. During the yearly October enrollment period, you can change from the Standard Plan to the Medicare Supplemental Plan. Plan changes are effective on Jan. 1 after the enrollment period. If you move out of the United States permanently you may be eligible to change from the Medicare Supplemental Plan to the Standard Plan.

This section explains the Medicare Supplemental Plan, which is available to a retiree and his spouse or children who are covered by Medicare Parts A and B. This plan coordinates benefits with the original Medicare plan only. **No benefits are provided for coordination with Medicare Advantage plans (Part C).** For more information, visit www.medicare.gov or call 800-633-4227. If you or your spouse or child is covered by the Medicare Supplemental Plan, the claims of covered family members without Medicare are paid through the Standard Plan's provisions.

General Information

The Medicare Supplemental Plan is similar to a Medigap policy — it “fills the gap” or pays the portion of Medicare-approved charges that Medicare does not, such as Medicare's deductibles and coinsurance. The Medicare Supplemental Plan payment is based on the Medicare-approved amount. Except as specified on pages 13-15, charges that are not covered by Medicare will not be payable as benefits under the supplemental plan.

For example:

In an outpatient setting, such as an emergency room, Medicare does not cover *self-administered drugs*, drugs that a person usually takes on his own, such as pills. This means that if a patient receives pain pills in an emergency room, the hospital will bill him for the drugs. Because Medicare does not pay for the pills, the Medicare Supplemental Plan will not pay for them either.

If your medical provider does not accept Medicare assignment, and charges you more than Medicare allows, you pay the difference. Contact Medicare if you need more information.

Using Medi-Call and Companion Benefit Alternatives for Preauthorization

You need to call Medi-Call or Companion Benefit Alternatives (CBA) only when Medicare

benefits are exhausted for inpatient hospital services and for extended care services, such as skilled nursing facilities, private duty nursing, home health care, durable medical equipment and Veterans Administration hospital services. See the inside cover of this handbook for the telephone numbers. Medicare has its own program for reviewing use of its services.

Filing Claims for Covered Family Members not Eligible for Medicare

Claims for covered family members who are not eligible for Medicare, but who are insured through the Medicare Supplemental Plan, are paid according to the Standard Plan provisions. Remember that some benefits require preauthorization by Medi-Call, National Imaging Associates, Catamaran or Companion Benefit Alternatives (CBA). See the inside cover of this handbook for the telephone numbers.

Medicare Deductibles and Coinsurance

Deductibles

Medicare Part A has an inpatient hospital deductible for each *benefit period*. That deductible for 2015 is \$1,260. A Medicare benefit period begins the day you go to a hospital or skilled nursing facility and ends when you have not received any hospital or skilled care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. *The Medicare Supplemental Plan will pay the Part A deductible each time it is charged.*

Medicare Part B has a deductible of \$147 a year in 2015. Part B, for which you pay a monthly premium, covers physician services, supplies and outpatient care. Please contact Medicare for more information. As a retiree, you must enroll in Part B as soon as you are eligible for Medicare, because Medicare is your primary coverage. If you are not covered by Part B, you will be required to pay the portion of your health care costs that Part B would have paid. *The Medicare Supplemental Plan pays the Part B deductible.*

Coinsurance

Medicare Part B pays 80 percent of the Medicare-approved amount for medical services, including outpatient mental health care. *The Medicare Supplemental Plan pays the remaining 20 percent.*

Medicare Supplemental Plan Deductibles and Coinsurance

The Medicare Supplemental Plan benefit period is Jan. 1-Dec. 31 and includes a \$200 deductible each calendar year that applies to private duty nursing services only. If you enroll in Medicare and change to the Medicare Supplemental Plan during the year, you must meet a new \$200 deductible for private duty nursing services.

What the Medicare Supplemental Plan Covers

Hospital Admissions

The Medicare Supplemental Plan pays for these services during a benefit period after Medicare has paid:

- The Medicare Part A inpatient hospital deductible

- The Medicare coinsurance amount for days 61 through 90 of a hospital stay in each Medicare benefit period
- The Medicare coinsurance amount for days 91 through 150 of a hospital stay for each of Medicare's 60 lifetime reserve days (The lifetime reserve days can be used once.)
- After all Medicare hospital benefits are exhausted, 100 percent of the Medicare Part A-eligible hospital expenses, if medically necessary*
- The coinsurance for durable medical equipment up to the Medicare-approved amount.

**Must call Medi-Call or Companion Benefit Alternatives (CBA) for approval.*

If You Exhaust the Inpatient Hospital Days Medicare Allows

If you are covered by the Medicare Supplemental Plan and you exhaust all Medicare-allowed inpatient hospital days, you must call Medi-Call or Companion Benefit Alternatives (CBA) for approval of any additional inpatient hospital days. Also, if you are covered by the Medicare Supplemental Plan, and you think that a hospital stay may exceed the number of days allowed under Medicare, you should choose a hospital within the SHP networks or BlueCard Program so that any days beyond what Medicare allows will be covered as a network benefit by the Medicare Supplemental Plan.

