

# FALL 2016

# benefits

## ADVANTAGE

### It's time to make choices for 2017

The 2016 *Benefits Advantage* details your insurance options for 2017, including the changes you can make during the October 1-31, 2016, open enrollment period. Please refer to your 2016 *Insurance Benefits Guide* (IBG) for comprehensive descriptions of the insurance programs the South Carolina Public Employee Benefit Authority (PEBA) offers.

#### Reminders

- You do not need to do anything if you are enrolled in the coverage of your choice. Please note that active employees need to enroll or re-enroll in the MoneyPlus medical spending or dependent care spending accounts during October enrollment to participate in 2017.
- Any changes that you make during open enrollment take effect January 1, 2017.
- By January, the 2017 *Insurance Benefits Guide*, which includes an overview of benefits, premiums and contact information for all insurance programs offered through PEBA, will be available online at [www.peba.sc.gov](http://www.peba.sc.gov). Printed copies will be mailed to all retirees, COBRA subscribers and survivors. Active employees will not receive a printed copy.

### What's new for 2017

Funded subscriber premiums for the State Health Plan Savings Plan, Standard Plan and Medicare Supplemental Plan will not increase in 2017. The employer premiums for the three plans will increase by 0.8 percent.

Other changes effective January 1, 2017, include:

- Ameda manual and electric breast pumps received from a participating provider will be provided at no cost to pregnant subscribers and covered spouses.
- The Prescription Drug Program's formulary will change to Express Scripts National Preferred Formulary. This change affects only active employees, non-Medicare retirees and Medicare retirees who opted

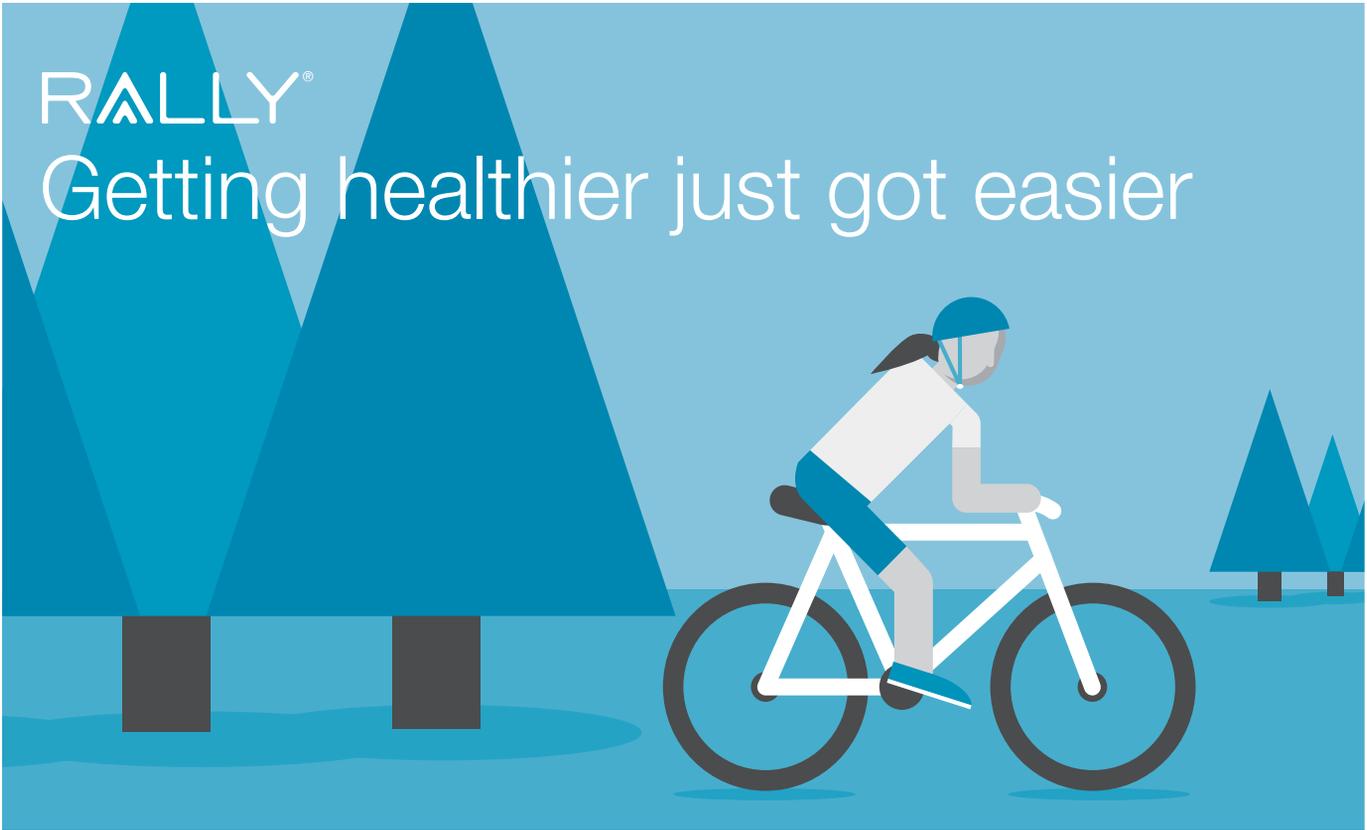
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# RALLY®

## 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 Age<sup>SM</sup>, 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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## Open enrollment is easy when you use MyBenefits

MyBenefits, PEBA's online insurance enrollment system, allows you to change your coverage during open enrollment anywhere you have internet access. Using MyBenefits saves a phone call or visit to your benefits office and ensures speedy transmission of your coverage changes.

After logging in at [MyBenefits.sc.gov](http://MyBenefits.sc.gov), select Open Enrollment from the menu to view your current coverage, along with premiums. Under Make Coverage Changes, you will see options available to you during open enrollment and the premiums associated with them. Employees and former employees of local subdivisions will need to contact their employer's benefits administrator for premiums, as the premiums can be different in these cases.

Select the changes you want and choose Next. You will see a summary page comparing your current coverage to those you have just entered. If you are satisfied with the changes, choose Apply.

To authorize your changes, you will need to enter the last four digits of your Social Security number and click Sign. Your changes are not complete until you submit your electronic

signature. You should also print a copy of the Summary of Change for your records. Make note that some transactions require supporting documentation, and cannot be approved until those documents are received.

If you change your mind about your selections before open enrollment ends at 11:59 p.m. on October 31, you can return to MyBenefits to make additional changes.

### Important reminders

- If you enroll a dependent for the first time, be sure to submit legible photocopies of eligibility documentation to your benefits administrator. Please see your 2016 *Insurance Benefits Guide* for a list of acceptable documentation.
- To see the benefits you have now, you can print your statement from MyBenefits.
- Use MyBenefits year-round to review your benefits, change your beneficiaries, and update your contact information.

### Can't remember your password?

Click the Forgot/Reset Password link on the MyBenefits home page. You will be asked to answer one

of the four security questions you chose when you created your account. After three incorrect attempts to answer the security question, your account will be reset and you will need to register as a new user.

### Register for MyBenefits in three easy steps

1. Visit [MyBenefits.sc.gov](http://MyBenefits.sc.gov).
2. You will need your benefits identification number (BIN), which is the numeric portion of your Member ID located on your State Health Plan card. You can also get it by clicking Get my BIN at the bottom right of the MyBenefits home page and following the instructions.
3. Click Register on the left of the MyBenefits page. Follow the instructions to enter your personal information and create a password. The password must be eight characters long and include at least one number and one special character (! : # \$ % \* [ ] { } @). You will also need to choose four security questions.

# What you can do during the 2016 open enrollment

Open enrollment is October 1-31, 2016. Any coverage changes that you make will take effect January 1, 2017. You do not need to do anything if you are satisfied with your current coverage; your coverage will continue for 2017. Active employees need to enroll or re-enroll in the MoneyPlus medical spending or dependent care spending accounts during October enrollment to participate in 2017.

## Health options

- Change from one health plan to another:
  - State Health Plan Savings Plan
  - State Health Plan Standard Plan
  - GEA TRICARE Supplement Plan (available to eligible members of the military community)
- Enroll yourself or any eligible dependents in health coverage
- Retirees and their dependents who are eligible for Medicare may enroll in or change to the Medicare Supplemental Plan
- Drop health coverage for yourself or any dependents

### Do you need documentation?

If you are enrolling a family member for the first time, documentation is required. Find the information and documents you need for each family member in the 2016 *Insurance Benefits Guide*.

If you change to the Savings Plan during October, the change will go into effect January 1, 2017. Beginning on that date, you will be eligible to contribute to a health savings account (HSA) if you

are not covered by other health insurance, including Medicare, and if you cannot be claimed as a dependent on another person's income tax return.

The HSA contribution limits for 2017 are \$3,400 for single coverage and \$6,750 for family coverage. Subscribers age 55 and older can contribute an additional \$1,000 catch-up amount. You can enroll in an HSA through Optum accounts administered by WageWorks.

If you are considering changing health plans for 2017, be sure to review the health plan comparison chart on Page 8 and note the differences in deductibles and copayments. Premiums are available on Pages 9-12.

## No dental options available this year

Changes to dental coverage may only be made during open enrollment in odd-numbered years. Your next opportunity to make changes in dental coverage is October 2017 for January 1, 2018.

## State Vision Plan

Enroll in or drop vision coverage for yourself and/or your eligible family members. See Pages 9-12 for premiums.

## Life insurance options – active employees only

- Active employees may enroll in or increase their Optional Life insurance coverage with medical evidence of good health during open enrollment. The effective date of the increase is January 1, 2017. Active employees who do not participate in the MoneyPlus pretax premium feature may enroll in or increase Optional Life throughout the year with medical evidence of good health. You may also decrease or cancel your coverage.
- You can decrease or cancel your Dependent Life-Spouse coverage. You cannot enroll your spouse in Dependent Life-Spouse coverage without medical evidence of good health. You can increase coverage, up to 50 percent of your

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## What you can do during the 2016 open enrollment

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optional life coverage or \$100,000, whichever is less, throughout the year with medical evidence of good health. To do so, see your benefits administrator.

- You may enroll in or drop Dependent Life-Child coverage for any eligible children throughout the year.

## Supplemental long term disability insurance

With medical evidence of good health, active employees may apply to enroll in coverage throughout the year.

## MoneyPlus

Active employees need to enroll or re-enroll in the MoneyPlus medical spending or dependent care spending accounts during October enrollment to participate in 2017. If you enroll in the Savings Plan during October, you may be eligible to enroll in a health savings account for 2017. See Page 6 for more information about MoneyPlus.

