Insurance Benefits Guide

2016

south carolina
peba
SM
state health plan | retirement systems

peba Perks℠
VALUE FOR A HEALTHIER STATE

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

South Carolina public employees help make the Palmetto State a better place — and PEBA helps make life better for public employees. In 2016, we are boosting several key preventive health benefits. It's always better to address a health issue early, before it becomes a health crisis. We hope you'll take action, especially since these programs are available at no cost to you. The goal is to improve the state of your health — and the state of South Carolina.

Value-based benefits at no cost to you*

Diabetes education: Living with diabetes can be challenging. Learn ways to manage the disease through a consultation with a health professional.

Preventive screening: By getting screened for health risks — with a blood pressure check, cholesterol check and other assessments — you might identify potential health problems. Screenings are worth more than $300 and can be done right at your workplace or at a nearby screening location.

Colonoscopy: This procedure can find and remove colon growths before they develop into cancer. This benefit covers not only the colonoscopy, but also the associated services for members.

Adult vaccinations: Vaccines save lives and improve the quality of life by preventing serious infectious diseases and their consequences. Following recommendations from the Centers for Disease Control (CDC), this benefit covers vaccines for adults, such as shingles, pneumonia and HPV.

Flu vaccine: Health providers encourage virtually everyone to receive the flu vaccine. It helps protect you from influenza, or lessen your symptoms if you do contract the flu.

No-Pay Copay: Receive a year's worth of free generic drugs for high blood pressure, high cholesterol, congestive heart failure or diabetes. Many diabetic supplies are also covered at network pharmacies.

Tobacco cessation: Tobacco use is the number one preventable cause of death and disease in the United States. A Quit for Life® health coach can help you make a plan and guide you through the steps to becoming tobacco-free. Medications for tobacco cessation are available at no cost to you.

*These value-based benefits are available at no cost to members at a participating provider.

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Disclaimer

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

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

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

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

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

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

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

General information

We know that your benefits are important to you and to your family. We also know that you lead busy lives, and it can be hard to find time to read complicated insurance materials. For that reason, we continually try to make the *Insurance Benefits Guide* easier to understand and use.

The "What's new for 2016?" section on Page 7 highlights major changes in insurance benefits offered for 2016 through the South Carolina Public Employee Benefit Authority (PEBA).

Every year there are changes in your insurance benefits. To avoid mistakes, please recycle your 2015 *Insurance Benefits Guide* and use this 2016 edition.

Below are changes to this guide:

- The Medicare chapter has been removed. In its place, you will find a section in the Retirement and Disability chapter about the circumstances under which you could become eligible for Medicare. For more detailed information about how PEBA's plans work with Medicare, see the *When You Become Eligible for Medicare* handbook, which is available online and from PEBA.
- The State Health Plan Medicare Prescription Drug Program has been replaced by Express Scripts Medicare®.
- The term life insurance offered through PEBA is underwritten by Minnesota Life, a Securian Financial Group Affiliate. The company is now referred to as "Securian" in the *Insurance Benefits Guide* and other PEBA material.
- "No-Pay Copay," formerly known as the Generic Copay Waiver program, is now the name of PEBA's program that waives generic copayments for drugs that treat high blood pressure, high cholesterol, congestive heart failure and diabetes. Diabetes supplies also are covered.

As always, this guide includes explanations of benefits, premiums and contact information, and provides you with an overview of the insurance programs offered through PEBA. Please remember only information concerning those benefits for which you are eligible and programs under which you are covered applies to you.

We encourage you to read each chapter that applies to you and to discuss your benefits with your family. Pay close attention to copayments, deductibles, preauthorization requirements and services that may be limited or not covered.

- For a detailed explanation of your benefits, check the appropriate chapter in this guide. If you still have questions, contact your benefits administrator.
- For information about processing and payment of claims, contact the claims processor, such as BlueCross BlueShield of South Carolina. Contact information is available on Page 213 of this guide.

PEBA is your insurance provider

The State Health Plan, which includes the Savings Plan, the Standard Plan and the Medicare Supplemental Plan, is self-insured. As the provider of a self-insured plan, PEBA does not pay premiums to an insurance company. Subscribers' premiums and employers' contributions are placed in a trust fund set up by the state to pay claims and administrative costs. Only about 4 percent of the funds collected as premiums go toward

administrative costs.

PEBA contracts with BlueCross BlueShield of South Carolina, Express Scripts and Companion Benefit Alternatives to process State Health Plan claims and administer some parts of the plan. PEBA determines the benefits you receive and is financially responsible for their cost. When you use your health insurance wisely, you help keep costs low for yourself and for other people insured by the plan.

What's new for 2016?

Changes listed below are effective January 1, 2016

General

- All employees who are eligible for health coverage are offered all insurance benefits that were previously only offered to full-time permanent employees. For eligibility details, see Pages 8-9.

State Health Plan

- Express Scripts is the new pharmacy benefits manager for the State Health Plan. Learn more about prescription drug coverage on Pages 67-72.
- The $12 office visit copay is waived for Standard Plan subscribers who receive care at a provider in BlueCross BlueShield of South Carolina's Patient-Centered Medical Home (PCMH) network. Additionally, coinsurance is 10 percent, rather than 20 percent, for care received at a PCMH for Standard and Savings Plan subscribers. For details on PCMHs, see Page 40.
- *PEBA Perks* are value-based benefits that are offered at no cost to members at network providers whose primary coverage is the SHP. The benefits available through *PEBA Perks* include diabetes education, colonoscopies, adult vaccinations and tobacco cessation. We will also continue to offer the benefits included in the *Free in '15* initiative as part of *PEBA Perks* in 2016. Those benefits include preventive screenings, No-Pay Copay (formerly known as Generic Copay Waiver program), shingles vaccines and flu vaccines. Learn more about *PEBA Perks* on Page 2.
- Contraceptives covered by the SHP are provided at no cost to subscribers and covered spouses. Details are available on Page 56.

MoneyPlus

- An employee is no longer required to complete one year of PEBA insurance-covered service by January 1 after October enrollment to establish a Medical Spending Account.
- All Medical Spending Account and Limited-use Medical Spending Account enrollees receive a myFBMC Card® at no charge.

Your insurance benefits: Help when you need it most

Your insurance, offered through the South Carolina Public Employee Benefit Authority (PEBA), provides a financial safety net when you are ill or injured. This chapter describes how to enroll in insurance coverage when you begin work for a state-covered employer. It also provides information that may be useful to anyone covered by any insurance plan PEBA

offers.

Eligibility

An employee

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

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

Types of employees

Employees fall into these categories:

- New full-time employees, who are expected by the employer to work at least 30 hours a week. Therefore, they are eligible for coverage within 31 days of their hire date.
- New variable-hour, part-time or seasonal employees, who are not expected by their employer to average 30 hours a week during the first 12 months they are employed. Because their employer cannot determine their eligibility, they may not enroll in benefits immediately. Their employer must measure their hours to determine whether these employees work an average of 30 hours a week during the 12 months beginning the first of the month after the employee is hired. If the employee works an average of 30 hours a week during this period, the employee is eligible for coverage during the 12-month period that follows.
- Ongoing employees, who have worked for their employer from October 4, 2014 - October 3, 2015, a period in which their employer measured their work hours. If the ongoing employee worked an average of 30 hours a week during this 12-month period, the employee is eligible for coverage during 2016, even if the employee's hours decrease during 2016.

If the ongoing employee worked an average of less than 30 hours a week during this period, the employee is not eligible for coverage during 2016, unless the employee gains coverage through some other provision of the plan.

Benefits-eligible employees may enroll in

- Health insurance – the State Health Plan Savings Plan and Standard Plan and, for eligible members of the military community, the TRICARE Supplement Plan.
  - Members enrolled in the Savings Plan are eligible for a Health Savings Account.
- State Dental Plan and Dental Plus
- State Vision Plan

- Basic, Optional and Dependent Life insurance
- Basic and Supplemental Long Term Disability insurance
- Dependent Care Spending Account
- Medical Spending Account or a Limited-use Medical Spending Account

Premiums may be paid through the Pretax Group Insurance Premium Feature.

If an employee's dependents meet other eligibility requirements, they also may be covered.

If you have questions about how your eligibility for benefits is affected by the Affordable Care Act, contact your benefits administrator.

For information about options for permanent, nonpermanent, seasonal and variable-hour employees who lose coverage, see Pages 25-28.

An eligible retiree

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

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

For insurance purposes, a member of a retirement system administered by PEBA must meet the minimum retirement eligibility requirements established by the system in which he participated when he left covered employment. Retirement systems administered by PEBA include South Carolina Retirement System (SCRS), Police Officers Retirement System (PORS), General Assembly Retirement System (GARS), Judges and Solicitors Retirement System (JSRS) and the State Optional Retirement Program (State ORP).

Please note: This is a brief summary of retiree insurance eligibility requirements. For detailed information, see Pages 161-165.

An eligible spouse

- Is a spouse, as defined by South Carolina law
- A former spouse who is required to be covered by a divorce decree.

You may cover your current spouse or your former spouse, but you cannot cover both spouses under any PEBA insurance program.

A spouse eligible for coverage as an employee of any participating group, including a local subdivision, or as a state-funded retiree, may not be covered as a spouse under any plan. A spouse who is a permanent, part-time teacher may be covered as an employee or as a spouse, but not as both. A spouse who is a non-funded retiree may be covered as a retiree or as a spouse, but not as both.

An eligible child

- Must be younger than age 26
- Must be the subscriber's natural child, adopted child (including child placed for legal adoption), stepchild, foster child, a child for whom the subscriber has legal custody or a child the subscriber is required to cover due to a court order.

A foster child is a child placed by an authorized placement agency with the subscriber, who is a licensed foster parent.

A child for whom the subscriber has legal custody is a child for whom the subscriber has guardianship responsibility, not merely financial responsibility, according to a court order or other document filed with the courts.

If you and your spouse are both eligible for coverage, only one of you can cover your children under any one plan. However, one parent can cover the children under health, and the other can cover the children under dental.

A child age 19 to age 25

According to the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, a child age 19-25 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.

Coverage under Dependent Life-Child Insurance

According to state law, a dependent child, age 19-24, must be a full-time student to be covered under Dependent Life-Child insurance. A child of any age who has been certified by PEBA as an incapacitated child may continue to be covered under Dependent Life-Child. For more information about eligibility for Dependent Life-Child coverage, see Pages 105-106.

To file a claim under Dependent Life-Child for a child age 19-24, a subscriber must obtain a statement on letterhead from the educational institution the child was attending that verifies he was a full-time student and gives his dates of enrollment. The statement should be given to the subscriber's benefits administrator, who will send it to Securian with the Notice of Death.

To file a claim for an incapacitated child, the subscriber must give certification of incapacitation to his BA, who will send it to Securian with the claim form.

Please note: If a child is found to be ineligible for Dependent Life-Child coverage, benefits will not be paid.

An incapacitated child

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

- The child must have been continuously covered by health insurance from the time of incapacitation

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

Incapacitation must be established no later than 31 days after the child's 26th birthday, when he is no longer eligible for coverage as a child. For Dependent Life-Child coverage, it must be established no later than 31 days after his 19th birthday, if he is not a full-time student. An Incapacitated Child Certification Form must be completed by the subscriber and the child's physician and then sent to PEBA for review. PEBA will send the form to Standard Insurance Company for review of the medical information. Additional medical documentation from the child's physician may be required by The Standard. The Standard will forward its recommendation to PEBA, which makes the final decision.