You must also call Medi-Call or CBA for preauthorization for services related to home health care, hospice, durable medical equipment and Veterans Administration hospital services.

Skilled Nursing Facilities

The Medicare Supplemental Plan will pay these benefits after Medicare has paid benefits during a benefit period:

- The coinsurance, after Medicare pays, up to the Medicare-approved amount for days 21-100 (Medicare pays 100 percent for the first 20 days)
- 100 percent of the approved days beyond 100 days in a skilled nursing facility, if medically necessary. (Medicare does not pay beyond 100 days.) The maximum benefit under the plan per year for covered services beyond 100 days is 60 days.

Preauthorization by Medi-Call is required.

Physician Charges

The Medicare Supplemental Plan will pay these benefits related to physician services approved by Medicare:

- The Medicare Part B deductible
- The coinsurance for the Medicare-approved amount for physician's services for surgery, necessary home and office visits, inpatient hospital visits and other covered physician's services
- The coinsurance for the Medicare-approved amount for physician's services provided in the outpatient department of a hospital for treatment of accidental injuries and medical emergencies; minor surgery; and diagnostic services.

Home Health Care

The Medicare Supplemental Plan will pay these benefits for medically necessary home health care services:

- The Medicare Part B deductible

- The coinsurance for any covered services or costs Medicare does not cover (Medicare pays 100 percent of Medicare-approved amount), up to 100 visits per benefit year. The plan does not cover services provided by a person who ordinarily resides in the home, is a member of the family or a member of the family of the spouse of the covered person.
- 20 percent of Medicare-approved amount for durable medical equipment.

Private Duty Nursing Services

Private duty nursing services are services that are provided by a registered nurse (RN) or a licensed practical nurse (LPN) and that have been certified in writing by a physician as medically necessary. Services must be preauthorized by Medi-Call. There is a \$200 annual deductible that applies, regardless of the time of year you enroll in the plan. Medicare does NOT cover this service. Once the deductible is met, the Medicare Supplemental Plan will pay 80 percent of covered charges for private duty nursing in a hospital or in the home. Coverage is limited to no more than three nurses per day, and the maximum annual benefit per year is \$5,000. The lifetime maximum benefit under the Medicare Supplemental Plan is \$25,000.

Prescription Drug Program

The Medicare Supplemental Plan covers prescription drugs when purchased from a participating pharmacy. For more information, see pages 78-84 of the 2015 *Insurance Benefits Guide*. For information about how PEBA Insurance Benefits coverage relates to Medicare Part D, see page 2 of this handbook.

Pap Test Benefit

Medicare covers a Pap test, pelvic exam and clinical breast exam every 24 months. These tests are covered yearly if you are at high risk. There is no patient liability if you receive the tests from a doctor who accepts assignment. Check with Medicare for more information.

Filing Claims as a Retiree with Medicare

If you are retired and covered by Medicare, Medicare is primary (pays first). In most cases, your provider will file your Medicare claims for you.

Claims Filed in South Carolina

The Medicare claim should be filed first. Claims for Medicare-approved medical charges incurred in South Carolina should be transferred automatically from Medicare to the SHP. If you or your doctor have not received payment or notification from the plan within 30 days after the Medicare payment is received, one of you must send BCBSSC, third-party claims processor for the SHP, a claim form and a copy of your Medicare Summary Notice (MSN) with your Benefits ID Number or Social Security number written on it. Your mental health and substance abuse claims also should be filed with BCBSSC and should include your MSN with your Benefits ID Number or Social Security number written on it. See the Appendix of your 2015 *Insurance Benefits Guide* if you need to file your own claim.

Claims Filed Outside South Carolina

If you receive services outside South Carolina, your provider will file its claim to the Medicare carrier in that state. Medicare will send you claim to BCBSSC.

When Traveling Outside the U.S.

Medicare does not cover services outside the United States and its territories. Because the Medicare Supplemental Plan does not allow benefits for services not covered by Medicare (other than private duty nursing), **Medicare Supplemental Plan members do not have coverage outside the U.S. if Medicare is their primary coverage.** For more information, see page 10.

Limited prescription drug coverage is available outside the U.S. to members enrolled in the SHP Prescription Drug Program. For more information, see the Appendix of the 2015 *Insurance Benefits Guide* or call Catamaran at 855-901-PEBA (7322).