## How to make your changes

- Make changes in your coverage (except for MoneyPlus) online using MyBenefits. See Page 3 for details.
- A printable Notice of Election form is online at [www.peba.sc.gov/iforms.html](http://www.peba.sc.gov/iforms.html). Give your completed form to your benefits administrator. If you are a retiree who worked for a state agency, public school district or higher education institution, PEBA is your benefits administrator. If you are a retiree who worked for a county, municipality or other local subdivision, your former employer is your benefits administrator.

## Follow up on your changes

If you make coverage changes during open enrollment, make sure your coverage is correct and the right premiums are being deducted. In January, after you receive your first paycheck, you can log in to MyBenefits at [MyBenefits.sc.gov](http://MyBenefits.sc.gov) and select Review Benefits from the drop-down list to see your 2017 benefits.

If you notice any discrepancies, contact your benefits administrator immediately.

## Attention retirees: do you qualify for Medicare?

Whether you qualify for Medicare because of age or a disability, here are some important tips to remember:

- If you or one of your dependents qualify for Medicare because of disability, you should submit a Notice of Election form to enroll in the Medicare Supplemental Plan within 31 days of Medicare eligibility. Be sure to submit a copy of your Medicare card with your form.
- When enrolling in Medicare,

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### What's new for 2017

Continued from Page 1

- out of the State Health Plan Medicare Prescription Drug Program. If you have questions about which prescription drug plan you are in, please contact Express Scripts at 855.612.3128.
- Telehealth services through Blue CareOnDemand<sup>SM</sup> will be a regular, covered service. See Page 40.
- The lifetime limit for hospice service will increase to \$7,500.

# Get more out of your paycheck with MoneyPlus

You can help increase the spendable income in your paycheck by participating in the MoneyPlus pretax flexible benefits program. All of the following program features are available to active employees. If you are a retiree, the only program feature in which you can participate is a health savings account, and you can participate only if you are enrolled in the State Health Plan Savings Plan and are not enrolled in Medicare.

Ready to save yourself some money? Continue reading to find out which program features best fit your needs and enroll this October.

## Pretax Group Insurance Premium feature

This feature allows you to pay premiums for health, vision, dental and optional life (for coverage up to \$50,000) before taxes are taken from your paycheck. Once you are enrolled in the pretax premium feature, you do not need to re-enroll each year.

Ex-spouse coverage is not eligible for pretax premiums. If you cover an ex-spouse on any benefit, you will not be eligible for pretax treatment of premiums. This does not affect the member's eligibility to participate in a medical spending account or dependent care spending account.

## Flexible spending accounts

To initiate or continue participation in 2017 in the dependent care spending account and/or the medical spending account or the limited-use medical spending account, you need to enroll or re-enroll, which you may do online at [www.myFBMC.com](http://www.myFBMC.com). You may also submit a paper MoneyPlus enrollment form in lieu of online enrollment by going through your benefits administrator.

New participants in the medical spending account or limited-use medical spending account will automatically receive the myFBMC Card® Visa® card for 2017.

In 2017, the dependent care spending account will be capped at \$1,700 for highly compensated employees. The \$1,700 cap is subject to adjustment if PEBA's dependent care spending account

does not meet the Average Benefits Test. The test is designed to make sure highly compensated employees don't 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.

## Health savings account (Savings Plan subscribers only)

The health savings account is only available if you are covered by the State Health Plan Savings Plan or another high-deductible health plan. It is not available to you if you are covered by Medicare or any other non-high-deductible health plan, or if you can be claimed as a dependent on another person's tax return. A MoneyPlus medical spending account—even a spouse's medical spending account—is considered other health insurance. If you enroll in the health savings account, you may contribute to a limited-use medical spending account, which can be used for dental and vision expenses.

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## 2017 contribution limits

<b>Medical Spending Account</b>
\$2,550
<b>Dependent Care Spending Account<sup>1</sup></b>
• \$2,500 (married, filing separately)
• \$5,000 (single and head of household or married and filing jointly)
<b>Health Savings Account</b>
• \$3,400 (single)
• \$6,750 (family)
• \$1,000 catch-up for age 55 and older

<sup>1</sup>In 2017, the Dependent Care Spending Account will be capped at \$1,700 for highly compensated employees.

# What will you pay?

## Understanding annual deductibles, copayments and coinsurance

When making decisions about benefits, you may consider your out-of-pocket expenses in addition to your monthly premiums. Different plans require coinsurance, copayments or deductibles that you must pay when using your benefits.

### Annual deductible

An annual deductible is the amount you must pay before the insurance plan will pay any benefits for your health care.

For specific information about how the plan you are considering handles copayments, coinsurance and deductibles, see Page 8.

### Copayment

Copayments are fees that must be paid at each visit to a health, dental or vision provider and when buying prescription drugs. These charges can vary by the type

of provider you visit and by the services you receive. You are responsible for paying copayments, even after you have met your annual deductible for the plan year. Copayments do not count toward your annual deductible or coinsurance maximum.

### Coinsurance

Coinsurance requires you pay a percentage of the covered cost of your health care after you have met your annual deductible. The insurance plan pays the balance of your health care. Your coinsurance payments are subject to a maximum for the plan year—January 1 through December 31. After you have reached your coinsurance maximum, you will no longer be required to pay coinsurance for the remainder of the plan year. You will still be responsible for copayments.

### Get more out of your paycheck with MoneyPlus Continued from Page 6

If you enrolled in the health savings account in 2016 and are still eligible to participate in one, you do not need to re-enroll for 2017. To start, stop or change the amount you contribute monthly, complete a MoneyPlus enrollment form and enter the new amount (\$0 to stop contributions) on the form. Return the form to your benefits administrator.

If you enroll in the Savings Plan in October, your enrollment will go into effect January 1, 2017. On that date, you will be eligible to contribute to a health savings account. You can enroll in the MoneyPlus health savings account in October and begin contributing January 1, 2017, if your medical

spending account has a \$0 balance on December 31, 2016. Otherwise, you must wait until April 1, 2017, to contribute to your health savings account.

For more details on any of the MoneyPlus program's features, read the *Tax-Favored Accounts Guide*, available at [www.peba.sc.gov/iresources.html](http://www.peba.sc.gov/iresources.html) and through your benefits administrator.

### 2017 fees per month

<b>Pretax Group Insurance Premium feature</b>	\$0.28
<b>Dependent Care Spending Account</b>	\$3.14
<b>Medical Spending Accounts (full and limited-use)</b>	\$3.14
<b>Health Savings Account (WageWorks fee)</b>	\$1.50
<b>Health Savings Account (Optum fee)<sup>2</sup></b>	\$1.50

<sup>2</sup>This fee is waived for accounts with balances of \$2,500 or more.

# Health benefits offered for 2017<sup>1</sup>

This chart is for comparison purposes only. For more information about these plans, refer to your *2016 Insurance Benefits Guide*.

Plan <sup>2</sup>	Savings Plan		Standard Plan <sup>3</sup>		Medicare Supplemental Plan <sup>3</sup>
	In-network	Out-of-network	In-network	Out-of-network	
<b>Availability</b>	Coverage worldwide		Coverage worldwide		<ul style="list-style-type: none"> <li>• Same as Medicare</li> <li>• Available to retirees and covered dependents/survivors who are eligible for Medicare</li> </ul>
<b>Annual deductible</b>	<ul style="list-style-type: none"> <li>• Single: \$3,600</li> <li>• Family: \$7,200<sup>4</sup></li> </ul>		<ul style="list-style-type: none"> <li>• Single: \$445</li> <li>• Family: \$890</li> </ul>		Pays Medicare Part A and Part B deductibles
<b>Coinsurance<sup>5</sup></b>	<ul style="list-style-type: none"> <li>• Plan pays 80%</li> <li>• You pay 20%</li> </ul>	<ul style="list-style-type: none"> <li>• Plan pays 60%</li> <li>• You pay 40%</li> </ul>	<ul style="list-style-type: none"> <li>• Plan pays 80%</li> <li>• You pay 20%</li> </ul>	<ul style="list-style-type: none"> <li>• Plan pays 60%</li> <li>• You pay 40%</li> </ul>	Pays Part B coinsurance of 20%
<b>Coinsurance maximum</b>	<ul style="list-style-type: none"> <li>• Single \$2,400</li> <li>• Family \$4,800</li> <li>• Excludes deductible</li> </ul>	<ul style="list-style-type: none"> <li>• Single \$4,800</li> <li>• Family \$9,600</li> <li>• Excludes deductible</li> </ul>	<ul style="list-style-type: none"> <li>• Single \$2,540</li> <li>• Family \$5,080</li> <li>• Excludes deductible and copayments</li> </ul>	<ul style="list-style-type: none"> <li>• Single \$5,080</li> <li>• Family \$10,160</li> <li>• Excludes deductible and copayments</li> </ul>	None
<b>Physicians' office visits and telehealth visits through Blue CareOnDemand<sup>5</sup></b>	<ul style="list-style-type: none"> <li>• No copayment</li> <li>• Plan pays 80%</li> <li>• You pay 20%</li> <li>• Chiropractic payments limited to \$500 a year, per person</li> </ul>	<ul style="list-style-type: none"> <li>• No copayment</li> <li>• Plan pays 60%</li> <li>• You pay 40%</li> <li>• Chiropractic payments limited to \$500 a year, per person</li> </ul>	<ul style="list-style-type: none"> <li>• \$12 copayment</li> <li>• Plan pays 80%</li> <li>• You pay 20%</li> <li>• Chiropractic payments limited to \$2,000 a year, per person</li> </ul>	<ul style="list-style-type: none"> <li>• \$12 copayment</li> <li>• Plan pays 60%</li> <li>• You pay 40%</li> <li>• Chiropractic payments limited to \$2,000 a year, per person</li> </ul>	Pays Part B coinsurance of 20%
<b>Hospitalization/emergency care</b>	No copayments		<ul style="list-style-type: none"> <li>• Outpatient facility services: \$95 copayment</li> <li>• Emergency care: \$159 copayment</li> <li>• Plan pays 80%</li> <li>• You pay 20%</li> </ul>	<ul style="list-style-type: none"> <li>• Outpatient facility services: \$95 copayment</li> <li>• Emergency care: \$159 copayment</li> <li>• Plan pays 60%</li> <li>• You pay 40%</li> </ul>	For inpatient hospital stays, the 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); 100% beyond 150 days (Medi-Call approval required)
<b>Prescription drugs</b>	Participating pharmacies and mail order: You pay the State Health Plan's allowed amount until the annual deductible is met. Afterward, the Plan will pay 80% of the allowed amount; you pay 20% in coinsurance. When the maximum is reached, the Plan will pay 100% of the allowed amount, and you may obtain the medication at no cost.		<ul style="list-style-type: none"> <li>• Participating pharmacies only (up to 30-day supply) <ul style="list-style-type: none"> <li>• Tier 1 (generic-lowest cost alternative): \$9</li> <li>• Tier 2 (brand-higher cost alternative): \$38</li> <li>• Tier 3 (brand-highest cost alternative): \$63</li> </ul> </li> <li>• Mail order and retail maintenance network pharmacies (up to 90-day supply) <ul style="list-style-type: none"> <li>• Tier 1: \$22</li> <li>• Tier 2: \$95</li> <li>• Tier 3: \$158</li> </ul> </li> <li>• Copay maximum: \$2,500</li> </ul>	<ul style="list-style-type: none"> <li>• Participating pharmacies only (up to 30-day supply) <ul style="list-style-type: none"> <li>• Tier 1 (generic-lowest cost alternative): \$9</li> <li>• Tier 2 (brand-higher cost alternative): \$38</li> <li>• Tier 3 (brand-highest cost alternative): \$63</li> </ul> </li> <li>• Mail order and retail maintenance network pharmacies (up to 90-day supply) <ul style="list-style-type: none"> <li>• Tier 1: \$22</li> <li>• Tier 2: \$95</li> <li>• Tier 3: \$158</li> </ul> </li> <li>• Copay maximum: \$2,500</li> </ul>	