Please send a copy of your most recent federal tax return, which shows the child is principally dependent on you, the subscriber, for support and maintenance. Also attach a completed Authorized Representative Form signed by the incapacitated child, a copy of guardianship papers or a power of attorney that verifies your authority to act for your incapacitated child. Any of these documents give PEBA permission to discuss or disclose the child's protected health information with the child's Authorized Representative.

A survivor

Spouses and children covered under the State Health Plan, the State Dental Plan, or the State Vision Plan are classified as "survivors" when a covered employee or retiree dies. For more information about survivor coverage, see Pages 28-29.

Initial enrollment

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

To enroll, you must complete a Notice of Election (NOE) form or your benefits administrator may enroll you online. Coverage is not automatic.

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

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

- Coverage of your spouse and/or children, who have been enrolled in the plan, begins on the same day your coverage begins.

Please note: Life insurance coverage is subject to the Dependent Non-confinement Provision (Page 110) as well as the Actively at Work requirement (Page 120). For more information about initial enrollment in Optional Life Insurance, see Page 107.

Active employment means performing all the regular duties of an occupation on an employer's scheduled workday. You may be working at your usual workplace or elsewhere, if you are required to travel. You are also considered engaged in active employment while on jury duty, on a paid vacation day or on one of your employer's normal holidays if you were engaged in active employment on the previous regular workday. Coverage will not be delayed if you are absent from work due to a health-related reason when your coverage would otherwise start.

If you do not enroll within 31 days of the date you become eligible for active benefits, retire or experience a special eligibility situation, you cannot enroll yourself or your eligible spouse and/or children until the next open enrollment, which is held yearly in October. Your coverage will begin the following January 1.

After you enroll, please check your pay stub to make sure the correct premiums are deducted. Generally, your coverage will continue from one year to the next as long as you are an ongoing employee or an eligible retiree and pay the premiums. To be covered by a Dependent Care Spending Account, a Medical Spending Account or a Limited-use Medical Spending Account, you must enroll yearly.

Information you need at enrollment

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

	Information required
For you	Social Security number; email address (at work or at home); annual salary; date of hire, which is the date you report to work
For each family member you wish to cover	Social Security number, date of birth
For you and any family members who are covered by Medicare Part A and/or Part B	Medicare number; reason for eligibility; effective date of Medicare coverage
For each beneficiary of your Basic and/or Optional Life coverage	Social Security number, date of birth, whether the beneficiary is primary, will receive the proceeds of your policy when you die, or contingent, will receive the proceeds if your primary beneficiary dies before you do
For a beneficiary that is an estate or a trust	Name, address, the date the trust was signed

Documents you need at enrollment

You must bring photocopies of these documents to the meeting during which you enroll in insurance coverage. You will also need this documentation when you add someone to your coverage during open enrollment or as a result of a special eligibility situation. Please do not submit original documents to PEBA. They cannot be returned.

Action	Information required
To cover a spouse	A copy of the marriage license or the Common Law Marriage Affidavit, which is a notarized statement signed by both spouses.
To cover a former spouse	Copy of the divorce decree ordering the subscriber to cover the former spouse.
To cover a natural child	A copy of the long-form birth certificate showing the subscriber as the parent.
To cover a stepchild	A copy of the long-form birth certificate showing the name of the natural parent plus proof that the natural parent and the subscriber are married
To cover an adopted child or a child placed for adoption	A copy of the long-form birth certificate showing the subscriber as the parent or a copy of legal adoption document from the court, stating the adoption is complete; or a letter of placement from an attorney, an adoption agency or the S.C. Department of Social Services, stating the adoption is in progress.
To cover a foster child	A court order or another legal document placing the child with the subscriber, who is a licensed foster parent.
To cover other children	For all other children for whom a subscriber has legal custody, a court order or other legal document granting custody of the child to the subscriber. The document must verify the subscriber has guardianship responsibility for the child, not just financial responsibility.
To cover an incapacitated child	Incapacitated Child Certification Form. (See the "Incapacitated Child" section on Page 10 for complete information on the process.) Plus, proof of the relationship. See the appropriate section above for the type of documentation required.
To enroll in the TRICARE Supplement Plan	A copy of the subscriber's TRICARE ID card.

Tips for completing a paper enrollment form, the Notice of Election

- As a new employee, fill out the form completely.
- Please write clearly.
- Under each benefit, choose a plan or mark "Refuse." If applicable, select a coverage level.
- If you have questions, ask your benefits administrator.
- Check the form for accuracy.
- Make sure you sign the form and give your benefits administrator copies of the appropriate documents.

Note: Your benefits administrator may enroll you online, which is the best way to ensure no errors are made. If he submits your benefit selections electronically, you must register in MyBenefits and then go online to approve your selections by electronically signing a Summary of Enrollment (SOE). Your benefits administrator also has the option of printing a paper SOE, which he will ask you to sign. Give copies of any documents to your benefits administrator, who will send them to PEBA.

Before you enroll, please review the detailed information about each plan which can be found in subsequent chapters of this guide. If you have specific questions, contact the vendor, which is listed on Pages 213-214. A list of coverage available to newly eligible employees is on Page 58-59, and information about coverage for retirees is on Page 173.

After your initial enrollment

Insurance cards

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

Please check to make sure that you have coverage before you go to a doctor or fill a prescription. If you have not received your cards, you can get your Benefits Identification Number through MyBenefits.

Benefits Identification Number (BIN)

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

The State Health Plan adds a three-letter prefix to your BIN and puts this number on your identification card. The BIN, with the three-letter prefix, is also used on Dental Plus cards. If you are not covered by a plan that uses the BIN, PEBA will send you your number. Keep your BIN in a safe place.

Subscribers need their BIN, without the prefix, to use MyBenefits, PEBA's online insurance benefits enrollment system. If you forget your BIN, you can get it through MyBenefits. Just click on "Get my BIN."

In a medical emergency

If, in an emergency, you need medical care before you receive your insurance cards, go to the PEBA website, www.eip.sc.gov, and select MyBenefits. Then select "Get my BIN?" Give your Benefits Identification Number to network providers. They will recognize it, and you will be able to use your coverage.

If you have problems or questions, contact your benefits administrator.

Dependent eligibility audits

Your employer-sponsored health insurance is a valuable benefit, but it is also an expensive one. It becomes more costly to you and your employer when ineligible individuals are covered. PEBA Insurance Benefits requires documentation of eligibility when family members enroll in coverage. It also checks the eligibility of covered family members through the Dependent Eligibility Audit. This process is designed to ensure only eligible individuals are covered under state benefits.

If you receive a letter asking you to provide specific documents showing that family members you cover are eligible, please respond as soon as possible. If you do not do

so within 60 days of the date of the letter from PEBA Insurance Benefits, family members whose eligibility has not been documented will be dropped from coverage.

Enrolling as a transferring employee

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

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

As an academic employee, you are considered a transfer if you complete a school term and move to another participating academic employer with less than a 26-week break in employment. Your insurance coverage with the employer you are leaving will remain in effect until you begin work with your new employer, typically September 1. On that date, your new employer will pick up your coverage. If you do not transfer to another participating academic employer, your coverage ends the last day of the month in which you were engaged in active employment.

Ongoing academic employees would be considered continuing employees and would be eligible to change their coverage if their break in employment was more than 15 calendar days and less than 26 weeks.

These ongoing academic employees would be treated as new employees if their break in employment was more than 26 weeks. They would be eligible to change their coverage.

All other ongoing employees would be considered continuing employees eligible to change their coverage if their break in employment was more than 15 calendar days and less than 13 weeks.

These ongoing employees would be treated as new employees if their break in coverage was more than 13 weeks. They would be eligible to change their coverage.

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

Open enrollment is offered every October

During the annual October open enrollment eligible employees, retirees, survivors and COBRA subscribers may change their coverage without regard to special eligibility situations.

Please note: You can add or drop State Dental Plan and Dental Plus coverage only during open enrollment in October of odd-numbered years, or within 31 days of a special eligibility situation.

Changing plans or coverage during open enrollment

You can change to or from the Savings Plan or the Standard Plan during open enrollment. Retirees and survivors and their eligible spouse and/or children who are covered by a health plan may change to the Medicare Supplemental Plan within 31 days of Medicare eligibility or during open enrollment. There may be exceptions to this rule.

Contact your benefits administrator for details

if you are an active employee or if you are a retiree, a survivor or COBRA subscriber of a local subdivision. Retirees, survivors and COBRA subscribers of other employers should contact PEBA, which is their benefits administrator.

Eligible members of the military community may add or drop TRICARE Supplement Plan coverage for themselves and for their eligible dependents during open enrollment.

You may add or drop State Vision Plan coverage for yourself and for your eligible spouse and/or children during open enrollment.

Other changes you may make in your coverage are explained in the *Benefits Advantage*, PEBA's open enrollment newsletter, which you receive each September. Open enrollment changes become effective the following January 1.

MyBenefits – PEBA's online insurance benefits enrollment system

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

Throughout the year subscribers can:

- Update contact information. (The information is sent to vendors and the subscriber's employer, as well as to PEBA.)
- Print a list of the insurance plans under which they are covered.
- Get their eight-digit Benefits Identification Number (BIN).
- Update beneficiaries.
- Approve changes made as a result of a special eligibility situation.

To protect the confidentiality of your insurance information, you must register the first time you use MyBenefits. After you register, you will see a screen listing your password and your answers to the security questions. You are now ready to use MyBenefits. Information about how to do so is offered as you work through the program.

Please note: If you have a question about a claim, contact the claims processor listed in the Appendix of this guide. For a description of your benefits, read the appropriate chapter of this guide or contact the claims processor.

Special eligibility situations

A special eligibility situation is an event that allows an eligible employee, retiree, survivor or COBRA subscriber to enroll in or drop coverage for himself and/or eligible family members outside an open enrollment period. To make a change, he must:

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

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

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

If you are an active employee and eligible to change your health, Dental/Dental Plus, State Vision Plan or Optional Life Insurance coverage due to a special eligibility situation,

you also may enroll in or drop the Pretax Group Insurance Premium Feature.

Please note: Rather than using a paper Notice of Election form, a benefits administrator may make changes electronically and send them to the subscriber through MyBenefits. He must approve and electronically sign the Summary of Change. His benefits administrator also may print a paper Summary of Change for the subscriber to sign. The subscriber should give copies of any required documents to his benefits administrator, who will send them to PEBA.

Marriage

If you, as a covered subscriber, wish to add a spouse because you marry, you can do so by completing a Notice of Election form and submitting proof of the marriage (a copy of your marriage license or an executed Common Law Marriage Affidavit) within 31 days of the date of your marriage. The forms are on PEBA's website. You also may contact PEBA or your benefits administrator for a copy of the affidavit.

If you are not covered, you may add health, Dental/Dental Plus and/or State Vision Plan coverage for yourself and your new spouse and/or new stepchildren within 31 days of the date of your marriage. If you add your new spouse or your new stepchildren to your health coverage, you may also change health plans. You may add your new spouse and/or new stepchildren to Dental/Dental Plus and State Vision Plan coverage. A copy of the marriage license is required to cover the new spouse. Long-form birth certificates are required for each stepchild you want to cover. Coverage becomes effective on the date of marriage, and you are responsible for any premiums owed.

Marriage also allows a covered subscriber to enroll in or increase Optional Life coverage up to $50,000 without evidence of insurability. For information about eligibility for Dependent Life - Spouse coverage, including amounts in which a newly eligible spouse may enroll without evidence of insurability, see the Dependent Life Insurance section, which begins on Page 121 in the Life Insurance chapter. Coverage becomes effective the first of the month after the date requested if the employee is actively at work. Otherwise, it becomes effective the first of the month after his return to work.