The Standard Plan

The Standard Plan offers worldwide coverage. It requires Medi-Call (800-925-9724) approval for inpatient hospital admissions, including admission to a hospital to have a baby; outpatient surgical services in a hospital or clinic; the purchase or rental of durable medical equipment; and skilled nursing care, hospice care and home health care. You are encouraged to call Medi-Call during the first trimester of your pregnancy. You must call National Imaging Associates (866-500-7664) for office-based or outpatient advanced radiology services, such as CT, MRI, MRA and PET scans. You must also call Companion Benefit Alternatives (CBA) (800-868-1032), the SHP's mental health/substance abuse manager, for preauthorization before you receive some mental health or substance abuse benefits. For more information, see page 84 of the 2015 *Insurance Benefits Guide*.

The plan has deductibles and coinsurance. Once you are covered by Medicare, Medicare becomes your primary insurance. The Standard Plan uses a carve-out method to pay claims. It is described on pages 9-10.

How the Standard Plan and Medicare Work Together

Using Medi-Call and CBA Preauthorization as a Retiree with Medicare

You still need to call Medi-Call or Companion Benefit Alternatives (CBA) when Medicare benefits are exhausted for inpatient hospital services (including hospital admissions outside South Carolina or the U.S.), and for extended care services, such as skilled nursing, home health care, durable medical equipment and Veterans Administration hospital services. Medicare has its own program for reviewing use of its benefits.

Note: Covered family members who are not eligible for Medicare and whose claims are processed under the Standard Plan must call Medi-Call or Companion Benefit Alternatives (CBA).

Please remember that while your physician or hospital may call Medi-Call or CBA for you, it is your responsibility to see that the call is made.

Hospital Network

When you are covered by Medicare, Medicare is the primary payer, and you may go to any hospital you choose. Medicare limits the number of days of a hospital stay that it will cover. If you are enrolled in the Standard Plan and your hospital stay exceeds the number of days allowed under Medicare, it may be important to you that you are admitted to a hospital within the SHP

network or BlueCard Program so that you will not be charged more than what the Standard Plan allows.

You must also call Medi-Call or Companion Benefit Alternatives (CBA) for approval of any additional inpatient hospital days beyond the number of days approved under Medicare and for services related to home health care, hospice, durable medical equipment and Veterans Administration hospital services.

Coverage Outside the U.S.

You are not generally covered outside the United States under Medicare. However, if you are covered by the Standard Plan, you have worldwide access to doctors and hospitals through the BlueCard Worldwide program.

Emergency Hospital Admissions Outside South Carolina or the U.S.

If you are admitted to a hospital outside the state or the country as a result of an emergency, notify Medi-Call or Companion Benefit Alternatives (CBA) and follow the BlueCard guidelines. For more information about BlueCard Worldwide, see pages 55-57 of your 2015 *Insurance Benefits Guide*.

Prescription Drug Coverage

Limited prescription drug coverage is available outside the U.S. to members enrolled in the SHP Prescription Drug Program. For more information, see the Appendix of the 2015 *Insurance Benefits Guide*.

Prescription Drug Program

The Standard Plan covers prescription drugs when purchased from a participating pharmacy. For more information, see pages 78-84 of the 2015 *Insurance Benefits Guide*.

Outpatient Facility Services

Outpatient services may be provided in the outpatient department of a hospital or a free-standing facility. If you are covered by Medicare, there is no need to call Medi-Call for preauthorization, nor do you need to select a center that participates in the network.

Transplant Contracting Arrangements

As part of this network, you have access to the leading transplant facilities in South Carolina and throughout the nation. If you are covered by Medicare, there is no need to call Medi-Call for preauthorization, nor do you need to select a facility that participates in the network.

Mammography Benefit

The State Health Plan pays for routine mammograms for covered women ages 35-74. You may have one baseline mammogram if you are age 35-39 and one routine mammogram every calendar year if you are age 40-74. There is no charge if you use a facility that participates in the program's mammography network.

Medicare covers a screening mammogram every 12 months for women age 40 and older. Medicare pays 100 percent of its allowance for covered routine mammograms. You pay nothing if you receive the test from a doctor who accepts assignment.

Pap Test Program

The SHP will pay for a Pap test each year, without any requirement for a copayment, deductible or coinsurance, for covered women ages 18-65. See page 75 of the 2015 *Insurance Benefits Guide* for more information. Medicare covers a Pap test, pelvic exam and clinical breast exam every 24 months. If you are at high risk, you may have one every 12 months. You pay nothing if you receive the test from a doctor who accepts assignment. Check with Medicare for more information.