Footnotes listed on Page 12

## 2017 monthly premiums for active employees<sup>1</sup>

Plan	Savings Plan	Standard Plan	TRICARE Supp <sup>2</sup>	Dental	Dental Plus <sup>6</sup>	Vision
Employee	\$9.70	\$97.68	\$62.50	\$0.00	\$25.96	\$7.00
Employee/spouse	\$77.40	\$253.36	\$121.50	\$7.64	\$52.46	\$14.00
Employee/children	\$20.48	\$143.86	\$121.50	\$13.72	\$60.50	\$14.98
Full family	\$113.00	\$306.56	\$162.50	\$21.34	\$78.60	\$21.98

Footnotes listed on Page 12

## 2017 monthly premiums for funded retirees<sup>1</sup>

### Retiree eligible for Medicare/spouse eligible for Medicare

Plan	Savings Plan	Standard Plan	Medicare Supp <sup>7</sup>	TRICARE Supp <sup>2</sup>	Dental	Dental Plus <sup>6</sup>	Vision
Retiree	N/A	\$79.68	\$97.68	N/A	\$0.00	\$25.96	\$7.00
Retiree/spouse	N/A	\$217.36	\$253.36	N/A	\$7.64	\$52.46	\$14.00
Retiree/children	N/A	\$125.86	\$143.86	N/A	\$13.72	\$60.50	\$14.98
Full family	N/A	\$270.56	\$306.56	N/A	\$21.34	\$78.60	\$21.98

### Retiree eligible for Medicare/spouse not eligible for Medicare

Plan	Savings Plan	Standard Plan	Medicare Supp <sup>7</sup>	TRICARE Supp <sup>2</sup>	Dental	Dental Plus <sup>6</sup>	Vision
Retiree/spouse	N/A	\$235.36	\$253.36	N/A	\$7.64	\$52.46	\$14.00
Full family	N/A	\$281.54	\$299.54	N/A	\$21.34	\$78.60	\$21.98

### Retiree not eligible for Medicare/spouse eligible for Medicare

Plan	Savings Plan	Standard Plan	Medicare Supp <sup>7</sup>	TRICARE Supp <sup>2</sup>	Dental	Dental Plus <sup>6</sup>	Vision
Retiree/spouse	\$77.40	\$235.36	\$253.36	N/A	\$7.64	\$52.46	\$14.00
Full family	\$113.00	\$281.54	\$299.54	N/A	\$21.34	\$78.60	\$21.98

### Retiree not eligible for Medicare/spouse not eligible for Medicare

Plan	Savings Plan	Standard Plan	Medicare Supp <sup>7</sup>	TRICARE Supp <sup>2</sup>	Dental	Dental Plus <sup>6</sup>	Vision
Retiree	\$9.70	\$97.68	N/A	\$62.50	\$0	\$25.96	\$7.00
Retiree/spouse	\$77.40	\$253.36	N/A	\$121.50	\$7.64	\$52.46	\$14.00
Retiree/children	\$20.48	\$143.86	N/A	\$121.50	\$13.72	\$60.50	\$14.98
Full family	\$113.00	\$306.56	N/A	\$162.50	\$21.34	\$78.60	\$21.98

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

Plan	Savings Plan	Standard Plan	Medicare Supp <sup>7</sup>	TRICARE Supp <sup>2</sup>	Dental	Dental Plus <sup>6</sup>	Vision
Retiree/children	\$20.48	\$143.86	\$161.86	N/A	\$13.72	\$60.50	\$14.98
Full family	\$113.00	\$306.56	\$324.56	N/A	\$21.34	\$78.60	\$21.98

Footnotes listed on Page 12

## 2017 monthly premiums for non-funded retirees<sup>1</sup>

### Retiree eligible for Medicare/spouse eligible for Medicare

Plan	Savings Plan	Standard Plan	Medicare Supp <sup>7</sup>	TRICARE Supp <sup>2</sup>	Dental	Dental Plus <sup>6</sup>	Vision
Retiree	N/A	\$442.66	\$460.66	N/A	\$13.48	\$25.96	\$7.00
Retiree/spouse	N/A	\$936.34	\$972.34	N/A	\$21.12	\$52.46	\$14.00
Retiree/children	N/A	\$682.96	\$700.96	N/A	\$27.20	\$60.50	\$14.98
Full family	N/A	\$1,170.74	\$1,206.74	N/A	\$34.82	\$78.60	\$21.98

### Retiree eligible for Medicare/spouse not eligible for Medicare

Plan	Savings Plan	Standard Plan	Medicare Supp <sup>7</sup>	TRICARE Supp <sup>2</sup>	Dental	Dental Plus <sup>6</sup>	Vision
Retiree/spouse	N/A	\$954.34	\$972.34	N/A	\$21.12	\$52.46	\$14.00
Full family	N/A	\$1,181.72	\$1,199.72	N/A	\$34.82	\$78.60	\$21.98

### Retiree not eligible for Medicare/spouse eligible for Medicare

Plan	Savings Plan	Standard Plan	Medicare Supp <sup>7</sup>	TRICARE Supp <sup>2</sup>	Dental	Dental Plus <sup>6</sup>	Vision
Retiree/spouse	\$796.38	\$954.34	\$972.34	N/A	\$21.12	\$52.46	\$14.00
Full family	\$1,013.18	\$1,181.72	\$1,199.72	N/A	\$34.82	\$78.60	\$21.98

### Retiree not eligible for Medicare/spouse not eligible for Medicare

Plan	Savings Plan	Standard Plan	Medicare Supp <sup>7</sup>	TRICARE Supp <sup>2</sup>	Dental	Dental Plus <sup>6</sup>	Vision
Retiree	\$372.68	\$460.66	N/A	\$62.50	\$13.48	\$25.96	\$7.00
Retiree/spouse	\$796.38	\$972.34	N/A	\$121.50	\$21.12	\$52.46	\$14.00
Retiree/children	\$577.58	\$700.96	N/A	\$121.50	\$27.20	\$60.50	\$14.98
Full family	\$1,013.18	\$1,206.74	N/A	\$162.50	\$34.82	\$78.60	\$21.98

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

Plan	Savings Plan	Standard Plan	Medicare Supp <sup>7</sup>	TRICARE Supp <sup>2</sup>	Dental	Dental Plus <sup>6</sup>	Vision
Retiree/children	\$577.58	\$700.96	\$718.96	N/A	\$27.20	\$60.50	\$14.98
Full family	\$1,013.18	\$1,206.74	\$1,224.74	N/A	\$34.82	\$78.60	\$21.98

Footnotes listed on Page 12

## 2017 monthly premiums for non-funded survivors<sup>1</sup>

### Spouse eligible for Medicare/children eligible for Medicare

Plan	Savings Plan	Standard Plan	Medicare Supp <sup>7</sup>	TRICARE Supp <sup>2</sup>	Dental	Dental Plus <sup>6</sup>	Vision
Spouse	N/A	\$442.66	\$460.66	N/A	\$13.48	\$25.96	\$7.00
Spouse/children	N/A	\$682.96	\$718.96	N/A	\$27.20	\$60.50	\$14.98
Children only	N/A	\$240.30	\$258.30 <sup>8</sup>	N/A	\$13.72	\$34.54	\$7.98

### Spouse eligible for Medicare/children not eligible for Medicare

Plan	Savings Plan	Standard Plan	Medicare Supp <sup>7</sup>	TRICARE Supp <sup>2</sup>	Dental	Dental Plus <sup>6</sup>	Vision
Spouse	N/A	\$442.66	\$460.66	N/A	\$13.48	\$25.96	\$7.00
Spouse/children	N/A	\$682.96	\$700.96	N/A	\$27.20	\$60.50	\$14.98
Children only	\$204.90	\$240.30	N/A	N/A	\$13.72	\$34.54	\$7.98

### Spouse not eligible for Medicare/children eligible for Medicare

Plan	Savings Plan	Standard Plan	Medicare Supp <sup>7</sup>	TRICARE Supp <sup>2</sup>	Dental	Dental Plus <sup>6</sup>	Vision
Spouse	\$372.68	\$460.66	N/A	N/A	\$13.48	\$25.96	\$7.00
Spouse/children	\$577.58	\$700.96	\$718.96 <sup>8</sup>	N/A	\$27.20	\$60.50	\$14.98
Children only	N/A	\$240.30	\$258.30 <sup>8</sup>	N/A	\$13.72	\$34.54	\$7.98

### Spouse not eligible for Medicare/children not eligible for Medicare

Plan	Savings Plan	Standard Plan	Medicare Supp <sup>7</sup>	TRICARE Supp <sup>2</sup>	Dental	Dental Plus <sup>6</sup>	Vision
Spouse	\$372.68	\$460.66	N/A	\$62.50	\$13.48	\$25.96	\$7.00
Spouse/children	\$577.58	\$700.96	N/A	\$121.50	\$27.20	\$60.50	\$14.98
Children only	\$204.90	\$240.30	N/A	\$61.00	\$13.72	\$34.54	\$7.98

Footnotes listed on Page 12

# 2017 monthly premiums for COBRAs<sup>1</sup>

## 18 and 36 months

Plan	Savings Plan	Standard Plan	Medicare Supp <sup>7</sup>	Dental	Dental Plus <sup>6</sup>	Vision
Subscriber	\$380.14	\$469.88	\$469.88	\$13.76	\$26.48	\$7.14
Subscriber/spouse	\$812.32	\$991.80	\$991.80	\$21.54	\$53.52	\$14.28
Subscriber/children	\$589.14	\$714.98	\$714.98	\$27.74	\$61.72	\$15.28
Full family	\$1,033.44	\$1,230.88	\$1,230.88	\$35.52	\$80.18	\$22.42
Children only	\$209.00	\$245.10	\$245.10	\$14.00	\$35.24	\$8.14

## 29 months

Plan	Savings Plan	Standard Plan	Medicare Supp <sup>7</sup>	Dental	Dental Plus <sup>6</sup>	Vision
Subscriber	\$559.02	\$691.00	\$691.00	\$13.76	\$26.48	\$7.14
Subscriber/spouse	\$1,194.58	\$1,458.52	\$1,458.52	\$21.54	\$53.52	\$14.28
Subscriber/children	\$866.38	\$1,051.44	\$1,051.44	\$27.74	\$61.72	\$15.28
Full family	\$1,519.78	\$1,810.12	\$1,810.12	\$35.52	\$80.18	\$22.42
Children only	\$307.36	\$360.44	\$360.44	\$14.00	\$35.24	\$8.14

Footnotes for comparison and premium charts on Pages 8-12:

<sup>1</sup>Premiums for local subdivisions may vary. To verify your rates, contact your benefits office.