You cannot cover your spouse if he is eligible, or becomes eligible, for coverage as an employee or as a funded retiree of a participating group. If you do not add your new spouse and/or your new stepchildren within 31 days of the date of marriage, you cannot add them until the next open enrollment period, which occurs yearly in October, or within 31 days of a special eligibility situation.

Legal separation

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

If you do not participate in the MoneyPlus pretax premium feature, you can remove your spouse from your coverage when you separate. If you remove your spouse from health, dental or vision coverage, you must also remove him from the other two programs. For example, if you remove your spouse from dental, you must also remove him from health and vision. To do so, give your benefits administrator a copy of a court order signed by a Family Court judge. A letter from

an attorney is not sufficient documentation. The court order must be attached to a Notice of Election form and must be given to your benefits administrator within 31 days of the date the court document was stamped. Your spouse's coverage will end the last day of the month after the date of separation. If you do not request your spouse be removed from coverage within 31 days of the date stamp on the order, you must wait until the divorce is final or another special eligibility situation occurs.

Also, if you do not participate in the MoneyPlus pretax premium feature and if your divorce is in process, you may enroll in or increase Optional Life coverage for up to $50,000 without evidence of insurability. To do so, you must submit a Notice of Election form to his benefits administrator within 31 days of the date of a court order signed by a Family Court judge. You can also decrease or cancel your Optional Life coverage. Changes are effective the first of the month after the date of the request if you are actively at work on that date. Otherwise, they are effective the first of the month after you return to work.

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

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

You cannot drop your spouse from your MoneyPlus coverage because you are in the process of a divorce. When a divorce is final, it is a change-in-status event that permits you to change your MoneyPlus account.

Divorce

If you divorce, you must remove your former spouse and former stepchildren from your coverage by completing a Notice of Election form and submitting a complete copy of the divorce decree within 31 days of the date stamped on the divorce decree. Coverage for your former spouse and former stepchildren will end the last day of the month after the date the divorce decree is stamped. If you fail to drop your former spouse or former stepchildren within 31 days of the date the court order or divorce decree is stamped by the court, the change in coverage is effective the first of the month after your signature on the Notice of Election form dropping your former dependents.

You may continue to provide health, vision and dental coverage for your former spouse and/or stepchildren only if the Family Court requires that you do so. You must provide a copy of the divorce decree ordering you to cover your former spouse and/or former stepchildren, as well as a Notice of Election form, to your benefits administrator, who will send both to PEBA. The document must list the plans under which your former spouse and/or former stepchildren must be covered. Retirees of state agencies, higher education institutions and school districts, survivors and COBRA subscribers should notify PEBA. Retirees of local subdivisions should notify their benefits administrator. The effective date is the first of the month after the divorce becomes final.

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

Dependent Life insurance under any circumstances.

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

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

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

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

Adding children

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

- Date of birth (effective on the date of birth)
- Marriage of the subscriber to the child's parent (effective on the date of the marriage)
- Gaining custody or guardianship with a court order (effective on the date the court stamped on the order)
- Adoption or placement for adoption (effective on the date of birth if adopted within 31 days of birth. Otherwise, effective on the date of adoption or placement for adoption.)
- Placement of a foster child (effective on the date of placement)
- Loss of other coverage (effective on the date of loss of coverage).

The newly eligible child must be offered health, Dental/Dental Plus and State Vision Plan coverage. The subscriber and all other previously covered family members may change health plans. A child who is eligible, but not newly eligible, cannot be added at this time. However, a spouse may be added.

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

An employee also may enroll in Dependent Life-Child.

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

To add a stepchild, submit a copy of his long-form birth certificate, showing the name of

the child's natural parent plus proof that the natural parent and the subscriber are married.

To add a child under 18 who is adopted or placed for adoption, you must submit a Notice of Election form with one of the following: 1) a copy of the long-form birth certificate showing the subscriber as the parent; 2) a copy of the legal adoption documentation from the court verifying the completed adoption or 3) a letter of placement from an adoption agency, attorney or the S.C. Department of Social Services verifying the adoption is in progress. The effective date of health, dental and vision coverage is the child's date of birth, if the child is placed within 31 days of birth. Otherwise, it is the date of adoption or placement. For information about international adoptions, see your benefits administrator.

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

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

If a court order is issued requiring you to cover your child, you must notify your employer and PEBA and elect coverage within 31 days of the date the court order was stamped by the court. Please note: if the court order was for health or dental coverage or for both, you must enroll yourself if you are not already covered. A copy of the entire court order or divorce decree stamped by the court must be attached to the Notice of Election form. It must list the names of the children to be covered and the type of coverage that must be provided.

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

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

Dropping a spouse and/or children

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

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

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

If your child becomes eligible for group health, dental, vision or life insurance sponsored by an employer, either as an employee or as a

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

Gaining other coverage

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

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

Gain of Medicare coverage

If you, your spouse or your child gains Medicare coverage, the family member who gained coverage may drop health coverage through PEBA within 31 days of the date Part A is effective. Attach a copy of the Medicare card to a Notice of Election form and give it to your benefits administrator within 31 days of the date on the confirmation letter from the Social Security Administration. Coverage will be canceled on the effective date of the Medicare Part A coverage or, in some circumstances, the first of the month after gain of Medicare.

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

For more information, see the *When You Become Eligible for Medicare* handbook, which is available at www.eip.sc.gov, or from PEBA.

Loss of other coverage

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

- If you are the employee or retiree, you lose other group health coverage and you are not already covered by health insurance through PEBA, you may enroll yourself and your eligible spouse and/or children in health, Dental/Dental Plus, and/or State Vision Plan coverage. If you are already covered by health, you cannot make changes.
- If your hours were reduced and you lost coverage and you are otherwise eligible as a spouse or a child, you may enroll in health, dental and vision coverage.
- If you are the employee or retiree and have a spouse or child who loses other group health coverage, you may enroll

the eligible spouse and/or children in health, Dental/Dental Plus, and/or State Vision Plan coverage. If you are not already covered, you may enroll yourself with the individual who lost coverage. You may enroll only the spouse and/or children who lost health insurance coverage. If you are already covered as an employee or retiree, you may change health plans (for example, Savings Plan to Standard Plan) when you add the spouse and/or children who lost health insurance coverage. Contributions toward your deductible will start over.

- If you, your spouse and/or children lose dental or vision coverage or both but do not lose health coverage, then you, your spouse and/or children who lost the dental or vision coverage or both may enroll in the type of coverage that was lost. If you are not already covered, you must enroll yourself with the individual who lost coverage.
- An employee who lost other life insurance coverage can enroll in Optional Life coverage for $10,000 or $20,000 with evidence of insurability.
- If you refused coverage because you were covered under your parent's plan and you lose that coverage, you may enroll yourself and/or your eligible family members in health, dental and vision coverage. For information about Optional Life, Dependent Life-Spouse, Dependent Life-Child or Supplemental Long Term Disability insurance, contact your benefits administrator.
- Loss of TRICARE coverage is a special eligibility situation that permits an eligible employee or retiree and his dependents, if the dependents are otherwise eligible for coverage through PEBA, to enroll in health, dental and vision coverage.

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

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

Gain of Medicaid or CHIP coverage

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

Eligibility for premium assistance through Medicaid or CHIP

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

Loss of Medicaid or CHIP coverage

If you refused coverage in PEBA-sponsored health, dental and vision insurance for yourself or for your eligible spouse and/or children because of coverage under Medicaid or CHIP and then lost eligibility for that coverage, you may be able to enroll in a PEBA plan. However, you must request enrollment within 60 days of the date the other coverage ends.

Leaves of absence

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

Premiums while on unpaid leave

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

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

If your coverage is canceled due to failure to pay premiums, you will not be eligible for COBRA continuation coverage, and you will not be eligible to re-enroll in benefits with your employer until the next open enrollment period, if you are eligible, or within 31 days of gaining eligibility under a provision of the plan. For more information on continuation of coverage under COBRA, see Pages 31-33.

Life insurance while on unpaid leave

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

Supplemental Long Term Disability Insurance while on paid or unpaid leave

Your Supplemental Long Term Disability (SLTD) insurance will end 30 days from your last day worked. There is no option to continue SLTD.

For more information, contact your benefits administrator.

Family and Medical Leave Act (FMLA) leave

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

Military leave

Under the Uniformed Services Employment and Re-employment Rights Act (USERRA)

employers are required to provide certain re-employment and benefits rights to employees who serve or have served in the uniformed services. If you are going on military leave or returning from military leave, please contact your benefits administrator for information.

Workers' Compensation

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

Health and wellness

PEBA's Health and Wellness Programs are designed to help subscribers and their families lead healthier lives. They promote good health through disease prevention, early detection of disease and chronic disease education.

In 2016, as part of PEBA Perks, these value-based preventive services are offered at no cost to Savings Plan and Standard Plan members:

- Colonoscopies, both routine and diagnostic, for members within the age ranges recommended by the U.S. Preventive Services Task Force. This includes the consultation, the prep kit, the procedure and associated anesthesia.
- Adult vaccinations at the intervals recommended by the Centers for Disease Control.
- Prescription drugs for smoking cessation, including Chantix and bupropion (generic Zyban).
- Diabetes education services offered by network providers.

For more information, see the State Health Plan section of the Health Insurance chapter, which begins on Page 31 or visit www.eip.sc.gov/wellness.

A major wellness benefit is the preventive screening. This comprehensive, biometric screening includes fasting blood work, a personal health risk appraisal, height and weight measurements, blood pressure and lipid panels. The confidential report highlights measurements outside the normal range, which may show the individual is at risk for developing diseases such as hypertension, diabetes and anemia. Participants are encouraged to give the screening results to their doctor.

This screening is available yearly to employees, retirees, subscribers with continued coverage under COBRA and their covered spouses whose primary insurance coverage is the Standard Plan or the Savings Plan. Subscribers whose primary coverage is Medicare are not eligible. Individuals are screened at their current or former workplace. To find out when a screening is scheduled, employees should contact their benefits administrator. Retirees should contact the staff at their former workplace. Regional screenings are offered, as are screenings at some participating providers.

Flu vaccinations are among the shots offered at no charge to all members covered under the Savings Plan or the Standard Plan. If a member receives the shot in a network doctor's office, the flu vaccine and the administration fee will be paid in full.

Any associated office visit charges will be processed according to regular plan coverage rules.

The Health and wellness section of PEBA's website also provides information about ways to improve your health. For more information about Health and Wellness Programs, contact your benefits office, or go to www.eip.sc.gov.

When coverage ends

Your coverage will end:

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

Coverage for your spouse and/or children will end:

- The date your coverage ends
- The date coverage for spouses and children is no longer offered or
- The last day of the month in which your spouse or child's eligibility for coverage ends.

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

COBRA

Eligibility

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

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

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

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

When continued coverage will not be offered

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

- As a result of a Dependent Eligibility

Audit

- For failure to pay premiums
- When coverage was canceled at the subscriber's request.

How to continue coverage under COBRA

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

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

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

Continued coverage starts when the first premium is paid. It is effective the day after your previous coverage ended. Coverage remains in effect only as long as the premiums are up to date. A premium is considered paid on the date of the postmark or the date it is hand-delivered, not the date on the check.

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

How continued coverage under COBRA may end

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

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

The qualified beneficiary, his personal representative or his guardian is responsible for notifying PEBA when he is no longer eligible for continued coverage. Continued coverage will be canceled automatically by PEBA in situations numbered 1, 3 and 6. The qualified beneficiary is responsible for submitting a Notice to Terminate COBRA Continuation Coverage, along with supporting documents, in situations numbered 2 and 5.