Maternity Management and Well Child Care Benefits

The SHP offers two programs geared toward early detection and prevention of illness among children. The Maternity Management benefit helps mothers-to-be receive necessary prenatal care. (This benefit applies to covered retirees and their spouses. It does not apply to covered children.) Covered children are eligible for Well Child Care checkups until they turn age 19. The plan pays 100 percent for routine immunizations when a network doctor provides the services. If your covered child has delayed, or missed, receiving immunizations at the recommended time, the plan will pay for “catch-up” immunizations for some vaccines until the child turns age 19. Check with BCBSSC or your network pediatrician to determine which immunizations are covered.

Filing Claims As a Retiree with Medicare

If you are retired and covered by Medicare, Medicare is primary (pays first). In most cases, your provider will file your Medicare claims for you.

Claims Filed in South Carolina

The Medicare claim should be filed first. Claims for Medicare-approved medical charges incurred in South Carolina should be transferred automatically from Medicare to the SHP. If you or your doctor have not received payment or notification from the plan within 30 days after the Medicare payment is received, one of you must send BCBSSC, third-party claims processor for the SHP, a claim form and a copy of your Medicare Summary Notice (MSN) with your Benefits ID Number or Social Security number written on it. Your mental health and substance abuse claims should also be filed with BCBSSC and should include your MSN with your Benefits ID Number or Social Security number on it. See the Appendix of the 2015 *Insurance Benefits Guide* if you need to file your own claim.

Claims Filed Outside South Carolina

If you receive services outside South Carolina, but in the U.S., your provider will file the claim with the Medicare carrier in the state where you received services. Medicare will send your claim to BCBSSC. If you or your doctor have not received payment or notification from the SHP within 30 days after the Medicare payment is received, one of you must send BCBSSC, third-party claims processor for the SHP, a claim form and a copy of your MSN, with your Benefits ID Number or Social Security number written on it.

If Medicare Denies Your Claim

If Medicare denies your claim, you are responsible for filing the denied claim with BCBSSC. You may use the same SHP claim forms active employees use. These forms are available on the PEBA Insurance Benefits website, www.eip.sc.gov, or from PEBA Insurance Benefits or BCBSSC. You will need to attach your MSN and an itemized bill to your claim form.

WHEN YOU OR YOUR ELIGIBLE FAMILY MEMBERS BECOME ELIGIBLE FOR MEDICARE before age 65, notify PEBA Insurance Benefits within 31 days of eligibility. If you do not notify PEBA Insurance Benefits and PEBA Insurance Benefits continues to pay benefits as if it were your primary insurance, when PEBA Insurance Benefits discovers you or a covered family member is eligible for Medicare, PEBA Insurance Benefits will:

- **Begin paying benefits as if you were enrolled in Medicare**
- **Seek reimbursement for overpaid claims back to the date you or your family members became eligible for Medicare.**

When you become eligible for Medicare, it is strongly advised you ENROLL IN MEDICARE PART A AND PART B if you are covered as a retiree or as a spouse or child of a retiree. Medicare becomes your primary insurance. If you are not enrolled in Part A and Part B, you will be required to pay the portion of your health care costs that Parts A and B would have paid.

Part D Creditable Coverage Letter

Important Notice from PEBA Insurance Benefits About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with PEBA Insurance Benefits and about your options under Medicare's prescription drug coverage. This information can help you decide whether you want to join a Medicare drug plan other than the State Health Plan Medicare Prescription Drug Program, which is sponsored by PEBA Insurance Benefits. If you are considering joining another Part D plan, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

- 1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (such as an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
- 2. PEBA Insurance Benefits offers the State Health Plan Medicare Prescription Drug Program and the State Health Plan Prescription Drug Program to members enrolled in Medicare. It has determined that the prescription drug coverage offered through the Standard Plan or the Medicare Supplemental Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays. It is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two-month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan other than the one sponsored by PEBA Insurance Benefits, you will lose your prescription drug coverage provided through your health plan with PEBA Insurance Benefits, and your premiums will not decrease. Be aware that you and your dependents will be able to get this coverage back.

Before you decide to switch to other Medicare drug coverage and drop your PEBA Insurance Benefits coverage, you should compare your PEBA Insurance Benefits coverage, including which drugs are covered, with the coverage and cost of any plans offering Medicare prescription drug coverage in your area.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

If you drop or lose your current coverage with PEBA Insurance Benefits and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1 percent of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19 percent higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage...

Contact PEBA Insurance Benefits at the address or telephone number listed below for further information.

NOTE: You will receive this notice each year before the next period you can join a Medicare drug plan and if this coverage through PEBA Insurance Benefits changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the *Medicare & You* handbook. You will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage: Visit www.medicare.gov.

Call your State Health Insurance Assistance Program (see page 1 of this handbook for the program's telephone number) for personalized help. You may also call 800-MEDICARE (800-633-4227). TTY users should call 877-486-2048.