<sup>2</sup>State 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.

<sup>3</sup>Refer to your 2016 *Insurance Benefits Guide* for information on how this plan coordinates with Medicare.

<sup>4</sup>If 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.

<sup>5</sup>Standard Plan subscribers who receive care at a BlueCross BlueShield of South Carolina-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 PCMH. More information about Blue CareOnDemand is available on Page 40.

<sup>6</sup>If you enroll in Dental Plus, you must also be enrolled in the State Dental Plan. You will pay the combined premiums for both plans.

<sup>7</sup>If the Medicare Supplemental Plan is elected, claims for covered subscribers not eligible for Medicare will be based on the Standard Plan provisions.

<sup>8</sup>This premium applies only if one or more children are eligible for Medicare.

## Attention retirees: do you qualify for Medicare?

Continued from Page 5

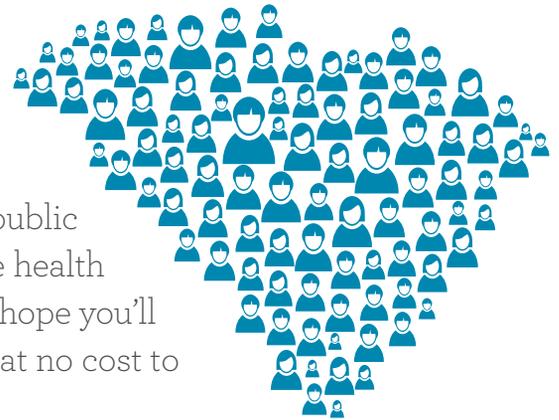
be sure to enroll in Part A and Part B. If you do not sign up for Part B, you will be required to pay the portion of your health care costs that Part B would have paid.

- PEBA automatically enrolls Medicare-eligible retirees and their Medicare-eligible dependents in the State

Health Plan Medicare Prescription Drug Program. Most subscribers covered by the Medicare Supplemental Plan or the Standard Plan may be better served if they remain enrolled in this plan.

The benefits offered by the Standard Plan and Medicare Supplemental Plan vary, especially

in how they coordinate with Medicare. To compare the plans and to determine which one best suits your needs, please refer to the 2016 *When You Become Eligible for Medicare* handbook available at [www.peba.sc.gov/iresources.html](http://www.peba.sc.gov/iresources.html).



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 offering several new preventive health benefits for primary members of the State Health Plan. We hope you'll take action, especially since these programs are available at no cost to you at network providers.

## *Value-based benefits at no cost to you in 2017*

### **Coming Attractions – maternity management**

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

### **Flu vaccine**

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 your 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 program**

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.

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

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*For details including important  
information about the products and  
services covered, visit [PEBAperks.com](http://PEBAperks.com).*

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## 2017 insurance vendor contact information

### BlueCross BlueShield of South Carolina

- Customer Service: 803.736.1576 or 800.868.2520
- Medi-Call: 803.699.3337 or 800.925.9724
- BlueCard Program: 800.810.BLUE (2583)
- StateSC.SouthCarolinaBlues.com

### State Health Plan Behavioral Health

- 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

### State Dental Plan

- Customer Service: 888.214.6230 or 803.264.7323
- StateSC.SouthCarolinaBlues.com

### Express Scripts

- Prescription Drug Program Customer Service: 855.612.3128
- Medicare Prescription Drug Program Customer Service: 855.612.3128
- www.Express-Scripts.com

### EyeMed

- Customer Care Center: 877.735.9314
- www.eyemed.com

### Securian Financial Group

#### Basic Life, Optional Life, Dependent Life

- Customer Service: 866.486.5298
- Fax: 651.665.4827
- Evidence of insurability: 800.872.2214

### Selman & Company

#### TRICARE Supplement Plan

- Customer Service: 866.637.9911, Opt. 1
- www.selmantricareresource.com/SC

### The Standard Insurance Company

#### Long Term Disability

- Customer Service: 800.628.9696
- Fax: 800.437.0961
- Medical evidence of good health: 800.843.7979
- www.standard.com/mybenefits/southcarolina

### WageWorks

#### MoneyPlus

- Customer Care Center: 800.342.8017
- Claims fax: 888.800.5217
- www.myFBMC.com

## Form 1095 for your 2016 taxes

The federal Affordable Care Act requires you and your dependents to have minimum essential health coverage. Internal Revenue Service Form 1095 provides information about your health plan, including coverage that was available (active employees only) and which individuals were covered. Your employer should send you Form 1095 by January 31, 2017.

The statement should be used to verify on your tax return that you and your dependents have minimum essential health coverage.

### Retirees, survivors and COBRA subscribers

If you and your dependents were enrolled in health coverage and at least one of you was not eligible for Medicare, your former employer will send you a Form 1095 by January 31, 2017.

If you and your dependents were eligible for Medicare all of 2016, you will not receive a Form 1095 from your former employer. Because Medicare, your primary health coverage, is a government-sponsored program, Medicare will file the statement for you.

### Changes in your subscriber type

If you were eligible for benefits as an active employee for part of the year and were enrolled part of the year as a retiree, survivor or COBRA subscriber and were not Medicare eligible, all of your coverage may be reported to you on one Form 1095.

The statement will include your coverage as an active employee and as a retiree, survivor or COBRA subscriber. The form shows you had minimum essential coverage, as required by the Affordable Care Act. You should not receive two statements from the same employer.

In some instances, you may receive two statements. If your coverage as an active employee, retiree, survivor or COBRA subscriber were from two different employers, you may receive two Form 1095s.

One will include your active coverage information. The other will include your retiree, survivor or COBRA coverage information.

## Free flu shot offered

As part of PEBA Perks, members covered by the State Health Plan can receive a flu shot at no cost when they go to a participating network pharmacy.

If a member is vaccinated at a network doctor's office, the charge for the flu vaccine and the administration fee will be covered at no member cost, but any associated office visit charges will be processed according to regular plan rules.

Because South Carolina's flu season generally runs from October to March, September or October are usually the best times to get the shot.

If you have questions about whether the vaccine is right for you, talk with your doctor.

## Take advantage of PEBA's online resources

### MyBenefits

[MyBenefits.sc.gov](http://MyBenefits.sc.gov)  
Insurance enrollment system

### Member Access

[retirement.sc.gov](http://retirement.sc.gov)  
Retirement transactions system

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## Gateway to wellness

### Website provides resources for State Health Plan members

The State Health Plan website, [StateSC.SouthCarolinaBlues.com](http://StateSC.SouthCarolinaBlues.com), is powered by BlueCross BlueShield of South Carolina and was developed with you in mind. The user-friendly features were designed to point you toward ways to get and stay healthy.

You will find explanations about coverage and resources, as well as information on reducing risks and managing medical and dental conditions. Other information includes:

- Patient-Centered Medical Homes
- Health management programs
- Member resources

## Get connected with PEBA

PEBA is always looking for the most efficient, effective and timely ways to deliver our services to you. Some of the ways we communicate general information and updates to you is through the agency's website, social media pages and email. To be added to PEBA's email list, simply register for MyBenefits. See Page 3 for more information.

### Social media



Stay informed about important updates related to your insurance and/or retirement benefits, and get access to other resources via



PEBA's social media pages. Search for SCPEBA on Facebook and Twitter.

### Tips for following PEBA on Facebook

Facebook recently changed the way it populates your news feed. This may mean PEBA's updates don't show up easily or as often. Here are some tips from *The Island Packet* and *The Beaufort Gazette* to ensure you see the posts you want in your feed:

#### Computer users:

- Go to PEBA's Facebook page ([www.facebook.com/SCPEBA](http://www.facebook.com/SCPEBA)).
- If you see the word Like, click it once to turn it to Liked, then click again and choose See First and On. If you want to control how you're notified when we post something new, click the small pencil icon next to the word Notification and make your choices.
- If you see the word Like, roll your cursor over it and then choose See First and On. If you want to control how you're notified when we post something new, click the small pencil icon next to the word Notification.

#### For phone or tablet users:

- Go to PEBA's Facebook page ([www.facebook.com/SCPEBA](http://www.facebook.com/SCPEBA)).
- Under the photo at the top, find the word Follow or Following or See First.
- If you see the word Following, click on it and then click See First.
- If you see the word Follow, click it and then click See First.
- If you see the words See First, you don't need to do anything at all.

Follow these steps for any Facebook page you want to be sure is included in your news feed.

## See for yourself the convenience of your vision benefits

Your life is busy, which means your benefits need to be convenient, easy-to-use and fit your lifestyle. In other words, your benefits should feel like a benefit.

That's why the State Vision Plan's benefits package allows you to use your in-network vision benefits online at [Glasses.com](#) and [ContactsDirect](#), in addition to thousands of independent providers and top optical retailers. All you need is a valid prescription from your eye doctor to get started. Log on to [www.eyemed.com](#) to use your benefits online or to find a provider near you. You will also find a detailed description of all your vision benefits.

The following chart provides a quick look at what you can expect from EyeMed's online providers.

Glasses.com	ContactDirect
<ul style="list-style-type: none"><li>• Access the award-winning 3D virtual try-on app.</li><li>• Choose from a large selection of high quality frames and lenses, including some of the world's leading brands.</li><li>• In-browsing benefit application allows you to see what you'll pay while you are shopping .</li><li>• In-Home-Try-On: try frames free for 15 days to make sure they're just right. If you need adjustments, they are available free at all LensCrafters across the country.</li></ul>	<ul style="list-style-type: none"><li>• Apply your in-network vision benefits to your online transaction.</li><li>• Order contact lenses and have them shipped straight to your door for free once your prescription is verified.</li></ul>

## Don't wait to get proof of insurance

Individuals often need proof of health insurance when they are traveling overseas, especially if they are students or will be employed in another country.