If you decide to terminate your COBRA coverage early, you generally won't be able to get a Marketplace plan outside of the open enrollment period. Furthermore, if following the expiration of the election period you

decide to terminate your COBRA coverage early, you cannot again change your mind and get COBRA coverage at a later date. A qualified beneficiary cancels COBRA coverage by submitting a completed *COBRA Notice to Terminate* form.

How Medicare affects continued coverage under COBRA

If you or your eligible spouse or child continued coverage and becomes eligible for Medicare Part A, Part B or both, please notify PEBA.

A subscriber or eligible spouse or child who is covered by Medicare and then becomes eligible for continued coverage can enroll in continued coverage under COBRA for secondary coverage. Medicare will be his primary coverage.

If a subscriber or a spouse or child gains Medicare coverage while enrolled in continued coverage under COBRA, he must drop his health insurance. However, he may keep his dental and vision insurance.

For more information about COBRA, contact your benefits office or PEBA.

When benefits provided under COBRA run out

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

Extending continued coverage

If you enroll in continued coverage under COBRA, an extension of the maximum period of coverage may be available if you, as a qualified beneficiary, are disabled or a second qualifying event occurs. You must notify your COBRA administrator, within certain time frames, of a disability or a second qualifying event to extend the period of continued coverage. Failure to provide timely notice of a disability or a second qualifying event may affect the right to extend the period of continued coverage under COBRA. For detailed information see the COBRA notice beginning on Page 201.

Other coverage options

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

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

You also may qualify for special enrollment in another group health plan for which you are

eligible, such as a spouse's plan, even if the plan generally does not accept late enrollees. However, you must request enrollment within 31 days.

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.

Death of a subscriber or covered spouse or child

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

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

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

Survivors

Spouses and children who are covered under the State Health Plan are eligible as survivors for a one-year waiver of health insurance premiums, including the tobacco-use surcharge, if it applies, when a covered employee dies.

Premiums are also waived for qualified survivors of funded retirees of state agencies, higher education institutions and public school districts. Participating local subdivisions may elect to, but are not required to, waive the premiums of survivors of retirees. A survivor of a retiree of a participating local subdivision should check with the retiree's benefits administrator to see whether the waiver applies.

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

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

The health and dental premiums of a covered spouse or child of a covered employee who was killed in the line of duty while working for a participating group will be waived for the first year after the employee's death. Dental premiums also will be waived for a covered spouse or child of an employee who was covered by the TRICARE Supplement Plan and who was killed in the line of duty while working for a participating group. The survivor must submit verification of death in the line of duty.

After the one-year waiver, a covered surviving spouse of a covered employee of a state agency, higher education institution or a public school district employee who was killed in the line of duty may continue coverage, at the employer-funded rate, until he remarries or otherwise becomes ineligible. A covered surviving child may continue coverage at the employer-funded rate until he is no longer eligible. Participating local subdivisions may elect to, but are not required to, contribute to a survivor's insurance premium, but the survivor may continue coverage, at the full rate, for as long as he is eligible.

A surviving spouse may continue coverage until he remarries. A child can continue coverage until he is no longer eligible. Please notify PEBA within 31 days of loss of eligibility for coverage. A person who is no longer eligible for coverage as a survivor may be eligible to continue coverage under COBRA. Contact PEBA for details.

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

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

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

Appeals

What if I disagree with a decision about eligibility?

This chapter includes a summary of the eligibility rules for benefits offered through PEBA. Eligibility determinations are subject to the provisions of the Plan of Benefits and to state law.

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

- If you are an employee, a Request for Review should be submitted through your benefits office. Your benefits administrator may write a letter or use the Request for Review form, which is on PEBA's website, www.eip.sc.gov.
- If you are a retiree, survivor or COBRA subscriber of a state agency, a public school district or a higher education institution, submit your request directly to PEBA, which is your benefits administrator.
- If you are a retiree, survivor or COBRA subscriber of a local subdivision, submit your request through the benefits office of your former employer, which is your benefits administrator.

If the request for review is denied, you may appeal by writing to the PEBA Appeals Committee within 90 days of notice of the decision. Please include a copy of the denial with your appeal. If the PEBA Appeals Committee denies your appeal, you have 30 days to seek judicial review as provided by Sections 1-11-710 and 1-23-380 of the S.C. Code of Laws, as amended.

Health insurance

What are my health plan choices?

Your health plan choices are the Standard Plan, the Savings Plan and, if you are retired and enrolled in Medicare, the Medicare Supplemental Plan. Eligible members of the military community may enroll in the GEA TRICARE Supplement Plan.

Eligibility, enrollment and other features that are common to the insurance programs offered through the South Carolina Public Employee Benefit Authority (PEBA), are available in this chapter of the guide.

Please note: The health insurance plans available through PEBA do not have a lifetime maximum benefit limitation with the exception of a lifetime maximum benefit payment of $15,000 for infertility treatment as describe on Pages 57-58.

Notice to subscribers: tobacco-use surcharge

If you are a State Health Plan subscriber with single coverage and you use tobacco, you will pay a $40 monthly surcharge. If you have subscriber/spouse, subscriber/children or full-family coverage and you or anyone you cover uses tobacco, the surcharge will be $60 monthly.

The surcharge is automatic for State Health Plan subscribers unless the subscriber certifies no one he covers uses tobacco or covered individuals who use tobacco have completed the Quit for Life® smoking cessation program. For information about Quit for Life, see Page 74.

To certify no one covered by his health insurance uses tobacco and no one has used it during the past six months, or all covered individuals who use tobacco have completed the Quit for Life® smoking cessation program, the subscriber must complete a Certification Regarding Tobacco Use form. If you have not certified or need to change your certification, go to PEBA's insurance benefits website, www.eip.sc.gov, and click on "Tobacco Information." Give your completed certification form to your benefits administrator, who will send it to PEBA. The certification will be effective the first of the month after PEBA receives the form.

A subscriber must pay all of his premiums, including the tobacco-use surcharge, if it applies, when they are due. If he does not, coverage for all of his plans will be canceled effective the last day of the month in which the premiums were paid in full.

The State Health Plan

The State Health Plan (SHP) offers the Standard Plan, the Savings Plan and, for retirees enrolled in Medicare, the Medicare Supplemental Plan. It is important that you understand how your plan works.

The Standard Plan has higher premiums but lower annual deductibles than the Savings Plan. When one family member meets his deductible, the Standard Plan will begin to pay benefits for him, even if the family deductible has not been met. With the Standard Plan, when you buy a prescription drug, you make a copayment rather than paying the allowed amount. (The allowed amount is the most a health plan allows for a covered service or product, whether it is provided in network or out of network.) Network providers have agreed to accept the allowed amount as their total fee. You do not have to meet your deductible to buy prescription drugs for the

copayment.

As a Savings Plan subscriber, you take greater responsibility for your health care costs and accept a higher annual deductible. You pay the full allowed amount for covered medical benefits (including mental health/substance abuse benefits and prescription drugs) until you reach the deductible. As a result, you save money on premiums. Another advantage is that because the Savings Plan is a tax-qualified, high-deductible health plan, you may establish a Health Savings Account (HSA) if you have no other health coverage, including Medicare, unless it is another high-deductible health plan, and you cannot be claimed as a dependent on another person's tax return. Funds in an HSA may be used to pay qualified medical expenses now and in the future.

For information about how the Standard Plan and the Medicare Supplemental Plan work with Medicare, see the *When You Become Eligible for Medicare* handbook, which is available online and from PEBA.

The *Plan of Benefits*, which contains a complete description of the plan, governs the Standard, Savings and Medicare Supplemental plans offered by the state. It is available on PEBA's insurance benefits website, www.eip.sc.gov, or from your benefits administrator.

Benefits at a glance: State Health Plan

This brief overview of your medical plan is for comparison only. The Plan of Benefits governs the Standard, Savings and Medicare Supplemental plans offered by the state.

Please note: The $12 Standard Plan physician office visit copayment is not charged for services received at a BlueCross BlueShield of South Carolina- (BCBSSC-) affiliated Patient-Centered Medical Home (PCMH). Savings Plan and Standard Plan members pay 10 percent coinsurance, rather than 20 percent coinsurance, for services received at a BCBSSC-affiliated PCMH.

Benefits at a glance

Comparison of health plans offered for 2016

Plan[1]	SHP Savings Plan		SHP Standard Plan[2]	
	In-network	Out-of-network[3]	In-network	Out-of-network[3]
Availability	Coverage worldwide		Coverage worldwide	
Annual deductible	• Single: $3,600 • Family: $7,200[4]		• Single: $445 • Family: $890	
Coinsurance[5]	• Plan pays 80% • You pay 20%	• Plan pays 60% • You pay 40%	• Plan pays 80% • You pay 20%	• Plan pays 60% • You pay 40%
Coinsurance maximum	• Single $2,400 • Family $4,800 • Excludes deductible	• Single $4,800 • Family $9,600 • Excludes deductible	• Single $2,540 • Family $5,080 • Excludes deductible and copayments	• Single $5,080 • Family $10,160 • Excludes deductible and copayments
Physicians office visits[5]	• No copayment • Plan pays 80% • You pay 20% • Chiropractic payments limited to $500 a year, per person	• No copayment • Plan pays 60% • You pay 40% • Chiropractic payments limited to $500 a year, per person	• $12 copayment • Plan pays 80% • You pay 20% • Chiropractic payments limited to $2,000 a year, per person	• $12 copayment • Plan pays 60% • You pay 40% • Chiropractic payments limited to $2,000 a year, per person
Hospitalization/ emergency care[6,7]	No copayments for outpatient facility services or emergency care		• Outpatient facility services: $95 copayment • Emergency care: $159 copayment • Plan pays 80% • You pay 20%	• Outpatient facility services: $95 copayment • Emergency care: $159 copayment • Plan pays 60% • You pay 40%
Prescription drugs[8]	Participating pharmacies and mail order: You pay the State Health Plan's allowed amount until your annual deductible is met. Afterward, the Plan will reimburse 80% of the allowed amount; you pay 20% in coinsurance. Drug costs are applied to your coinsurance maximum. When your coinsurance maximum is reached, the Plan will reimburse 100% of the allowed amount.		**Participating pharmacies only (up to 31-day supply)** • Tier 1 (generic-lowest cost alternative): $9 • Tier 2 (brand-higher cost alternative): $38 • Tier 3 (brand-highest cost alternative): $63 **Mail order and retail maintenance network pharmacies (up to 90-day supply)** • Tier 1: $22 • Tier 2: $95 • Tier 3: $158 • Copay maximum: $2,500	
Prescription drug deductible per year			No annual deductible	
Lifetime maximum	None		None	
Tax-favored medical accounts	• Health Savings Account • Limited-use Medical Spending Account		Medical Spending Account	

Footnotes available on following page.

Plan[1]	Medicare Supplemental Plan
Availability	• Same as Medicare • Available to retirees and covered dependents/ survivors who are eligible for Medicare
Annual deductible	Pays Medicare Part A and Part B deductibles
Coinsurance[5]	Pays Part B coinsurance of 20%
Coinsurance maximum	None
Physicians office visits[5]	Pays Part B coinsurance of 20%
Hospitalization/ emergency care[6,7]	**Inpatient hospital stays** • Plan pays Medicare deductible, coinsurance for days 61-150; (Medicare benefits may end sooner if the member has previously used any of his 60 lifetime reserve days) • Plan pays 100% beyond 150 days (Medi-Call approval required) **Skilled nursing facility care** • Plan pays coinsurance for days 21-100 • Plan pays 100% of approved days beyond 100 days, up to 60 days per year
Prescription drugs[8]	**Participating pharmacies only (up to 31-day supply)** • Tier 1 (generic-lowest cost alternative): $9 • Tier 2 (brand-higher cost alternative): $38 • Tier 3 (brand-highest cost alternative): $63 **Mail order and retail maintenance network pharmacies (up to 90-day supply)** • Tier 1: $22 • Tier 2: $95 • Tier 3: $158 • Copay maximum: $2,500

Footnotes for comparison chart on Pages 33-34

[1]State Health Plan subscribers who use tobacco or cover dependents who use tobacco will pay a $40-per-month surcharge for subscriber-only coverage. The surcharge is $60 for other levels of coverage. The tobacco-use surcharge does not apply to TRICARE Supplement subscribers.