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether you have maintained creditable coverage and, therefore, whether you are required to pay a higher premium (a penalty).

Contact PEBA Insurance Benefits below for further information.

Note: You will get this notice each year before the next period you can join a Medicare drug plan and if this coverage through PEBA Insurance Benefits changes. You may also request a copy.

South Carolina Public Employee Benefit Authority
Insurance Benefits
P.O. Box 11661
Columbia, SC 29211-1661

803-734-0678 (Greater Columbia area)
888-260-9430 (toll-free outside the Columbia area)
eipcustomerservice@peba.sc.gov
www.eip.sc.gov

Medicare Part D: Frequently Asked Questions

Q: I received a notice recently about Medicare Part D from PEBA Insurance Benefits. What is this?

A: Even though the Medicare prescription drug benefit went into effect on January 1, 2006, PEBA Insurance Benefits will continue to provide you and your covered dependents with your state prescription drug coverage. The notice tells you this coverage is at least as good as the Medicare drug benefit, and it is proof of such coverage. Please keep this notice where you can easily find it.

Q: Do I need to do anything right now?

A: No. There is nothing you need to do if you plan to keep your state coverage through PEBA Insurance Benefits.

Q: What do I need to do if I want to switch to a Medicare plan?

A: If you switch to a Medicare drug plan other than the one sponsored by PEBA Insurance Benefits, you need to enroll within the seven-month initial enrollment period of your Medicare eligibility. More information is available by calling Medicare at 800-MEDICARE (800-633-4227) or at 877-486-2048 (TTY). However, enrolling in a Medicare drug plan will disqualify you from prescription drug coverage under your PEBA Insurance Benefits plan. If you enroll in a Medicare drug plan other than the one sponsored by PEBA Insurance Benefits, you will lose your PEBA Insurance Benefits drug coverage, and there will be no reduction in your health insurance premium.

Q: If I keep my current coverage, can I switch to a Medicare plan later?

A: Yes. Open enrollment for Medicare coverage is held yearly between Oct. 15 and Dec. 7.

Q: Will I pay higher premiums for a Medicare prescription drug plan if I keep my state coverage through PEBA Insurance Benefits and switch later?

A: No. Since Medicare recognizes your current state coverage through PEBA Insurance Benefits is at least as good as the standard Medicare plan, you will not pay more if you later enroll in a Medicare plan. Remember that you may only enroll in a Medicare prescription drug plan during: 1) open enrollment for Medicare, which is Oct. 15 to Dec. 7 of each year; or 2) if your PEBA Insurance Benefits coverage ends.

Q: Is extra help or limited-income assistance available for prescription drug coverage?

A: Under Medicare Part D, the federal government offers Extra Help, a program to help pay costs of a Medicare prescription drug plan for people with limited income and resources. If you think you may qualify, you can apply for assistance by filling out an

application online at www.socialsecurity.gov or by calling the Social Security Administration at 800-772-1213 or 800-325-0778 (TTY). You also may call the State Health Insurance Assistance Program (SHIP) at 803-734-9900 (Greater Columbia area) or 800-868-9095 (toll-free outside the Columbia area).