Please ask for proof of insurance from PEBA as soon as you know it is needed, as the request may take up to 10 business days to process. Requests must be in writing and must specify what information should be provided.

Requests can be made through the Contact Us link at [www.peba.sc.gov/contact/email/insurance.html](#) or by mailing a letter to:

S.C. PEBA  
Insurance Benefits  
202 Arbor Lake Drive  
Columbia, SC 29223

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# Federally mandated notices

Federal law requires health plans to send a variety of notices to participating employees and dependents, concerning their rights under the health plan. The notices are included on Pages 18-39. It is important that you read these notices. It is also important that each family member you cover be familiar with this information. Questions regarding these notices can be directed to PEBA at 803.737.6800, 888.260.9430 or online at [www.peba.sc.gov](http://www.peba.sc.gov).

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## About your coverage

The Affordable Care Act requires all group health plan and health insurance issuers offering group health coverage to provide their subscribers with a summary of benefits and coverage.

To comply with this requirement, PEBA will post the 2017 Summaries of Benefits and Coverage (SBCs) to its website at [www.peba.sc.gov/iresources.html](http://www.peba.sc.gov/iresources.html) by October 1, 2016. You will be able to view and print the SBCs for the State Health Plan Standard and Savings plans.

If you do not have access to the Internet, copies of the SBCs are available from your employer. Retirees, COBRA subscribers and survivors who do not have access to the internet can request a paper copy at no charge by calling PEBA at 803.737.6800 or 888.260.9430.

## Notification of grandfathered status under the ACA

PEBA offers “grandfathered health plans” 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 ACA, 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, such as 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](http://www.peba.sc.gov).

You may also contact the U.S. Department of Health and Human Services at [www.healthcare.gov](http://www.healthcare.gov).

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## Behavioral health disorders

Subject to all the terms, conditions, limitations and exclusions of the Plan, and including the requirements herein, the Plan will pay covered expenses for inpatient, outpatient or Partial Hospitalization Programs rendered by a behavioral health provider for behavioral health disorders, alcoholism and drug abuse. All care must be in accord with the utilization guidelines established by the Behavioral Health Manager for specified levels of care, and, where applicable, precertified by the Behavioral Health Manager.

Notwithstanding anything in this Plan to the contrary, in accordance with the Mental Health Parity Act of 1996 (Act), as amended, and any regulations issued thereunder, the Plan will provide parity in the application of aggregate lifetime and annual dollar limits for mental health and substance use disorder benefits as compared with other dollar limits for medical benefits.

The Plan will not place financial requirements or treatment limitations on mental health and substance use disorder benefits that are more restrictive than the most common financial requirements and treatment limitations placed on other medical benefits, as such requirements and limitations placed on other medical benefits, as such requirements and limitations are set forth in the Schedule of Benefits.

To the extent the Plan provides out-of-network coverage for other medical benefits, it will also provide out of-network coverage for mental health and substance use disorder benefits. This paragraph shall not apply to any Plan Year in which the Plan meets the cost exemption under Section 712(c)(2) of the Act and the Plan Administrator, in its sole discretion, 2016 State Health Plan Plan of Benefits Document 54 chooses to apply such exemption.

The criteria for medical necessity determination made under this Plan with respect to mental health or substance use disorder benefits shall be made available by the Plan Administrator to any current or potential Covered Person, beneficiary, or contracting provider upon request.

## Coverage options

Under the 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 for 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. You must request enrollment within 31 days. Remember, if 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.

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## Notice of privacy practices

Effective April 14, 2003

Revised September 1, 2016

**This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. Please share this information with your covered adult dependents.**

The South Carolina Public Employee Benefit Authority (PEBA) is committed to protecting the privacy of your protected health information. PEBA may access your medical claims information and related protected health information in order to provide you with health insurance and to assist you in claims resolution. This notice explains how PEBA may use and disclose your protected health information, PEBA's obligations related to the use and disclosure of your protected health information and your rights regarding your protected health information. PEBA is required by law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH Act), to make sure that protected health information that identifies you is kept private, to give you this notice of its privacy practices and to follow the terms of its current notice. This notice applies to all of the records of your protected health information maintained or created by PEBA. All PEBA employees will follow the practices described in this notice.

If you have any questions about this Notice of Privacy Practices, please contact:

S.C. Public Employee Benefit Authority

Attn: HIPAA Privacy Officer

202 Arbor Lake Drive

Columbia, SC 29223

Phone: 803.737.6800 | Fax: 803.726.9877

E-mail: [privacyofficer@peba.sc.gov](mailto:privacyofficer@peba.sc.gov)

## How PEBA may use and disclose protected health information

The following describes different ways PEBA may use and disclose your protected health information. For each category of use or disclosure, this notice may present some examples. Not every use or disclosure in a category will be listed. However, all of the ways that PEBA is permitted to use and disclose information will fall within one of the categories.

- **For treatment.** PEBA may use and disclose your protected health information to coordinate and manage your health care-related services by one or more of your health care providers. For example, a representative of PEBA, a case manager and your doctor may discuss the most beneficial treatment plan for you if you have a chronic condition such as diabetes.
- **For payment.** PEBA may use and disclose your protected health information to bill, collect payment and pay for your treatment/services from an insurance company or another third party; to obtain premiums; to determine or fulfill its responsibility for coverage or provision of benefits; or to provide reimbursement for health care. For example, PEBA may need to give your protected health information to another insurance provider to facilitate the coordination of benefits or to your employer to facilitate the employer's payment of its portion of the premium.
- **For health care operations.** PEBA may use and disclose protected health information about you for other PEBA operations. PEBA may use protected health information in connection with conducting quality assessment and improvement activities; reviewing the competence or qualifications of health care professionals; evaluating practitioner, provider and health plan performance; underwriting, premium rating and other activities relating to health plan coverage;

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## Notice of privacy practices

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conducting or arranging for medical review, legal services, audit services and fraud and abuse detection programs; business planning and development such as cost management; and business management and general administrative activities. For example, PEBA may disclose your protected health information to an actuary to make decisions regarding premium rates, or it may share your protected health information with other business associates that, through written agreement, provide services to PEBA. These business associates, such as consultants or third-party administrators, are required to protect the privacy of your protected health information.

- **For purposes of administering the plan.** PEBA may disclose your protected health information to its Plan sponsor, the South Carolina Public Employee Benefit Authority, for the purpose of administering the Plan. For example, PEBA may disclose aggregate claims information to the Plan sponsor to set Plan terms.
- However, consistent with the Genetic Information Nondiscrimination Act (GINA), PEBA will not use or disclose, for underwriting purposes, protected health information that is genetic information.
- **Business associates.** PEBA may contract with individuals or entities known as Business Associates to perform various functions on PEBA's behalf or to provide certain types of services. For example, PEBA may disclose your protected health information to a Business Associate to process your claims for Plan benefits, pharmacy benefits, or other support services, but the Business Associate must enter into a Business Associate contract with PEBA agreeing to implement appropriate safeguards regarding your protected health information.
- **Treatment alternatives and health-related benefits and services.** PEBA may use and disclose your protected health information to contact you about health-related benefits or services that may be of interest to you. For example, you may be contacted and offered enrollment in a program to assist you in handling a chronic disease such as disabling high blood pressure.
- **Individuals involved in your care or payment for your care.** PEBA may, in certain circumstances, disclose protected health information about you to your representative such as a friend or family member who is involved in your health care, or to your representative who helps pay for your care. PEBA may disclose your protected health information to an agency assisting in disaster relief efforts so that your family can be notified about your condition, status and location.
- **Research.** PEBA may use and disclose your de-identified protected health information for research purposes or PEBA may share protected health information for research approved by an institutional review board or privacy board after review of the research rules to ensure the privacy of your protected health information. For example, a research project may compare the health/recovery of patients who receive a medication with those who receive another medication for the same condition.
- **As required by law.** PEBA will disclose protected health information about you when it is required to do so by federal or South Carolina law. For example, PEBA will report any suspected insurance fraud as required by South Carolina law.
- **To avert a serious threat to health or safety, or for public health activities.** PEBA may use and disclose protected health information about you when necessary to prevent a serious threat

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## Notice of privacy practices

### Continued from Page 21

to your health and safety, or to the health and safety of the public, or for public health activities.

- **Organ and tissue donation.** If you are an organ donor, PEBA may disclose your protected health information to organizations that handle organ, eye or tissue procurement, transplantation or donation.
- **Coroners, medical examiners and funeral directors.** PEBA may share your protected health information with a coroner/medical examiner or funeral director as needed to carry out their duties.
- **Military and veterans.** If you are a member of the armed forces, PEBA may disclose protected health information about you after the notice requirements are fulfilled by military command authorities.
- **Workers' compensation.** PEBA may disclose protected health information about you for workers' compensation or similar programs that provide benefits for work-related injuries or illness.
- **Health oversight activities.** PEBA may disclose your protected health information to a health oversight agency for authorized activities such as audits and investigations.
- **Lawsuits and disputes.** PEBA may disclose your protected health information in response to a court or administrative order, a subpoena, discovery request, or other lawful process if PEBA receives assurance from the party seeking the information that you have either been given notice of the request, or that the party seeking the information has tried to secure a qualified protective order regarding this information.
- **Law enforcement.** PEBA may disclose information to a law enforcement official in response to a court order, subpoena, warrant,

summons, or similar process.

- **National security, intelligence activities and protective services.** PEBA may disclose your protected health information to authorized officials for intelligence, counterintelligence and other national security activities; to conduct special investigations; and to provide protection for the President, other authorized persons or foreign heads of state.
- **Inmates.** If you are an inmate of a correctional institution or are in the custody of a law enforcement official, PEBA may disclose your protected health information if the disclosure is necessary to provide you with health care, or to protect your health and safety or the health and safety of others.
- **Fundraising.** PEBA will not use or release your protected health information for purposes of fund-raising activities.
- **Sale or marketing.** Your authorization is required for PEBA's use or disclosure of any PHI for marketing purposes, or for any disclosure by PEBA that constitutes the sale of PHI.

## Your rights regarding your protected health information

You have the following rights regarding the protected health information that PEBA has about you:

- **Right to inspect and copy.** You have the right to request to see and receive a copy of your protected health information or, if you agree to the preparation cost, PEBA may provide you with a written summary. If PEBA maintains an electronic health record containing your protected health information, you have the right to request that PEBA send a copy of your protected health information in an electronic format to you. Some protected health information is exempt from disclosure. To see or obtain a copy of your protected health

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## Notice of privacy practices

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information, send a written request to: S.C. Public Employee Benefit Authority, Attn: HIPAA Privacy Officer, 202 Arbor Lake Drive, Columbia, SC 29223. PEBA may charge a fee for the costs associated with your request. In limited cases, PEBA may deny your request. If your request is denied, you may request a review of the denial.