[2]Refer to the *When You Become Eligible for Medicare* handbook for information on how this plan coordinates with Medicare.

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

[4]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.

[5]$12 copayment waived for routine Pap tests, routine mammograms and well child care visits. 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.

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

[7]$159 copayment for emergency care waived if admitted.

[8]Prescription drugs are not covered out of network.

How the SHP pays for covered benefits

PEBA contracts with several companies to process your claims in a cost-effective, timely manner:

- BlueCross BlueShield of South Carolina (BCBSSC) is the medical claims processor. Medi-Call, a division of BCBSSC, provides medical preauthorization and case management services. For more information about Medi-Call, see Pages 46-48.
- Companion Benefit Alternatives (CBA), a wholly owned subsidiary of BCBSSC, is the behavioral health manager, handling mental health and substance abuse treatment preauthorization, case management and provider networks. For more information, see Pages 72-74.
- Express Scripts processes prescription drug claims. For more information, see Pages 67-72.

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

Allowed amount

The allowed amount is the most a plan allows for a covered service. Network providers have agreed to accept the allowed amount as their total fee, leaving you responsible only for copayments and 20 percent coinsurance after your annual deductible is met. (Savings Plan subscribers do not pay copayments.) For out-of-network services, you will pay more in coinsurance and the provider may charge more than the allowed amount. See Balance Billing on Page 45.

How the Standard Plan works

Annual deductible

The annual deductible is the amount you must pay each year for covered medical benefits (including mental health and substance abuse benefits) before the plan begins to pay a percentage of the cost of your covered medical benefits. The annual deductibles are:

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

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

If the subscriber and his spouse, who is also covered as an employee or retiree, select the same health plan, they share the family deductible. Both spouses must be listed on the same Notice of Election form.

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

Copayments

Standard Plan subscribers pay these

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

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

copayments:

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

The $12 Standard Plan copayment for services received in a professional provider's office is not charged for services at a BCBSSC-affiliated Patient-Centered Medical Home. See Page 40.

A prescription drug copayment is a fixed total amount a Standard Plan subscriber pays for each prescription. The copayment maximum for each family member covered is $2,500. The difference between the cost of a brand name drug and generic drug does not count toward the annual prescription drug copayment. Drug costs do not apply to the annual deductible or the coinsurance maximum. For more information, see Pages 67-72.

A copayment for services in a provider's office, for outpatient facility services or for care in an emergency room is the amount a Standard Plan subscriber pays before the cost of care begins to apply to his deductible or to his coinsurance maximum.

You continue to pay these copayments even after you meet your annual deductible and reach your coinsurance maximum. These copayments do not apply to your annual deductible or your coinsurance maximum.

The copayment for each visit to a professional provider's office is $12. This copayment is waived for routine Pap tests, routine mammograms and well child care visits. The following example uses a physician's office visit that has a $56 allowed amount in the Standard Plan.

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

Coinsurance

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

If you use out-of-network providers, the plan pays 60 percent of the plan's allowed amount for your covered medical and mental health/substance abuse benefits, and you pay 40 percent as coinsurance, which applies to your out-of-network coinsurance maximum. Any charge above the plan's allowed amount for a covered medical or mental health/substance abuse benefit is your responsibility. See Pages 45-46 to learn more about balance billing and the out-of-network differential.

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

A different coinsurance rate applies for infertility treatments and prescription drugs associated with infertility. See Pages 57-58.

Coinsurance maximum

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

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

Standard Plan subscribers continue to pay copayments even after they meet their annual deductible and coinsurance maximum. Copayments for services in a provider's office, for outpatient facility services and in an emergency room do not apply to the annual deductible or to the coinsurance maximum. Prescription drug copayments apply to the $2,500 prescription drug copayment maximum but do not apply to the annual deductible or the coinsurance maximum.

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

How the Savings Plan works

Annual deductible

The annual deductible is the amount you must pay each year for covered medical and mental health/substance abuse benefits and prescription drugs before the Savings Plan begins to pay a percentage of the cost of your covered benefits. The annual deductibles are:

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

There is no individual deductible if more than one family member is covered. If the subscriber and spouse, who is also covered as an employee or retiree, select the same health plan, they will share the family deductible. The deductible is not met for any covered individual until the total allowed amount paid for covered benefits exceeds $7,200. For example, even if one family member has paid $3,601 for covered medical benefits, the plan will not begin paying a percentage of the cost of his covered benefits until his family has paid $7,200 for covered benefits. However, if the subscriber has paid $2,199 for covered benefits, the spouse has paid $3,001 for covered benefits and a child has paid $2,000 for covered benefits, the plan will begin paying a percentage of the cost of the covered benefits for all family members.

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

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

deductible.

Coinsurance

After you meet your annual deductible, the Savings Plan pays 80 percent of the allowed amount for your covered medical, prescription drug and mental health/substance abuse benefits if you use network providers. You pay 20 percent as coinsurance. After you meet your coinsurance maximum, you are reimbursed for 100 percent of the allowed amount.

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

If you use out-of-network providers, the plan pays 60 percent of the plan's allowed amount for your covered medical and mental health/substance abuse benefits, and you pay 40 percent as coinsurance. Any charge above the plan's allowed amount for a covered medical or mental health/substance abuse benefit is your responsibility. See Pages 45-46 to learn more about balance billing and the out-of-network differential. Prescription drug benefits are paid only if you use a network provider.

A different coinsurance rate applies for infertility treatments and prescription drugs associated with infertility. See Pages 57-58.

Coinsurance maximum

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

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

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

Coordination of benefits

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

All State Health Plan benefits are subject to coordination of benefits (COB). COB is used to make sure a person covered by more than one insurance plan is not reimbursed more than once for the same expenses.

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

- The plan that covers a person as an

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

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

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

As part of coordination of benefits with the Standard Plan and the Savings Plan:

On your Notice of Election form, you are asked if you are covered by more than one group insurance plan. Your response is recorded and placed in your file; however, BlueCross BlueShield of South Carolina (BCBSSC) may send you a coordination of benefits questionnaire every year. Complete this form and return it to BCBSSC promptly since claims will not be processed or paid until BCBSSC receives your information. You can also update this information by calling BCBSSC or by visiting www.StateSC.SouthCarolinaBlues.com. Go to "Member Resources," select "Forms and Documents" and then "Other Health/ Dental Insurance."

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

- For a medical or a mental health/ substance abuse claim, you or your provider must file the Explanation of Benefits from your primary plan with BCBSSC.
- For prescription drug benefits, you must present your card for your primary coverage first. Otherwise, the claim will be rejected because the pharmacist's electronic system will show that the SHP is secondary coverage. After the pharmacy processes the claim with your primary coverage, you must file a paper claim through Express Scripts for payment of any secondary benefits. Prescription drug claim forms are on Express Scripts', website, www.Express-Scripts.com. You may also ask your benefits administrator for the form.
- The State Health Plan will pay the lesser of: 1) what it would pay if it were the primary payer; or 2) the balance after the primary plan's network discounts and/ or payments are deducted from the total charge.
- The State Health Plan's limit on balance billing does not apply; therefore, it is important that you use a provider in your primary plan's network.
- You also will be responsible for the State Health Plan copayments and deductible and the State Health Plan coinsurance if the coinsurance maximum has not been met.

Please note: If your coverage with any other

health insurance program is canceled, request a letter of termination. The letter of termination must be submitted to BCBSSC promptly because claims will not be processed or paid until BCBSSC receives your information. Learn more about the claims process in the Appendix of this guide.

Patient-Centered Medical Home

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

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

To encourage members to receive care at a PCMH, the State Health Plan, beginning January 1, 2016, will not charge Standard Plan members the $12 copayment for a physician office visit. After Savings Plan and Standard Plan subscribers meet their deductible, they will pay 10 percent coinsurance, rather than 20 percent, for services at a BCBSSC-affiliated PCMH.

PCMHs are available in many South Carolina counties. To find a list and to learn more about PCMHs, go to StateSC.SouthCarolinaBlues.com. On the home page, select the box labeled "PCMH."

Using State Health Plan provider networks

When you are ill or injured, you decide where to go for your care. The State Health Plan operates as a preferred provider organization, or PPO. As such, it has networks of physicians and hospitals, ambulatory surgical centers and mammography testing centers. There also are networks available to subscribers for ambulatory surgery centers, durable medical equipment, labs, radiology and X-ray, physical therapy, occupational therapy, speech therapy, skilled nursing facilities, long term acute care facilities, hospices and dialysis centers. These providers have agreed, as part of the network, to accept the plan's allowed amount for covered benefits as payment in full. Network providers will charge you for your deductible, copayments and coinsurance when the services are provided. They also will file your claims.

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

Please note: Even if you are at a network hospital or at a network provider's office, the provider may employ out-of-network contract providers or technicians. If an out-of-network provider renders services, even in a network facility, he can still balance bill you, and you will still pay the out-of-network differential. For more information, see Pages 45-46.

In the United States, prescription drug benefits are paid only if you use a network provider.

How to find a medical or mental health/substance abuse network provider

To view the online provider directory, go to the BCBSSC state-specific website, StateSC.SouthCarolinaBlues.com, and select "Find a Doctor."

- Now you can search for a provider by name, location and specialty.
- You can also search for "ER Alternatives," which list places you can go for care other than an emergency room (i.e., urgent care centers and walk-in clinics).
- To see only State Health Plan network providers, key in "ZCS," the three letters at the beginning of your benefits identification number.

If you do not have Internet access, call BCBSSC at 803.736.1576 (Greater Columbia area) or 800.868.2520 (toll-free) to request a list of State Health Plan providers in your area.

BlueCard® and BlueCard Worldwide®

State Health Plan members have access to doctors and hospitals throughout the United States and around the world through the BlueCard Program and Blue Cross and Blue Shield provider networks. If you are covered by the State Health Plan and need mental health or substance abuse care outside South Carolina, call 800.810.2583.

Inside the United States

With the BlueCard program, you can choose network doctors and hospitals that suit you best. Follow these steps to use your health coverage when you are away from home but within the United States:

1. Always carry your health plan and your prescription drug identification cards.
2. To find the names and addresses of nearby doctors and hospitals, choose "Links" on PEBA's insurance benefits website. Follow the steps above and enter the location where you need a provider. You also may call BlueCard Access at 800.810.2583.
3. State Health Plan subscribers must call Medi-Call within 48 hours of receiving emergency care. The toll-free number is on your State Health Plan identification card.
4. When you arrive at a participating doctor's office or hospital, show your identification card. The provider will recognize the Blue Cross Blue Shield logo, which will ensure that you get the highest level of benefits with no balance billing.
5. The provider should file claims with the Blue Cross and Blue Shield affiliate in the state where the services were provided.

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

For information about out-of-network benefits, see Pages 44-46.

Outside the United States

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

Please note: Medicare does not offer benefits outside the United States. Since the State Health Plan's Medicare Supplemental Plan does not allow benefits for services not covered by Medicare, Medicare Supplemental Plan subscribers do not have coverage outside the United States. See PEBA's *When You Become Eligible for Medicare* handbook for more information.