Comparison of Health Plans for Retirees

Type	PPO		
	To receive a higher level of benefits, subscribers should use a network provider.		
Plan	Medicare	Medicare Supplemental	SHP Standard Plan ¹
Availability	United States (Contact Medicare about any services outside the U.S.)	Same as Medicare	Coverage worldwide
Cancellation Policy	Call Medicare for details	Canceled for failure to pay premiums	Canceled for failure to pay premiums
Annual Deductible	Part A: \$1,260 (per benefit period) Part B: \$147	Pays Medicare Part A and Part B deductibles	\$445 (single) \$890 (family) Carve-out method applies
Copayments	Inpatient hospital: Part A deductible (\$1,260 per benefit period)	Pays Medicare Part A deductible (Call Medi-Call for hospital stays over 150 days, skilled nursing, private duty nursing, home health care, durable medical equipment and VA hospital services)	Outpatient hospital, outpatient facility services: \$95 copayment Emergency care: \$159 copayment (Call Medi-Call for hospital stays over 150 days, skilled nursing, home health care, durable medical equipment and VA hospital services)
Coinsurance	Part A: 100% Part B: 80% (You pay 20%)	Pays Part B coinsurance of 20%	Carve-out method applies Plan allows 80%
Coinsurance Maximum	None	None	Network \$2,540 (single) \$5,080 (family)
			Out-of-network \$5,080 (single) \$10,160 (family)
Physician Visits	Medicare pays 80% You pay 20% Medicare covers a "Welcome to Medicare" preventive visit and a yearly "Wellness" visit. No charge if they are from a doctor who accepts assignment.	Plan pays Part B coinsurance of 20%	Carve-out method applies; \$12 copayment ; Plan allows 80% in-network, 60% out-of-network; Well Child Care visits and immunizations paid at 100% in-network until child turns age 19.
Prescription Drugs (SHP Medicare Prescription Drug Program and SHP Prescription Drug Program)	Covered under Medicare Part D. Subscribers to health plans offered through PEBA Insurance Benefits will be better served if they remain covered by the Part D plan sponsored by PEBA Insurance Benefits.	Participating pharmacies only (up to 31-day supply): \$9 Tier 1 (generic—lowest cost), \$38 Tier 2 (brand—higher cost), \$63 Tier 3 (brand—highest cost) Mail-order (up to 90-day supply): \$22 Tier 1, \$95 Tier 2, \$158 Tier 3 Copay max: \$2,500	Participating pharmacies only (up to 31-day supply): \$9 Tier 1 (generic—lowest cost), \$38 Tier 2 (brand—higher cost), \$63 Tier 3 (brand—highest cost) Mail order (up to 90-day supply): \$22 Tier 1, \$95 Tier 2, \$158 Tier 3 Copay max: \$2,500
Mental Health/Substance Abuse	Inpatient: Medicare pays 100% for days 1-60 (Part A deductible applies); You pay \$315/day for days 61-90; You pay \$630/day for days 91-150 (subject to 60 lifetime reserve days); You pay all costs after 150 days. Outpatient: Medicare pays 80% (Part B deductible applies)	Inpatient: Plan pays Medicare deductible; \$315 coinsurance for days 61-90; \$630 coinsurance for days 91-150; After 150 days CBA approval required. Outpatient: Plan pays Medicare deductible, 20% coinsurance	Carve-out method applies Plan allows 80% in-network
Lifetime Maximum	None	None	None

& Family Members Eligible for Medicare

Plan	Medicare	Medicare Supplemental	SHP Standard Plan ¹
Inpatient Hospital Days	Medicare pays 100% for days 1-60 (Part A deductible applies); You pay \$315/day for days 61-90; You pay \$630 for days 91-150 (subject to 60 lifetime reserve days); You pay all costs beyond 150 days	Plan pays Medicare deductible; coinsurance for days 61-150 (Medicare benefits may end sooner than day 150 if the member has previously used any of his 60 lifetime reserve days) Pays 100 percent beyond 150 days. (Medi-Call or CBA approval required).	Carve-out method applies Plan allows 80% (Call Medi-Call if hospital stay exceeds 150 days)
Skilled Nursing Facility	Medicare pays 100% for days 1-20; You pay \$157.50 for days 21-100	Plan pays \$157.50 for days 21-100; With Medi-Call approval, Plan pays 100% of approved days beyond 100 days (limited to 60 days)	Carve-out method applies. Plan allows 80%, up to 60 days. (Call Medi-Call or CBA if hospital stay exceeds 100 days)
Private Duty Nursing	Not covered	\$200 annual deductible Plan pays 80% if Medi-Call approved You pay 20% \$5,000 annual maximum \$25,000 lifetime maximum	Not covered.
Home Health Care	Medicare pays 100%	Medi-Call available to assist with referrals Up to 100 visits.	Carve-out method applies Plan allows 80% You pay 20% Up to 100 visits.
Hospice Care	Plan pays 100%	Medi-Call available to assist with referrals	Medi-Call available to assist with referrals
Durable Medical Equipment	Medicare pays 80% of Medicare-approved amount (Medicare approval required) You pay 20%	Plan pays 20% coinsurance (Medi-Call required)	Carve-out method applies Plan allows 80% (Medi-Call approval required)
Routine Mammography Screening	No charge if the doctor accepts assignment; guidelines apply.	Plan pays 20% coinsurance	Ages 35-74 at participating facilities only; guidelines apply
Pap Test	Routine every 24 months (yearly if high risk) No patient liability if the doctor accepts assignment.	Plan pays 20% coinsurance. Otherwise, plan pays yearly for one routine Pap test for covered women ages 18-65. Diagnostic only age 66 and older.	Routine yearly, ages 18-65; Diagnostic only, age 66 and older; Plan allows 100% for Pap test (Carve-out method applies when Medicare pays)
Ambulance	Medicare pays 80% You pay 20%	Plan pays 20% coinsurance	Carve-out method applies Plan allows 80%
Eyeglasses	None, except for prosthetic lenses from cataract surgery.	None, except for prosthetic lenses from cataract surgery.	None, except for prosthetic lenses from cataract surgery.

¹The "carve-out" method is used to pay claims for retired subscribers covered by the Standard Plan and Medicare. For information about it, see pages 9-10.