- **Right to amend.** If you believe that your protected health information is incorrect or incomplete, you may ask PEBA to amend the information by sending a written request to: S.C. Public Employee Benefit Authority, Attn: HIPAA Privacy Officer, 202 Arbor Lake Drive, Columbia, SC 29223, stating the reason you believe your information should be amended. PEBA may deny your request if you ask it to amend information that was not created by PEBA, the information is not part of the protected health information kept by or for PEBA, the information is not part of the information you would be permitted to inspect and copy or your protected health information is accurate and complete. You have the right to request an amendment for as long as PEBA keeps the information.
- **Right to an accounting of disclosures.** You have the right to request a list of the disclosures of your protected health information PEBA has made. This list will NOT include protected health information released to provide treatment to you, to obtain payment for services or for health care operations; releases for national security purposes; releases to correctional institutions or law enforcement officials as required by law; releases authorized by you; releases of your protected health information to you; releases as part of a limited data set; releases to representatives involved in your health care; releases otherwise required by law or regulation and releases made prior to April 14, 2003. You

must submit your request for an accounting of disclosures in writing to: S.C. Public Employee Benefit Authority, Attn: HIPAA Privacy Officer, 202 Arbor Lake Drive, Columbia, SC 29223, indicating a time period that may not go back beyond six years. Your request should indicate the form in which you want the list (for example, by paper or electronically). The first list that you request within a 12-month period will be provided free of charge; however, PEBA may charge you for the cost of providing additional lists within a 12-month period.

- **Right to request restrictions of use and disclosure.** You have the right to request a restriction on the protected health information that PEBA uses or discloses. You also have the right to request a limit on the protected health information that PEBA discloses about you to someone who is involved in your care or the payment for your care. Please note that the protected health information collected by PEBA is not used for any other purpose than as necessary for the administration of your benefits as described above and is kept confidential pursuant to the requirements of state and federal law, including the protections under HIPAA and HITECH. PEBA is not required to agree to your request(s). If PEBA does agree, PEBA will comply with your request(s) unless the information is needed to provide you with emergency treatment. In your request, you must specify what information you want to limit and to whom you want the limits to apply. You must make these request(s), in writing, to: S.C. Public Employee Benefit Authority, Attn: HIPAA Privacy Officer, 202 Arbor Lake Drive, Columbia, SC 29223
- **Right to request confidential communications.** You have the right to request that PEBA communicate about your protected health information by alternative means or to an alternative location to avoid endangering you.

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## Notice of privacy practices

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PEBA will accommodate your request if (a) it is reasonable, (b) you state clearly that failure to communicate your protected health information by the alternative means or to the alternative location could endanger you, and (c) you provide reasonable alternative means or location for communicating with you. You must make these request(s), in writing, to: S.C. Public Employee Benefit Authority, Attn: HIPAA Privacy Officer, 202 Arbor Lake Drive, Columbia, SC 29223.

- **Right to restrict release of information for certain services.** Unless the disclosure is required by law, you have the right to restrict the disclosure of information regarding services for which you have paid in full or on an out-of-pocket basis. This information can be released only upon your written authorization.
- **Right to a paper copy of this notice.** You have the right to request a paper copy of this notice at any time by contacting PEBA's HIPAA Privacy Officer at: S.C. Public Employee Benefit Authority, Attn: HIPAA Privacy Officer, 202 Arbor Lake Drive, Columbia, SC 29223. You may obtain a copy of this notice at PEBA's website at [www.peba.sc.gov](http://www.peba.sc.gov).
- **Right to breach notification.** You have the right to be notified of any breach of your unsecured protected health information.

## Complaints

If you believe that your protected health information rights, as stated in this notice, have been violated, you may file a complaint with PEBA's HIPAA Privacy Officer and/or with the Office for Civil Rights, US Department of Health and Human Services.

To file a complaint with the PEBA's HIPAA Privacy Officer, contact:

S.C. Public Employee Benefit Authority  
Attn: HIPAA Privacy Officer

202 Arbor Lake Drive

Columbia, SC 29223

Phone: 803.737.6800 | Fax: 803.726.9877

E-mail: [privacyofficer@peba.sc.gov](mailto:privacyofficer@peba.sc.gov)

To file a complaint with the Office for Civil Rights, U.S. Department of Health and Human Services, contact:

Office for Civil Rights

U.S. Department of Health and Human Services

61 Forsyth Street, S.W.-Suite16T70

Atlanta, GA 30303-8909

Phone: 404.562.7886 | Fax: 404.562.7881

TDD: 404.562.7884

PEBA will not intimidate, threaten, coerce, discriminate against or take other retaliatory actions against any individual who files a complaint.

## Changes to this notice

PEBA reserves the right to change this notice. PEBA may make the changed notice effective for medical information it already has about you as well as for any information it may receive in the future. PEBA will post a copy of the current notice on its website and in its office. PEBA will mail you a copy of revisions to this policy at the address that is on file with PEBA at the time of the mailing.

## Other uses of protected health information

This notice describes and gives some examples of the permitted ways your protected health information may be used or disclosed. PEBA will ask for your written permission before it uses or discloses your protected health information for purposes not covered in this notice. If you provide PEBA with written permission to use or disclose information, you can change your mind and revoke your permission at any time by notifying PEBA in writing. If you revoke your permission, PEBA will no longer use or disclose the information for that purpose. However, PEBA will not be able to take back any disclosure that it made with your permission.

# Well Child Care benefits

Well Child Care benefits are designed to promote good health and aid in the early detection and prevention of illness in children enrolled in the State Health Plan. Covered children are eligible for Well Child Care check-ups until they turn age 19. 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 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 Care checkups

The plan pays 100 percent of the allowed amount for approved routine exams,

Centers for Disease Control-recommended immunizations and American Academy of Pediatrics-recommended lab tests when a network doctor provides these checkups:

- Younger than 1 year old: five visits
- 1 year old: three visits
- 2 years old until they turn 19 years old: one visit a year

The Well Child Care exam must occur after the child's birthday.

## Immunizations for children

Benefits are provided for all immunizations at the appropriate ages recommended by the Centers for Disease Control for children until they turn age 19. To be sure the immunization will

be covered, the child must have reached the age at which the schedule says the immunization should be given.

If your covered child has delayed or missed receiving immunizations at the recommended times, the plan will pay for catch-up immunizations until he turns age 19, subject to the limitations outlined above. The schedule below provides general information but is subject to change. Please contact your State Health Plan pediatrician or call Medi-Call for the most up-to-date information.

## 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

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## Minimum hospital stays for newborns and mothers

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.

## Children 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 age 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 he works for an employer that participates in PEBA insurance benefits. The child may be covered under his parent's health, dental and vision coverage. The child is not eligible for Basic Life, Optional Life, Dependent Life-Child or Long Term Disability insurance.

A child who is eligible for benefits because he works for a participating employer must make a choice. He may be covered by his parents as a child or he may 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, if a child is eligible as an employee under the plan, he is not eligible as a dependent.

## Savings Plan additional benefit

Savings Plan participants age 19 and older may receive an annual physical exam from a network provider in his 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. 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.

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## Benefits for women

### Mammography program

Routine mammograms are covered at 100 percent as long as you use a provider in the mammography network and you meet eligibility requirements. Even though a doctor's order is not required for plan coverage of a routine mammogram, most centers ask for one, so it is recommended that you get 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 age 40 through 74.

It is recommended that you schedule your mammogram after your birthday. To find a mammography network provider, go to Find a Doctor on [StateSC.SouthCarolinaBlues.com](http://StateSC.SouthCarolinaBlues.com). If you do not have internet access, contact your provider or call BlueCross BlueShield of South Carolina at 803.736.1576 or 800.868.2520 for assistance.

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

Preventive mammogram benefits are in addition to benefits for diagnostic mammograms. Any charges for additional mammograms are subject to copayments, the deductible and coinsurance.

Women, age 40 and older, covered as retirees and enrolled in Medicare, should contact Medicare or see the 2016 *When You Become Eligible for Medicare* 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.

### Pap test benefit

#### Standard Plan members

The plan covers only the cost of the lab work associated with a Pap test each calendar year, without any requirement for a deductible or coinsurance, for covered women ages 18 through 65. 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.

It is strongly advised that the member contact 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 members

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.

## Preventive benefits

The Standard Plan and the Savings Plan have benefits that can help make it easier for you and your family to stay healthy. You also are eligible for health and wellness programs. By helping prevent potentially expensive health problems and hospital admissions, these benefits help control medical costs, which save you and the plan money.

Please note: Preventive and routine services, other than those listed below, generally are not covered by the plan.

### Immunization benefits

Adult vaccinations at the intervals recommended by the Centers for Disease Control are covered at no charge 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](http://www.cdc.gov/vaccines/schedules) and select Adults (19 years and older).

### Additional information about Zostavax, the shingles vaccine

Some network pharmacies administer Zostavax, the shingles vaccine. Coverage includes the fee for giving the shot. If the vaccine is obtained at a network pharmacy and the vaccination is not given on site, Zostavax needs to be kept frozen and taken immediately to a doctor's office for administration. Zostavax, like all prescription drugs, is covered only if it is obtained from a network provider.

## Coverage schedule for adult immunizations

Immunization <sup>1</sup>	Primary coverage	
	State Health Plan <sup>2</sup>	Medicare <sup>3</sup>
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. <b>Medicare supplement members:</b> Your medical plan will pay remaining Medicare deductible and coinsurance if Medicare pays. <b>Medicare carve-out members:</b> 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. <b>Medicare Supplement Members:</b> Your medical plan will pay remaining Medicare deductible and coinsurance if Medicare pays. <b>Medicare Carve-Out Members:</b> 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.

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Immunization <sup>1</sup>	Primary coverage	
	State Health Plan <sup>2</sup>	Medicare <sup>3</sup>
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. <b>Medicare supplement members:</b> Your medical plan will pay remaining Medicare deductible and coinsurance if Medicare pays. <b>Medicare carve-out members:</b> 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.
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. <b>Medicare supplement and carve-out members:</b> 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.

<sup>1</sup>Benefits are available only when performed by a medical or pharmacy network provider. Any associated office visit costs are not covered.

<sup>2</sup>Members 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 Plan descriptions for more information on which routine services are covered and not covered under each Plan to understand your benefits and potential member costs.

<sup>3</sup>Medicare 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.