To take advantage of the BlueCard Worldwide program, follow these steps:

1. Always carry your State Health Plan identification card.
2. Before your trip:
   - If you have questions, call the phone number on the back of your identification card to check your benefits and for preauthorization, if necessary. (Your health care benefits may be different outside of the United States.)
   - The BlueCard Worldwide Service Center can help you find providers in the area where you are traveling. It can also provide other helpful information about health care overseas. To reach the center, go to PEBA's insurance benefits website at www.eip.sc.gov and go to "Links" and select "Medical/My Health Toolkit (BlueCross BlueShield of South Carolina)." Go to "Find a Doctor" and select "Worldwide Directory." You also may call toll-free at 800.810.2583 or collect at 804.673.1177.
3. During your trip:
   - If you need to find a doctor or hospital or need medical assistance, go to the state BCBSSC website through "Links" on the PEBA insurance benefits website at www.eip.sc.gov. Go to "Find a Doctor" and select "Worldwide Directory." You must accept the terms and conditions and login with the first three letters of your identification number. Then you may "Select a Provider Type." You also can choose a specialty, city, nation and distance from the city.
   - You may also call the BlueCard Worldwide Service Center toll-free at 800.810.2583 or collect at 804.673.1177 (24 hours a day, seven days a week).
   - If you are admitted to the hospital, call the BlueCard Worldwide Service Center toll-free at 800.810.2583 or collect at 804.673.1177 as soon as possible.
   - The BlueCard Worldwide Service Center will work with your plan to arrange direct billing with the hospital for your inpatient stay.
   - When direct billing is arranged, you are responsible for the out-of-pocket expenses (non-covered services, deductibles, copayments and coinsurance) you normally pay. The hospital will submit your claim on your behalf.
   - Please note: If direct billing is not arranged between the hospital and your plan, you must pay the bill up front and file a claim. For outpatient care and doctor visits, pay the provider when you receive care and file a claim.
4. To file a claim for services you paid for when you received care or paid to providers that are not part of the BlueCard Worldwide network, complete a BlueCard Worldwide International Claim Form and send it to the BlueCard

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

5. The claim form is on the BCBSSC website, StateSC.SouthCarolinaBlues.com. Click on "Member Resources" and then "Forms and Documents." Then select "BlueCard Worldwide International Claim Form." You may also call the service center toll-free at 800.810.2583 or collect at 804.673.1177. The address of the service center is on the claim form. BlueCard Worldwide will arrange billing to BCBSSC.

If you need proof of insurance for overseas travel, please request it from PEBA in writing through the "Contact Us" link on PEBA's insurance benefits website or in a letter. The request must be made least 10 working days in advance. If proof of insurance is not requested by the deadline, you may not receive it by the time you need it.

Please note: Some toll-free numbers do not work overseas. You can always reach BlueCard Worldwide by calling collect at 804.673.1177. We recommend you take this number with you when you leave the United States.

Mental health/substance abuse provider network

The State Health Plan offers coverage for mental health and substance abuse services on the same terms as medical coverage. Preauthorization is required from Companion Benefit Alternatives (CBA), the mental health and substance abuse benefits manager, for most hospital services and some outpatient services (see Mental Health and Substance Abuse Benefits on Pages 72-74). A greater percentage of the cost of your covered benefits will be paid if you use a network provider.

Go to "Find a Doctor" on the state BCBSSC website, StateSC.SouthCarolinaBlues.com, to get an up-to-date list of network providers. When you get to the site, enter your "Location" and the "Specialty." Be sure to "view" the provider's networks. Get a printable version of the directory from the Companion Benefit Alternatives website, CompanionBenefitAlternatives.com, by going to "Looking for a Mental Health Provider?" and selecting "Get Started" and following the prompts. The directory can be searched using the "binoculars" search feature. For help selecting a provider, call Companion Benefit Alternatives at 800.868.1032. To find a provider outside of the United States, select "Worldwide Directory" within "Find a Doctor or Hospital" link on the state BCBSSC website or call collect 804.673.1177.

If you do not have Internet access, contact your benefits office or, if you are a retiree, survivor or COBRA participant, contact BCBSSC, for a printed list of providers.

For more information about your mental health and substance abuse benefits, see Pages 72-74.

Prescription drug provider network

Because the State Health Plan offers no out-of-network coverage for prescription drugs in the United States, it is important that you use a network provider. You can search for a

network provider on the pharmacy benefits manager's website, www.Express-Scripts.com. You also can use the mobile application. On the Express Script's website, sign in and go to "Locate a Pharmacy."

You can search by ZIP code or city and state. With a mobile device, you can get turn-by-turn directions to the nearest participating retail pharmacy.

If you do not have Internet access, ask your benefits administrator to print a list of network pharmacies near you. If you are a retiree, COBRA or survivor subscriber, call Express Scripts for to get a list of network pharmacies near you.

Please note: Not all network pharmacies belong to the Retail Maintenance Network, which offers 90-day supplies of drugs at mail-order prices. You can get a list of the Retail Maintenance Network pharmacies from PEBA's insurance benefits website, www.eip.sc.gov, at "Online Directories" or from your benefits administrator. For more information, see Pages 70-71.

For more information about your prescription drug benefits, see Pages 67-72.

Out-of-network benefits

You can use providers for medical and mental health/substance abuse care that are not part of the network and still receive some coverage. Before the State Health Plan will pay 100 percent of the plan's allowed amount:

- For out-of-network benefits, Standard Plan subscribers pay a $5,080 individual coinsurance maximum or a $10,160 family coinsurance maximum after they meet their annual deductible. Savings Plan subscribers pay a $4,800 individual coinsurance maximum or a $9,600 family coinsurance maximum after they meet

Standard Plan

Network provider	
Billed charge	$5,000
Allowed amount[1]	$4,000
Annual deductible	- $445
Allowed amount after annual deductible	$3,555
Allowed amount after annual deductible	$3,555
	x 20%[2]
Coinsurance, which goes toward your coinsurance maximum	$711
Coinsurance	$711
Annual deductible	+ $445
Your total payment	**$1,156**

[1]Network providers are not allowed to charge more than the allowed amount.
[2]In this example, the Standard Plan paid 80 percent of the $3,555 allowed amount after the deductible, totaling $2,844.

Out-of-network provider	
Billed charge	$5,000
Allowed amount	- $4,000
Balance bill[1]	$1,000
Allowed amount	$4,000
Annual deductible	- $445
Allowed amount after annual deductible	$3,555
Allowed amount after annual deductible	$3,555
	x 40%[2]
Coinsurance, which goes toward your coinsurance maximum	$1,422
Coinsurance	$1,422
Annual deductible	$445
Balance bill	+ $1,000
Your total payment	**$2,867**

[1]Out-of-network providers can charge you any amount they choose above the allowed amount and bill you the balance above the allowed amount.
[2]In this example, the Standard Plan paid 60 percent of the $3,555 allowed amount after the deductible, totaling $2,133.

Savings Plan

Network provider	
Billed charge	$5,000
Allowed amount[1]	$4,000
Annual deductible	- $3,600
Allowed amount after annual deductible	$400
Allowed amount after annual deductible	$400
	x 20%[2]
Coinsurance, which goes toward your coinsurance maximum	$80
Coinsurance	$80
Annual deductible	+ $3,600
Your total payment	**$3,680**

[1]Network providers are not allowed to charge more than the allowed amount.
[2]In this example, the Savings Plan paid 80 percent of the $400 allowed amount after the deductible, totaling $320.

Out-of-network provider	
Billed charge	$5,000
Allowed amount	- $4,000
Balance bill[1]	$1,000
Allowed amount	$4,000
Annual deductible	- $3,600
Allowed amount after annual deductible	$400
Allowed amount after annual deductible	$400
	x 40%[2]
Coinsurance, which goes toward your coinsurance maximum	$160
Coinsurance	$160
Annual deductible	$3,600
Balance bill	+ $1,000
Your total payment	**$4,760**

[1]Out-of-network providers can charge you any amount they choose above the allowed amount and bill you the balance above the allowed amount.
[2]In this example, the Savings Plan paid 60 percent of the $400 allowed amount after the deductible, totaling $240.

their annual deductible. Subscribers to both plans also may have to fill out claim forms.

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

There is no out-of-network coverage for prescription drugs filled at a pharmacy in the United States. Limited drug coverage is offered to members enrolled in the State Health Plan Prescription Drug Program who become ill while traveling overseas. For more information, see Pages 193-194.

Balance billing

If you use a provider that is not part of the network, you may be subject to balance billing. When the State Health Plan is your primary coverage, network providers are prohibited from billing you for covered benefits except for copayments, coinsurance and the deductible. However, an out-of-network provider may bill you for more than the plan's allowed amount for the covered benefit, which will increase your out-of-pocket cost. The difference between what the out-of-network provider charges and the allowed amount is called the "balance bill." The balance bill does not contribute toward meeting your annual deductible or coinsurance maximum.

Out-of-network differential

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

provider:

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

Managing your medical care

Medi-Call

With the State Health Plan, some covered services require preauthorization before you receive them. A phone call can get things started. Your health care provider may make the call for you, but it is your responsibility to make sure the call is made.

Medi-Call numbers are:

- 800.925.9724 (South Carolina, nationwide, Canada)
- 803.699.3337 (Greater Columbia area)
- 803.264.0183 (fax)

Please note: Some medical, mental health/substance abuse and prescription drug benefits require preauthorization. See Page 73 for mental health and Page 70 for prescription drugs.

What are the penalties for not calling?

If you do not preauthorize treatment when required, you will pay a $200 penalty for each hospital, rehabilitation or skilled nursing facility or mental health/substance abuse admission. In addition, the coinsurance maximum will not apply. You will continue to pay your coinsurance, no matter how much you pay out-of-pocket.

How to preauthorize your treatment

You can reach Medi-Call by phone from 8:30 a.m. to 5 p.m., Monday through Friday, except holidays. You may fax information to Medi-Call 24 hours a day; however, Medi-Call will not respond until the next business day. If you send a fax to Medi-Call, provide, at a minimum, this information so the review can begin:

- Subscriber's name
- Patient's name
- Subscriber's benefits identification number or Social Security number
- Information about the service requested
- A telephone number at which you can be reached during business hours.

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

- You need any type of inpatient care in a hospital, including admission to a hospital to have a baby[1]
- Your preauthorized outpatient services result in a hospital admission – you must call again for the hospital admission
- You need outpatient surgery for a septoplasty (surgery on the septum of the nose)
- You need outpatient or inpatient surgery for a hysterectomy
- You need sclerotherapy (vein surgery) performed in an inpatient, outpatient or office setting

- You will receive a new course of chemotherapy or radiation therapy (one-time notification per course)
- You are admitted to a hospital in an emergency – your admission must be reported within 48 hours or the next working day after a weekend or holiday admission[1]
- You are pregnant – you are encouraged to notify Medi-Call within the first three months of your pregnancy. (See Pages 48-49 for more information.)
- You have an emergency admission during pregnancy[2]
- Your baby is born (if you plan to file a claim for any birth-related expenses)[2]
- Your baby has complications at birth
- Before your baby is given Synagis (a drug to protect high-risk babies from respiratory syncytial virus disease) outside of the hospital nursery
- You are to be, or have been, admitted to a long-term acute care facility, skilled nursing facility, or need home health care, hospice care or would like an alternative treatment plan
- You need durable medical equipment
- You or your covered spouse decides to undergo in vitro fertilization, GIFT, ZIFT or any other infertility procedure
- You or your covered family member needs to be evaluated for a transplant
- You need inpatient rehabilitative services and related outpatient physical, speech or occupational therapy.