Please note:

This chart is just a summary of your benefits. Please see the 2015 Insurance Benefits Guide, BlueCross BlueShield of South Carolina, Catamaran or Medicare for details.

Premiums

2015 Funded Retiree Monthly Premiums¹

Tobacco users will pay a \$40- or \$60-per-month surcharge *in addition* to health premiums

Retiree eligible for Medicare/spouse eligible for Medicare

	Savings	Standard	Medicare Supp ²	TRICARE Supp ³	Dental	Dental Plus ⁴	Vision
Retiree	N/A	\$ 79.68	\$ 97.68	N/A	\$ 0.00	\$24.58	\$ 7.00
Retiree/spouse	N/A	\$217.36	\$253.36	N/A	\$ 7.64	\$49.66	\$14.00
Retiree/children	N/A	\$125.86	\$143.86	N/A	\$13.72	\$57.26	\$14.98
Full family	N/A	\$270.56	\$306.56	N/A	\$21.34	\$74.22	\$21.98

Retiree eligible for Medicare/spouse not eligible for Medicare

	Savings	Standard	Medicare Supp ²	TRICARE Supp ³	Dental	Dental Plus ⁴	Vision
Retiree/spouse	N/A	\$235.36	\$253.36	N/A	\$ 7.64	\$49.66	\$14.00
Full family	N/A	\$281.54	\$299.54	N/A	\$21.34	\$74.22	\$21.98

Retiree not eligible for Medicare/spouse eligible for Medicare

	Savings	Standard	Medicare Supp ²	TRICARE Supp ³	Dental	Dental Plus ⁴	Vision
Retiree/spouse	\$ 77.40	\$235.36	\$253.36	N/A	\$ 7.64	\$49.66	\$14.00
Full family	\$113.00	\$281.54	\$299.54	N/A	\$21.34	\$74.22	\$21.98

Retiree not eligible for Medicare/spouse not eligible for Medicare

	Savings	Standard	Medicare Supp ²	TRICARE Supp ³	Dental	Dental Plus ⁴	Vision
Retiree	\$ 9.70	\$ 97.68	N/A	\$ 62.50	\$ 0.00	\$24.58	\$ 7.00
Retiree/spouse	\$ 77.40	\$253.36	N/A	\$121.50	\$ 7.64	\$49.66	\$14.00
Retiree/children	\$ 20.48	\$143.86	N/A	\$121.50	\$13.72	\$57.26	\$14.98
Full family	\$113.00	\$306.56	N/A	\$162.50	\$21.34	\$74.22	\$21.98

Retiree not eligible for Medicare/spouse not eligible for Medicare/one or more children eligible for Medicare

	Savings	Standard	Medicare Supp ²	TRICARE Supp ³	Dental	Dental Plus ⁴	Vision
Retiree/children	\$ 20.48	\$143.86	\$161.86	N/A	\$13.72	\$57.26	\$14.98
Full family	\$113.00	\$306.56	\$324.56	N/A	\$21.34	\$74.22	\$21.98

¹ Rates for local subdivisions may vary. To verify your rates, contact your benefits office.

² If the Medicare Supplemental Plan is elected, claims for covered persons not eligible for Medicare will be based on the Standard Plan provisions.

³ The tobacco-use surcharge does not apply to TRICARE Supplement subscribers.

⁴ If you enroll in Dental Plus, you must also be enrolled in the State Dental Plan. You pay the combined premiums for the plans.

2015 Non-Funded Retiree Monthly Premiums¹

Tobacco users will pay a \$40- or \$60-per-month surcharge *in addition* to health premiums

Retiree eligible for Medicare/spouse eligible for Medicare

	Savings	Standard	Medicare Supp ²	TRICARE Supp ³	Dental	Dental Plus ⁴	Vision
Retiree	N/A	\$ 424.26	\$ 442.26	N/A	\$11.72	\$24.58	\$ 7.00
Retiree/spouse	N/A	\$ 899.90	\$ 935.90	N/A	\$19.36	\$49.66	\$14.00
Retiree/children	N/A	\$ 654.74	\$ 672.74	N/A	\$25.44	\$57.26	\$14.98
Full family	N/A	\$1,125.14	\$1,161.14	N/A	\$33.06	\$74.22	\$21.98

Retiree eligible for Medicare/spouse not eligible for Medicare

	Savings	Standard	Medicare Supp ²	TRICARE Supp ³	Dental	Dental Plus ⁴	Vision
Retiree/spouse	N/A	\$ 917.90	\$ 935.90	N/A	\$19.36	\$49.66	\$14.00
Full family	N/A	\$1,136.12	\$1,154.12	N/A	\$33.06	\$74.22	\$21.98