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## Part D creditable coverage letter

### Important notice from PEBA 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 and about your options under Medicare's prescription drug coverage. This information can help you decide whether you want to join a Medicare prescription drug plan other than Express Scripts Medicare, the State Health Plan's Medicare prescription drug program.

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 a health maintenance organization or preferred provider organization) that offers prescription drug coverage. All Medicare prescription 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 offers Express Scripts Medicare 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 prescription drug plan.

#### When can you join a Medicare prescription drug plan?

You can join a Medicare prescription 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 to join a Medicare prescription drug plan.

#### What happens to your current coverage if you decide to join a Medicare prescription drug plan?

If you decide to join a Medicare prescription drug plan other than the one sponsored by PEBA, you will lose your prescription drug coverage provided through your health plan with PEBA, 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 prescription drug coverage and drop your PEBA coverage, you should compare your PEBA coverage, including which drugs are covered, with the coverage and cost of any plans offering Medicare prescription

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## Part D creditable coverage letter

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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 and don't join a Medicare prescription drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare prescription 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 at the address or telephone number listed on the right.

Note: You will receive this notice each year before the next period you can join a Medicare prescription drug plan and if this coverage through PEBA 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 prescription drug plans.

For more information about Medicare prescription drug coverage: Visit [www.medicare.gov](http://www.medicare.gov).

For assistance, you may 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 prescription 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 for further information.

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

South Carolina Public Employee Benefit Authority  
202 Arbor Lake Drive  
Columbia, SC 29223  
803.737.6800  
888.260.9430  
[www.peba.sc.gov](http://www.peba.sc.gov)

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## Initial COBRA notice

### Continuation coverage rights under COBRA

The Consolidated Omnibus Budget Reconciliation Act (COBRA) requires that health, vision, dental and/or Medical Spending Account coverage continue to be offered to you and/or your covered dependents when you are no longer eligible for group coverage.

The following is a copy of your Initial COBRA Notice. When you became covered under group benefits offered by the State of South Carolina through the South Carolina Public Employee Benefit Authority (PEBA), you received an Initial COBRA Notice.

This notice contains important information about your right to continue your coverage if you lose it under certain circumstances, as well as other health coverage alternatives that may be available to you through the Health Insurance Marketplace. It also explains what you must do to protect your right to continued coverage.

It is important that you read this notice. It is also important that each family member you cover be familiar with this information.

If you cover a family member who does not live with you, you must notify your benefits office so a COBRA notice can be sent to him. Also, if you move, please inform your benefits office of your new address or change your address through MyBenefits, PEBA's online insurance enrollment system.

Under the rules of the plan and federal law, you must notify your benefits office of certain events, including your divorce or legal separation, or if a person you cover loses eligibility under the rules of the plan.

Please carefully read the section in the notice about your notification responsibilities. If you fail to follow the procedures, your rights under COBRA could be lost.

If you have questions about this notice or your rights and responsibilities under COBRA, please contact your benefits administrator.

### Your rights and obligations under COBRA

#### What is COBRA continuation coverage?

Under the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), coverage under the State of South Carolina Public Employee Benefit Authority (PEBA) may be continued when it otherwise would end due to a qualifying event. This continuation of coverage is typically referred to as "COBRA coverage" but it is actually the same coverage that PEBA gives to other participants or beneficiaries under the state insurance program who are not receiving COBRA coverage.

Each qualified beneficiary who elects COBRA coverage will have the same rights as other participants or beneficiaries, including open enrollment and special enrollment rights.

COBRA (and the description of COBRA coverage contained in this notice) applies only to the group health benefits offered by PEBA (the Health, Dental, Dental Plus, Vision and MoneyPlus Medical Spending Account) and not to any other benefits offered by PEBA.

PEBA provides no greater COBRA rights than what COBRA requires—nothing in this notice is intended to expand your rights beyond COBRA's requirements.

#### Who is entitled to elect COBRA coverage?

If a qualified beneficiary loses coverage under group health benefits due to one of the qualifying events

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## COBRA notice

### Continued from Page 32

listed below, the qualified beneficiary will be allowed to continue group health benefits for a specified period of time at group rates.

After a qualifying event occurs and any required notice of that event is properly provided to the benefits office, COBRA coverage will be offered to each qualified beneficiary who is losing coverage as a result of that event.

### Who is a qualified beneficiary?

To be a qualified beneficiary, a person:

- Must have been covered (under Health, Dental, Dental Plus, Vision and/or a MoneyPlus Medical Spending Account) on the day before the qualifying event; AND
- Must be a covered employee, the covered spouse of the employee or a covered child of the employee.

Two situations may occur during the COBRA coverage period that would cause a child (who was not covered at the time of the qualifying event) to gain the status of a qualified beneficiary. These are addressed later in this notice.

### What is a qualifying event?

A qualifying event is a life event that occurs that would cause a qualified beneficiary to lose coverage under group health benefits offered by PEBA (Health, Dental, Dental Plus, Vision and/or a MoneyPlus Medical Spending Account).

For a covered employee – If you are the covered employee, you will experience a qualifying event and will have the right to elect COBRA coverage if you lose your group health benefits because any of the following happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than

your gross misconduct.

For a covered spouse – If you are the covered spouse of an employee, you will experience a qualifying event and will have the right to elect COBRA coverage if you lose your group health benefits because any of the following happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his gross misconduct; or
- You become divorced or legally separated from your spouse. Also, if your spouse (the employee) reduces or eliminates your group health benefits in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce or separation.

For a covered child – If you are the covered child of an employee, you will experience a qualifying event and will have the right to elect COBRA coverage if you lose your group health benefits because any of the following happens:

- Your parent (the employee) dies;
- Your parent's (the employee) hours of employment are reduced;
- Your parent's (the employee) employment ends for any reason other than his gross misconduct; or
- You stop being eligible for coverage under PEBA as a child (for example, you turn age 26). For more information about when a child ceases to be eligible for coverage under PEBA, please refer to the *Insurance Benefits Guide* located on PEBA's website at [www.peba.sc.gov/assets/insurancebenefitsguide.pdf](http://www.peba.sc.gov/assets/insurancebenefitsguide.pdf).

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## COBRA notice

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### What do you do when a qualifying event occurs?

YOU MUST GIVE NOTICE OF SOME QUALIFYING EVENTS: divorce, legal separation, and a child loses eligibility for coverage. For these qualifying events, the benefits office will offer you COBRA coverage only if you notify the benefits office within 60 days after the later of: (1) the date of the qualifying event; and (2) the date on which the qualified beneficiary loses (or would lose) coverage under PEBA as a result of the qualifying event.

To notify the benefits office of these qualifying events, complete the "Notice of COBRA Qualifying Event" form and deliver it to the benefits office.

When the qualifying event is the end of employment or reduction of hours of employment, you do not need to notify the benefits office of any of these qualifying events.

The benefits office will offer COBRA coverage to the appropriate qualified beneficiaries. When the qualifying event is the death of the employee, the benefits office will offer survivor coverage. Refer to the *Insurance Benefits Guide* for details.

### How do you provide a proper and timely notice?

Any notice that you provide must be in writing and must be submitted on the forms provided by PEBA. These forms are available at no cost from the benefits office or PEBA at 803.737.6800 (toll-free at 888.260.9430) or can be printed from [www.peba.sc.gov/iforms.html](http://www.peba.sc.gov/iforms.html).

Oral notice, including notice by telephone, is not acceptable. Procedures for making a proper and timely notice are:

Step 1 - Complete the proper form.

Step 2 - Make a copy of the form for your records.

Step 3 - Attach the required documentation depending upon the qualifying event (as indicated on the form).

Step 4- Mail or hand-deliver the form and required documentation.

Step 5- Call within 10 days to ensure the form and required documentation have been received.

If mailed, your notice must be postmarked no later than the last day of the applicable notice period. If hand-delivered, your notice must be received by the individual at the address specified for delivery no later than the last day of the applicable notice period.

### How can you elect COBRA coverage?

Once the benefits office learns a qualifying event has occurred, the qualified beneficiaries will be notified of their rights to elect COBRA coverage. Each qualified beneficiary has an independent election right and has 60 days to elect coverage.

The 60-day election window is measured from the later of the date coverage is lost due to the event or from the date of notification to the qualified beneficiaries. This is the maximum period allowed to elect COBRA coverage. PEBA does not provide an extension of the election period beyond what is required by law.

The covered employee or the employee's covered spouse can elect continuation coverage on behalf of all qualified beneficiaries. A parent may elect to continue coverage on behalf of a covered child who is losing coverage as a result of the qualifying event.

For each qualified beneficiary who elects to continue group health benefits, COBRA coverage will begin on the date that coverage under PEBA would be lost because of the event.

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## COBRA notice

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**If COBRA coverage is not elected for a qualified beneficiary within the 60-day election window, he will lose all rights to elect COBRA coverage and will cease to be a qualified beneficiary.**

## How long does COBRA coverage last for Health, Dental, Dental Plus and/or Vision?

COBRA coverage is a temporary continuation of coverage. The COBRA coverage periods described here are maximum coverage periods.

18 months – When the loss of coverage is due to the end of employment (other than for reasons of gross misconduct) or reduction in hours of employment, coverage under the Health, Dental, Dental Plus and Vision components generally may be continued up to 18 months.

There are three possible situations that may provide coverage beyond 18 months when loss of coverage is due to end of employment or reduction in hours of employment.

1. *Medicare Entitlement Rule (for covered dependents only)* – When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits during the 18 months before the qualifying event, COBRA coverage for qualified beneficiaries (other than the employee) can last up to 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight (8) months before the date on which employment ends, his spouse and children who are qualified beneficiaries who lost coverage as a result of his termination will be offered 28 months of continuation coverage (36-8=28). The covered employee, however, is offered only 18 months. This COBRA coverage period is available only if the covered employee becomes entitled to Medicare during the 18 months before the end of

employment or reduction of hours.

2. *Social Security Disability Extension* – If any of the qualified beneficiaries is determined by the Social Security Administration to be disabled, the maximum COBRA coverage period that results from a covered employee's end of employment or reduction of hours (generally 18 months) may be extended to a total of up to 29 months. This extension is available only for qualified beneficiaries who are receiving COBRA coverage because of a qualifying event that was the employee's termination of employment or reduction of hours. The Social Security Administration must determine that the qualified beneficiary's disability started before the 61st day after the covered employee's termination of employment or reduction of hours and the disability must last until at least the end of the 18-month period of continuation coverage.

To qualify for the disability extension, you must notify your COBRA ADMINISTRATOR in writing at the address where you deliver your COBRA premium payments of the Social Security Administration's determination of disability and you must do so within 60 days after the latest of:

- The date of the Social Security Administration's disability determination;
- The date the covered employee's employment ended or the date of reduction of hours; and
- The date the qualified beneficiary loses (or would lose) coverage under PEBA as a result of the covered employee's termination or reduction of hours.