[1]For mental health or substance abuse services, you must call Companion Benefit Alternatives at 800.868.1032 for preauthorization before a non-emergency admission or, in the case of an emergency admission, within 48 hours or the next working day, whichever is longer.
[2]Contacting Medi-Call for the delivery of your baby does not add the baby to your health insurance. You must add your child by submitting a completed Notice of Election form and the required documentation, a long-form birth certificate, within 31 days of birth for benefits to be payable.

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

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

Advanced radiology preauthorization: National Imaging Associates

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

Doctors can get more information on the BCBSSC website, StateSC.SouthCarolinaBlues.com, or by calling 800.444.4311. To request preauthorization over the Internet, providers

can go to National Imaging Associate's website, www.RadMD.com. They may also call National Imaging Associates at 866.500.7664, Monday through Friday, from 8 a.m. to 8 p.m., ET.

If a subscriber or a covered family member is scheduled to receive a CT, MRI, MRA or PET scan from an out-of-network provider in South Carolina or any provider outside of South Carolina, it is the subscriber's responsibility to make sure his provider calls for preauthorization. A subscriber may begin the process by calling National Imaging Associates at 866.500.7664. The subscriber should be able to give National Imaging Associates the name and phone number of the ordering physician and the name and phone number of the imaging center or the physician who will provide the radiology service.

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

A subscriber can check the status of a preauthorization request online through "My Health Toolkit" at StateSC.SouthCarolinaBlues.com.

What are the penalties for not calling?

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

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

Maternity Management

If you are a mother-to-be, you are encouraged to enroll and participate in the free maternity management program. Medi-Call administers PEBA's comprehensive maternity management program, "Coming Attractions." This program manages mothers throughout their pregnancy and post-partum care. It also manages Neonatal Intensive Care Unit infants or other babies with special needs until they are 1 year old. Once enrolled in the "Coming Attractions" maternity management program, expectant mothers will receive educational materials throughout their pregnancy and the baby's first year of life. You do not have to wait until you have seen your physician to enroll in "Coming Attractions." Enrollment is easy.

There are two ways to enroll:

1. Call Medi-Call at 803.699.3337 (Greater Columbia area) or 800.925.9724 (toll free outside the Columbia area) and talk to a maternity nurse to complete a maternity health screening.
2. Enroll online by going to PEBA's insurance benefits website at http://www.eip.sc.gov. Go to "Links" and select "Medical/My Health Toolkit." Log in to your My Health Toolkit® account. Select "Wellness," then "Personal Health Record." From your Activity Center, complete the available maternity health screening, which is listed as Initial Maternity Screening or Coming Attractions.

A Medi-Call maternity nurse will complete a Maternity Health Screening when you enroll. It is used to identify potential high-risk factors during your first trimester. If high-risk factors are identified, you will be scheduled for follow-up calls. If no risks are identified, you should call with any changes in your condition. Otherwise, your maternity nurse will call you during your second and third trimester. Your maternity nurse also will call you after your baby is born.

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

Please note: If you fail to preauthorize a hospital admission related to your pregnancy or to have your baby, you will pay a $200 penalty for each admission, as you would for any admission, whether the admission was maternity related or not. Also, the coinsurance you pay will not count toward your coinsurance maximum. For more information, see Page 46 or call your maternity nurse.

For more information about maternity benefits, see Pregnancy and Pediatric Care on Pages 58-59.

Wellness Management

No-Pay Copay

The No-Pay Copay, formerly the Wellness Incentive Program, enables eligible State Health Plan members with cardiovascular disease, congestive heart failure or diabetes to qualify for a generic drug copayment waiver, which means 12 months of free generic drugs that treat these conditions. Diabetes testing supplies (glucometer, test strips, control solution, lancet, syringes, pen needles, etc.) purchased at a network pharmacy are also covered at no charge. The waiver can be renewed yearly. This program is designed to encourage participants to take more responsibility for their health and save themselves and the plan money.

Employees, retirees, COBRA subscribers and survivors and their covered family members are eligible to qualify if the State Health Plan is their primary insurance. Children are eligible. If a subscriber is enrolled in the Medicare Supplemental Plan but covers family members who are not eligible for Medicare, these dependents are eligible for the program.

If Medicare or other coverage becomes primary while a member is receiving the waiver and the member remains enrolled in the State Health Plan Prescription Drug Program, the waiver will continue for the 12-month period, but it will not be extended. If a member enrolls in Express Scripts Medicare®, the State Health Plan's Medicare Part D program, the waiver ends immediately.

Members are identified for one of the qualifying conditions through claims analysis or a preauthorization for services. Members who are eligible will receive a letter or a phone call from BCBSSC explaining the details of the No-Pay Copay program, including how to qualify for the program.

When a member meets the requirements to qualify for the waiver, he is sent a letter telling him when he will begin to receive free generic medication. About three months before the waiver ends, he will receive a letter telling him

what he needs to do to requalify. If a member loses eligibility, he also receives a letter.

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

Weight Management for Adults

The BlueCross Weight Management program is designed to help you achieve weight-loss goals through small changes you can make while still getting on with your life. You will receive information about weight management and a confidential survey will help a registered nurse tailor the program to meet your needs. Program candidates are identified through claims analysis, a preauthorization for services, doctor referral or self-referral. BCBSSC Wellness Management, 855.838.5897, is available 8:30 a.m. to 8 p.m., Monday-Thursday and until 5 p.m. on Friday. If you think you qualify but have not received a letter or would like more information, call 855.838.5897 and select option 2.

Healthy Weight for Kids and Teens

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

Health Management Program

Managing a chronic condition can be difficult; however, studies show you can help control your symptoms by making lifestyle changes and by following your doctor's advice. You can also delay, or even prevent, many of the complications of the disease.

The Health Management Program is designed for Standard Plan and Savings Plan subscribers and their covered family members who have diabetes, heart disease or chronic respiratory conditions. BCBSSC selects participants by reviewing medical, pharmacy and laboratory claims. If you are identified as someone who could benefit from the Health Management Program, you are automatically enrolled. You may, however, opt out of the program.

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

If you have diabetes, congestive heart failure or cardiovascular disease, BCBSSC may send you a letter saying you also are eligible for the No-Pay Copay program.

About your privacy

In compliance with federal law, your health information will always be kept confidential.

Your employer does not receive the results of any surveys you complete. Enrolling will not affect your health benefits now or in the future.

Health Management for Migraine Program

This program encourages a member to work with his doctor to create a plan to ease the pain of migraine headaches. A health coach helps the member learn to identify migraine triggers, develop healthy habits to prevent migraines and comply with his treatment plan. Members, who must be at least age 18, are invited to participate based on medical and pharmacy claims. You can also enroll by calling 855.838.5897, option 2.

Medical Case Management

Facing a serious illness or injury can be confusing and frustrating. You may not know where to find support or information to help you cope with your illness, and you may not know what treatment options are available. Case management can help.

The case management programs available to State Health Plan members are explained below. Each program includes teams of specially trained nurses and doctors. Their goal is to assist participants in coordinating, assessing and planning health care. They do so by giving a patient control over his care and respecting his right to knowledge, choice, a direct relationship with his physician, privacy and dignity. None of the programs provide medical treatment. All the programs recognize that, ultimately, decisions about your care are between you and your physician. Each program may involve a home or facility visit to a participant but only with permission.

By working closely with your doctor, using your benefits effectively and using the resources in your community, the case management programs may help you through a difficult time. For more information on any of these programs, call 800.925.9724 and ask to be transferred to the case management supervisor.

BlueCross Medi-Call Case Management Program

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

Case managers talk with patients, family members and providers to coordinate services among providers and support the patient through a crisis or chronic disease. Case management intervention may be short- or long-term. Case managers combine standard preauthorization services with innovative approaches for patients who require high levels of medical care and benefits. Case managers can often arrange services or identify community resources available to meet the patient's needs.

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

A Medi-Call nurse stays in touch with the

patient, caregivers and providers to assess and re-evaluate the treatment plan and the patient's progress. All communication between BlueCross BlueShield of South Carolina and the patient, family members or providers complies with HIPAA privacy requirements. If a patient refuses medical case management, Medi-Call will continue to preauthorize appropriate treatment.

Complex Care Management Program

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

The complex care management program provides you with information and support through a case manager, who is a registered nurse. This nurse coordinator can help you identify treatment options; locate supplies and equipment recommended by your doctor; coordinate care; and research the availability of transportation and lodging for out-of-town treatment. The nurse stays in touch weekly with patients and caregivers to assess and re-evaluate the treatment plan and the patient's progress. This program helps you make informed decisions about your health when you are seriously ill or injured. Participation is voluntary. You can leave the program at any time, for any reason. Your benefits will not be affected by your participation.

Here is how the program works: BlueCross BlueShield of South Carolina will refer you to the program if it may benefit you. You will receive a letter explaining the program, and a representative will contact you. A team of specially trained nurses and doctors will review your medical information and treatment plan. (Your medical history and information will always be kept confidential among your caregivers and the complex care management team.) Your nurse case manager will be your main contact. You and your doctor, however, will always make the final decision about your treatment. Complex care management does not replace your doctor's care. Always check with your doctor before following any medical advice.

Renal Disease Case Management Program

Renal Disease Case Management provides renal disease management care for select State Health Plan members receiving renal dialysis. This program's nurses provide education and care coordination that may help prevent acute illnesses and hospitalizations.

Here is how the program works: Members receiving renal dialysis are referred to the program. A nurse then contacts the individual to confirm that he is a good candidate for renal case management. The nurse, who has many years of renal dialysis experience, provides education and helps coordinate care.

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

Online health tools

My Health Toolkit

Personal Health Record

Your Personal Health Record, which is on the state BCBSSC website, is safe and secure. Through it, you have access to your health information, including your claims and the prescription drugs you are taking, 24 hours a day, seven days a week.

You can enter medical information, such as allergies, vaccinations, test results and personal or family medical history. This information can be shared with family members or new doctors as you feel is appropriate. Through the "My Care Plan" section, you can get information about your health conditions and other medical topics that interest you. If you participate in the Health Management Program, your health coach can use it to send you messages, assign tasks and provide you with additional information about your condition.

To review your record, go to the state BCBSSC website, StateSC.SouthCarolinaBlues.com, log in to "My Health Toolkit" and select "Personal Health Record." You will be asked to select the member before you will be taken to the "Personal Health Record" home page.

Personal Health Assessment

A Personal Health Assessment (PHA) is available to State Health Plan members who are 18 years and older. To access the survey, go to the state BCBSSC website, StateSC.SouthCarolinaBlues.com, log in to "My Health Toolkit" and select "Personal Health Assessment" from the "Wellness" menu.

The survey asks questions and then provides a score based on your responses. To get the most useful results, you need measurements of your cholesterol, triglycerides, glucose and blood pressure, as well as of the circumference of your neck and waist. You should have access to most of this information if you participate in a State Health Plan preventive screening. See Page 24 for more information.

The Personal Health Assessment gives you access to programs designed to address your risk factors. These interactive tools will help you reach your goals at your own pace. You can print your Personal Health Assessment results and recommendations, and you will continue to have access to them online. The program is on a secure website. All assessments remain confidential. You can retake the survey each year to measure your progress.

Wellness

The Wellness section of My Health Toolkit offers ways to improve your health. Go to the state BCBSSC website, StateSC.SouthCarolinaBlues.com, and log in to "My Health Toolkit." Click on "Wellness" and choose "Health Library." Information in the Health Library includes Aging and Health, Kids' and Teens" Health, Men's Health, Women's Health, a Drug Information Center and Health A-Z, fact sheets on a wide variety of topics.