Retiree not eligible for Medicare/spouse eligible for Medicare

	Savings	Standard	Medicare Supp ²	TRICARE Supp ³	Dental	Dental Plus ⁴	Vision
Retiree/spouse	\$759.94	\$ 917.90	\$ 935.90	N/A	\$19.36	\$49.66	\$14.00
Full family	\$967.58	\$1,136.12	\$1,154.12	N/A	\$33.06	\$74.22	\$21.98

Retiree not eligible for Medicare/spouse not eligible for Medicare

	Savings	Standard	Medicare Supp ²	TRICARE Supp ³	Dental	Dental Plus ⁴	Vision
Retiree	\$354.28	\$ 442.26	N/A	\$ 62.50	\$11.72	\$24.58	\$ 7.00
Retiree/spouse	\$759.94	\$ 935.90	N/A	\$121.50	\$19.36	\$49.66	\$14.00
Retiree/children	\$549.36	\$ 672.74	N/A	\$121.50	\$25.44	\$57.26	\$14.98
Full family	\$967.58	\$1,161.14	N/A	\$162.50	\$33.06	\$74.22	\$21.98

Retiree not eligible for Medicare/spouse not eligible for Medicare/one or more children eligible for Medicare

	Savings	Standard	Medicare Supp ²	TRICARE Supp ³	Dental	Dental Plus ⁴	Vision
Retiree/children	\$549.36	\$ 672.74	\$ 690.74	N/A	\$25.44	\$57.26	\$14.98
Full family	\$967.58	\$1,161.14	\$1,179.14	N/A	\$33.06	\$74.22	\$21.98

¹ Rates for local subdivisions may vary. To verify your rates, contact your benefits office.

² If the Medicare Supplemental Plan is elected, claims for covered persons not eligible for Medicare will be based on the Standard Plan provisions.

³ The tobacco-use surcharge does not apply to TRICARE Supplement subscribers.

⁴ If you enroll in Dental Plus, you must also be enrolled in the State Dental Plan. You pay the combined premiums for the plans.

2015 Non-Funded Survivor Monthly Premiums¹

Tobacco users will pay a \$40- or \$60-per-month surcharge *in addition* to health premiums

Spouse eligible for Medicare/children eligible for Medicare

	Savings	Standard	Medicare Supp ²	TRICARE Supp ⁴	Dental	Dental Plus ⁵	Vision
Spouse	N/A	\$424.26	\$ 442.26	N/A	\$11.72	\$24.58	\$ 7.00
Spouse/children	N/A	\$654.74	\$ 690.74	N/A	\$25.44	\$57.26	\$14.98
Children only	N/A	\$230.48	\$248.48 ³	N/A	\$13.72	\$32.68	\$ 7.98

Spouse eligible for Medicare/children not eligible for Medicare

	Savings	Standard	Medicare Supp ²	TRICARE Supp ⁴	Dental	Dental Plus ⁵	Vision
Spouse	N/A	\$424.26	\$442.26	N/A	\$11.72	\$24.58	\$ 7.00
Spouse/children	N/A	\$654.74	\$672.74	N/A	\$25.44	\$57.26	\$14.98
Children only	\$195.08	\$230.48	N/A	N/A	\$13.72	\$32.68	\$ 7.98

Spouse not eligible for Medicare/children eligible for Medicare

	Savings	Standard	Medicare Supp ²	TRICARE Supp ⁴	Dental	Dental Plus ⁵	Vision
Spouse	\$354.28	\$442.26	N/A	N/A	\$11.72	\$24.58	\$ 7.00
Spouse/children	\$549.36	\$672.74	\$690.74 ³	N/A	\$25.44	\$57.26	\$14.98
Children only	N/A	\$230.48	\$248.48 ³	N/A	\$13.72	\$32.68	\$ 7.98

Spouse not eligible for Medicare/children not eligible for Medicare

	Savings	Standard	Medicare Supp ²	TRICARE Supp ⁴	Dental	Dental Plus ⁵	Vision
Spouse	\$354.28	\$442.26	N/A	\$ 62.50	\$11.72	\$24.58	\$ 7.00
Spouse/children	\$549.36	\$672.74	N/A	\$121.50	\$25.44	\$57.26	\$14.98
Children only	\$195.08	\$230.48	N/A	\$ 61.00	\$13.72	\$32.68	\$ 7.98

¹ Rates for local subdivisions may vary. To verify your rates, contact your benefits office.

² If the Medicare Supplemental Plan is elected, claims for covered subscribers not eligible for Medicare will be based on the Standard Plan provisions.

³ This premium applies only if one or more children are eligible for Medicare.

⁴ The tobacco-use surcharge does not apply to TRICARE Supplement subscribers.

⁵ If you enroll in Dental Plus, you must also be enrolled in the State Dental Plan. You pay the combined premiums for the plans.

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