**You also must provide this notice within 18 months after the covered employee's employment ended or his hours were reduced to be entitled to a disability extension.** In providing this notice, you must use PEBA's

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## COBRA notice

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form, Notice to Extend COBRA Continuation Coverage (you may get a copy of this form from the benefits office or PEBA at no charge, or you can print the form at [www.peba.sc.gov/iforms.html](http://www.peba.sc.gov/iforms.html)). You must follow the notice procedures outlined in the section entitled "How do you provide a proper and timely notice?" **If these procedures are not followed or if the notice is not provided during the 60-day notice period and within 18 months after the covered employee's employment ended or hours were reduced, THERE WILL BE NO DISABILITY EXTENSION OF COBRA COVERAGE.**

3. *Second Qualifying Event Extension* – If your family experiences a second qualifying event during the 18 months (or, in the case of a disability extension, the 29 months) following the covered employee's end of employment or reduction of hours, the maximum COBRA coverage period may be extended to a total of up to 36 months from the date of the original qualifying event. Such second qualifying events may include the death of the employee, divorce or legal separation from the employee, or dependent child losing eligibility for coverage under PEBA.

**This extension due to a second qualifying event is available only if you notify your COBRA ADMINISTRATOR in writing at the address where you deliver your COBRA premium payments of the second qualifying event within 60 days after the date of the second qualifying event.** In providing this notice, you must use PEBA's form entitled "Notice to Extend COBRA Continuation Coverage." (You may get a copy of this form from PEBA at no charge, or you can print the form at [www.peba.sc.gov](http://www.peba.sc.gov).) You must follow the procedures specified in the section entitled "How do you provide a proper and timely notice?" **If these procedures are not followed or if the notice is**

**not provided during the 60-day notice period, THERE WILL BE NO EXTENSION OF COBRA COVERAGE DUE TO A SECOND QUALIFYING EVENT.**

36 months – When the loss of coverage is due to the death of the employee, divorce or legal separation from the employee, or a child losing eligibility for coverage under PEBA, a spouse or child who is a qualified beneficiary will have the opportunity to continue coverage under Health, Dental, Dental Plus and Vision for 36 months from the date of the original qualifying event.

### How long does COBRA coverage last for the MoneyPlus Medical Spending Account (MSA)?

COBRA coverage under the MoneyPlus Medical Spending Account (MSA) can last only until the end of the plan year, including the grace period, in which the qualifying event occurred. The period of COBRA coverage under the MoneyPlus MSA cannot be extended under any circumstances. COBRA coverage under the MoneyPlus MSA will be offered only to a qualified beneficiary losing coverage who has an "underspent account."

An account is underspent if the annual limit elected under the MoneyPlus MSA by the covered employee, reduced by reimbursable claims submitted up to the time of the qualifying event, is equal to or more than the amount of the contributions for MoneyPlus MSA COBRA coverage that will be charged for the remainder of the plan year. COBRA coverage will consist of the MoneyPlus MSA coverage in force at the time of the qualifying event (i.e., the elected annual limit reduced by reimbursable claims submitted up to the time of the qualifying event).

The use-it-or-lose-it rule will continue to apply, so any unused amounts will be forfeited at the end of the plan year, including the grace period. COBRA coverage

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## COBRA notice

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will terminate at the end of the plan year.

Unless otherwise elected, all qualified beneficiaries who were covered under the MoneyPlus MSA will be covered together for continuation under COBRA coverage. However, each qualified beneficiary could alternatively elect separate COBRA coverage to cover that beneficiary only, with a separate annual limit and a separate contribution

### How much does COBRA coverage cost?

Generally, each qualified beneficiary is required to pay 100 percent of the applicable premium for the coverage that is continued, plus a 2 percent administration charge. The premium includes both the employee's and employer's share of the total premium.

If continuation coverage is extended due to a disability and the disabled qualified beneficiary elects the extension, the rate is 150 percent of the applicable premium. If only non-disabled qualified beneficiaries extend coverage, the rate will remain at 102 percent.

There may be other coverage options for you and your family. When key parts of the health care law take effect, you'll be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll.

Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for 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, if you request enrollment within 30 days.

## More information about individuals who may be qualified beneficiaries

*Children born to or placed for adoption with the covered employee during COBRA coverage period*

A child born to, adopted by, or placed for adoption with a covered employee during a period of COBRA coverage is considered to be a qualified beneficiary provided that, if the covered employee is a qualified beneficiary, the covered employee has elected COBRA coverage for himself or herself.

The child's COBRA coverage begins when the child is enrolled in the PEBA's plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the employee.

To be enrolled in PEBA's plan, the child must satisfy the applicable eligibility requirements (for example, regarding age).

*Alternate recipients under QMCSOs or NMSNs*

A child of the covered employee who is receiving benefits under PEBA pursuant to a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) received by PEBA during the covered employee's period of employment is entitled to the same rights to elect COBRA as an eligible child of the covered employee.

### Are there other coverage options besides COBRA continuation coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period."

Some of these options may cost less than COBRA continuation coverage. You can learn more about

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COBRA notice

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many of these options at [www.healthcare.gov](http://www.healthcare.gov).

### For more information

This notice is a summary and does not fully describe COBRA coverage, other rights under PEBA, or details about your group health benefits. More information is available in the *Insurance Benefits Guide*.

If you have any questions concerning the information in this notice, your rights to coverage, contact your benefits office, or contact PEBA at 803.737.6800, toll-free at 888.260.9430, or visit [www.peba.sc.gov](http://www.peba.sc.gov).

For more information about your rights under COBRA, contact the Centers for Medicare and Medicaid Services at [www.cms.gov/COBRAContinuationofCov/](http://www.cms.gov/COBRAContinuationofCov/) or [phig@cms.hhs.gov](mailto:phig@cms.hhs.gov).

### Keep the benefits office informed of address changes

To protect your rights, notify the benefits office of any changes in the employee's address and the addresses of covered family members as soon as possible.

### Plan administrator/PEBA

The State of South Carolina Public Employee Benefit Authority is the plan administrator for the group health benefits, which include Health, Dental, Dental Plus, Vision and the MoneyPlus Medical Spending Account.

You can contact PEBA at 803.737.6800 or toll-free at 888.260.9430, or visit [www.peba.sc.gov](http://www.peba.sc.gov). PEBA's mailing address is 202 Arbor Lake Drive, Columbia, SC 29223.

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## Reconstructive surgery

No benefits will be provided under any Article of this Plan for any service, supply or charges for the following:

Hospital and physician services and prescription drugs related to procedures or goods that have primarily cosmetic effects including but not limited to cosmetic surgery, or the complications resulting therefrom.

Cosmetic goods, procedures or surgery shall mean all goods, procedures, and surgical procedures performed to improve appearance or to correct a deformity without restoring a bodily function.

In the instances of the following and other procedures which might be considered "cosmetic"— e.g., rhinoplasty (nose), mentoplasty (chin), rhytidoplasty (face lift), glabellar rhytidoplasty, surgical planing (dermabrasion), blepharoplasty (eyelid), mammoplasty (suspension or augmentation), superficial chemosurgery (acid peel of the face) and rhytidectomy (abdomen, legs, hips, or buttocks including lipectomy or adipectomy) — benefits may only be provided when the malappearance or deformity was caused by physical trauma, surgery, or congenital anomaly (as opposed to familial characteristics or aging phenomenon).

Notwithstanding the foregoing, in accordance with the Women's Health and Cancer Rights Act, if a Covered Person is receiving benefits under the Plan in connection with a mastectomy as defined in paragraph 9.J. of the

[Continued on next page](#)

## Rate this newsletter

Please let us know how we're doing by responding to the items below, clipping this survey from the newsletter and returning to: S.C. PEBA, Attn: Communications, 202 Arbor Lake Drive, Columbia, SC 29223. Thank you!

### Rate the content/usefulness of this newsletter.

Excellent     Above Average     Average     Below Average     Poor

### Rate the readability of this newsletter.

Excellent     Above Average     Average     Below Average     Poor

### Rate the appearance of this newsletter.

Excellent     Above Average     Average     Below Average     Poor

### Comments

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## Reconstructive surgery Continued from Page 38

2016 SHP Plan of Benefits and if the Covered Person elects breast reconstruction in connection with such mastectomy, the Plan shall cover:

1. reconstruction of the breast on which the mastectomy has been or will be performed;
2. surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. prostheses and physical complications at all stages of the mastectomy, including lymphedemas, in a manner determined in consultation with the attending Physician and the Covered Person.

The Plan shall not: (1) deny any Covered Person eligibility or continued eligibility to enroll or to renew coverage under the terms of the Plan solely for the purpose of avoiding the coverage provided under this subparagraph; or (ii) penalize or otherwise reduce or limit the reimbursement of an attending provider, or provide incentives (monetary or otherwise) to an attending provider, to induce the provider to provide care to a Covered Person in a manner inconsistent with the coverage provided in this paragraph.



202 Arbor Lake Drive  
Columbia, SC 29223

## Blue CareOnDemand<sup>SM</sup> video visits

Why wait for the care you need now? Blue CareOnDemand is a faster, easier way to see doctors. Beginning January 1, 2017, State Health Plan primary members can consult licensed health care professionals 24/7/365 through the convenience of video visits.

Blue CareOnDemand is a great solution when:

- You need to see a doctor, but can't fit it into your schedule;
- Your doctor's office is closed;
- You, or your child, feel too sick to leave the house; or
- You're traveling.

Licensed health care professionals can treat many of the most common health conditions through video visits, including cold and flu symptoms, allergies, bronchitis and other respiratory infections, urinary tract infections, skin irritations, sinus problems, migraines, and more!

There are two easy ways to access Blue CareOnDemand:

- Visit [www.BlueCareOnDemandSC.com](http://www.BlueCareOnDemandSC.com); or
- Download the Blue CareOnDemand mobile app for your Apple or Android device.

Beginning January 1, 2017, you will need to register and create a patient profile on your first visit to the mobile app or website.

If you have questions, please call the number on the back of your State Health Plan ID card or visit [www.StateSC.SouthCarolinaBlues.com](http://www.StateSC.SouthCarolinaBlues.com).

## Have you moved? Let us know!

If you have recently moved or if you plan to move soon, be sure to use MyBenefits, to change your address in our system.

It is particularly important that you keep your address up-to-date to ensure that you receive explanations of benefits and other information, including Internal Revenue Service Form 1095. You will receive Form 1095 by January 31 which you will need to file your 2016 federal income tax return.

The form shows you have "minimum essential" health insurance coverage, as required by the federal Affordable Care Act.