State Health Plan benefits

The Standard Plan and the Savings Plan pay benefits for treatment of illnesses and injuries if the Plan of Benefits defines the treatment as medically necessary. This section is a general description of the plan. The Plan of Benefits contains a complete description of the benefits. Its terms and conditions govern all health benefits offered by the state. Contact your benefits administrator or PEBA for more

information. Some services and treatment require preauthorization by Medi-Call, National Imaging Associates, Express Scripts or Companion Benefit Alternatives. For details read the Medi-Call section beginning on Page 46, the National Imaging Associates section on Pages 47-48 and the mental health and substance abuse section on Page 73.

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

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

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

Advanced Practice Registered Nurse

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

The State Health Plan only recognizes certified nurse midwives as providers of midwife covered services. A certified nurse midwife is an Advanced Practice Registered Nurse licensed as a midwife by the State Board of Nursing or by a sister state having substantially-equivalent licensing standards. The services of lay midwives and midwives licensed by the S.C. Department of Health and Environmental Control are not reimbursed.

Alternative treatment plan

An alternative treatment plan is an individual program to permit treatment in a more cost-effective and less intensive manner. An alternative treatment plan requires the approval of the treating physician, Medi-Call and the patient. Services and supplies authorized by Medi-Call as medically necessary because of the approved alternative treatment plan will be covered.

Ambulance service

Ambulance service, including air ambulance service, is covered to the nearest hospital to obtain medically necessary emergency care. Ambulance service is also covered to transport a member to the nearest hospital that can provide medically necessary inpatient services when those services are not available at the current facility. No benefits are payable for ambulance service used for routine, non-emergency transportation, including, but not limited to, travel to a facility for scheduled medical or surgical treatments, such as dialysis or cancer treatment. All claims for ambulance service are subject to medical review. Ambulance services are reimbursed at 80 percent of the allowed amount; however, non-

participating providers can balance bill you up to the total of their charge for the service. Please note, all ambulance services may not be in-network. For information on balance billing, see Page 45.

Autism Spectrum Disorder benefits

Applied Behavior Analysis for treatment of Autism Spectrum Disorder is covered subject to Companion Benefit Alternatives' guidelines and preauthorization requirements.

Bone, stem cell and solid organ transplants

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

All transplant services must be approved by Medi-Call (see Page 46). You must call Medi-Call, even before you or a covered family member is evaluated for a transplant.

Through the Blue Distinction Centers for Transplants network, State Health Plan members have access to the leading organ transplant facilities in the nation. Contracts are also in effect with local providers for transplant services so members may receive transplants at those facilities. You will save a significant amount of money if you receive your transplant services at a Blue Distinction Centers for Transplants network facility or a South Carolina network transplant facility. If you receive transplant services at one of these network facilities, you will not be balance billed. You will be responsible only for your deductible, coinsurance and any charges not covered by the plan. In addition, these network facilities will file all claims for you.

Transplant services at nonparticipating facilities are covered by the plan; however, the State Health Plan pays only the State Health Plan-allowed amount for transplants performed out-of-network. If you do not receive your transplant services at a network facility, you may pay substantially more. In addition to the deductible and coinsurance, members using out-of-network facilities are responsible for any amount in excess of the allowed amount, or balance bill, and pay 40 percent coinsurance. Costs for transplant care can vary by hundreds of thousands of dollars. If you receive services outside the network, you cannot be assured that your costs will not exceed those allowed by the plan. For information on balance billing, see Page 45. You may also call Medi-Call for more information.

Chiropractic care

You are covered for specific office-based services from a chiropractor, including detection and correction by manual or mechanical means of structural imbalance, distortion or subluxation in the body to remove nerve interference and the effects of such nerve interference, where such interference is the result of, or related to, distortion, misalignment or subluxation of, or in, the vertebral column. Diagnostic X-rays are covered if medically necessary. Both plans are limited to one manual therapy per visit, which is subject to the plan maximum. For Standard Plan members, chiropractic benefits are limited to $2,000 per person each year. With the Savings Plan, they are limited to $500 per person each year for each covered person after the annual deductible has been

met. Services of a massage therapist are not covered.

Colonoscopies

Effective January 1, 2016, colonoscopies, both diagnostic and routine, are provided at no cost to members at network providers for State Health Plan primary members. Routine colonoscopies are covered within the age ranges recommended by the United States Preventive Services Task Force. Coverage includes the consultation, generic prep kit, procedure and associated anesthesia.

Contraceptives

Effective January 1, 2016, routine contraceptive prescriptions, including birth control pills and injectables (including, but not limited to, Depo-Provera and Lunelle), filled at a participating pharmacy or through the plan's mail-order pharmacy, are covered at no cost to State Health Plan primary subscribers and covered spouses. Birth control implants and injectables given in a doctor's office are covered as a medical, not pharmacy, benefit. Contraceptives are covered for covered children only to treat a medical condition and must be preauthorized by Express Scripts. The member still pays the cost share in these cases.

Cranial remodeling band or helmet

The plan covers a cranial remodeling band when preauthorization review determines it to be medically necessary for the correction of a child's moderate to severe positional head deformities associated with premature birth, restrictive intrauterine positioning, cervical abnormalities, birth trauma, torticollis or sleeping positions. Remodeling must begin between 4 and 12 months of age, following a failed two-month trial of conservative treatment (e.g., repositioning, neck exercises, etc.).

Diabetic supplies

Insulin is allowed under the prescription drug program or under the medical plan but not under both. Insulin is covered as either a preferred or a non-preferred drug. Diabetic supplies, including syringes, lancets and test strips, are covered at participating pharmacies for a $9 generic copayment, per item, for each supply of up to 31 days. Generic drugs to treat diabetes and diabetes testing supplies are covered at no charge for Standard Plan and Savings Plan members enrolled in the No-Pay Copay program, formerly the Wellness Incentive Program. Because insulin is not a generic drug, it is not eligible for the waiver. For more information, see Page 63. Claims for diabetic durable medical equipment should be filed though your medical coverage.

Please note: Effective January 1, 2016, diabetes education services offered by network providers are covered at no cost to State Health Plan primary members.

Doctor visits

Treatments or consultations for an injury or illness are covered when they are medically necessary within the terms of the plan and not associated with a service excluded by the plan. Some mental health and substance abuse outpatient visits still require preauthorization. For details on mental health and substance abuse benefits, see Pages 72-74.

Durable medical equipment

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

- Any purchase or rental of durable medical

equipment

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

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

Home health care

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

Hospice care

The plan will pay up to $6,000 for hospice care for a patient certified by his physician as having a terminal illness and a life expectancy of six months or less. The benefit also includes a maximum of $200 for bereavement counseling. These services must be preauthorized by Medi-Call.

Infertility

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

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

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

Prescription drugs for treatment of infertility are subject to a 30 percent coinsurance payment through both the Savings Plan and the Standard Plan. This expense does not apply to the $2,500 per person prescription

drug copayment maximum for the Standard Plan. It does apply to the Savings Plan deductible. The 70 percent plan payment for prescription drugs for infertility treatments applies to the $15,000 maximum lifetime payment for infertility treatments. Call Express Script's Customer Service at 853.612.3128 for more information about prescription drugs.

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

Please note: When you become pregnant, you are encouraged to enroll in the "Coming Attractions" Maternity Management Program. See Pages 48-49 for more information.

Inpatient hospital services

Inpatient hospital care, including a semi-private room and board, is covered. In addition to normal visits by your physician while you are in the hospital, you are covered for one consultation per consulting physician for each inpatient hospital stay. Inpatient care must be approved by Medi-Call (Page 46) or Companion Benefit Alternatives. For more information, see Page 73.

Outpatient facility services

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

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

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

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

Please note: When lab tests are ordered, you may wish to talk with your provider about having the service performed at an independent lab. This would enable you to avoid the $95 copayment for outpatient facility services or the $12 copayment for a physician office visit.

Pregnancy and pediatric care

Maternity benefits are provided to subscribers and their covered spouses. Covered children do not have maternity benefits. Maternity benefits include necessary prenatal and postpartum care, including childbirth, miscarriage and complications related to pregnancy. When you become pregnant, you are encouraged to enroll in the "Coming

Attractions" Maternity Management Program. See page 62 for information.

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.

The State Health Plan only recognizes certified nurse midwives as providers of midwife covered services. A certified nurse midwife is an Advance Practice Registered Nurse who is licensed by the State Board of Nursing, or by a sister state having a substantially-equivalent license standards, as a midwife. Services from an Active Practice Registered Nurse are covered even if these services are not performed under the immediate direction of a doctor. The services of lay midwives and midwives licensed by the S.C. Dept. of Health and Environmental Control are not reimbursed.

Please note: Breast pumps are not covered.

Prescription drugs

Prescription drugs, including insulin, are covered at a participating pharmacy, subject to plan exclusions and limitations. Drugs in FDA Phase I, II or III testing are not covered. Prescription drugs associated with infertility treatments have a different coinsurance rate. See Page 71 for more information.

Effective January 1, 2016:

- Contraceptives covered by the State Health Plan will be provided at no cost to State Health Plan primary subscribers and covered spouses. They must be obtained from a network provider.
- Prescription drugs for smoking cessation, including Chantix and bupropion (generic Zyban), are provided at no cost to State Health Plan primary members. They must be obtained from a network provider.

Non-sedating antihistamines and drugs for treating erectile dysfunction are not covered under the Savings Plan.

Reconstructive surgery after a medically necessary mastectomy

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

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

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

Rehabilitation care

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

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

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

Rehabilitation benefits are not payable for:

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

Rehabilitation – acute

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

Rehabilitation – long-term

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

Second opinions

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

Skilled nursing facility

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

Speech therapy

The plan covers short-term speech therapy to restore speech or swallowing function that has been lost as a result of disease, trauma, injury or congenital defect (e.g., cleft lip or cleft palate). Speech therapy must be prescribed by a physician and provided by a licensed speech therapist. Speech therapy, whether it is offered in an inpatient setting or in the member's home, requires preauthorization by Medi-Call. For more information, contact BCBSSC customer service at 803.736.1576 or 800.868.2520.

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

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

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

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

Surgery

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

Other covered benefits

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

- Blood and blood plasma, excluding storage fees
- Nursing services (part-time/intermittent)
- Dental treatments or surgery to repair damage from an accident, for up to one year from the date of the accident
- Dental surgery for bony, impacted teeth when supported by X-rays.

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

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

Effective January 1, 2016, adult vaccinations at the intervals recommended by the Centers for Disease Control are covered at no charge to Savings Plan, Standard Plan and Medicare

Coverage schedule for adult immunizations

Immunization[1]	Primary coverage	
	State Health Plan[2]	Medicare[3]
Flu *Ages 19 years and up*	Pays at 100% of allowed amount with no member cost share amounts.	Medicare benefits are available under Medicare Part B for these immunizations. **Medicare supplement members:** Your medical plan will pay remaining Medicare deductible and coinsurance if Medicare pays. **Medicare carve-out members:** Your medical plan will coordinate with Medicare to determine if any secondary benefits are available.
Hepatitis A *Ages 19 years and up*	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 *Ages 19 years and up*	Pays at 100% of allowed amount with no member cost share amounts.	Medicare benefits are available under Medicare Part B for these immunizations. **Medicare Supplement Members:** Your medical plan will pay remaining Medicare deductible and coinsurance if Medicare pays. **Medicare Carve-Out Members:** Your medical plan will coordinate with Medicare to determine if any secondary benefits are available.
Hib (Haemophilus Influenzae B) *Ages 19 years and up*	Pays at 100% of allowed amount with no member cost share amounts.	Medicare benefits are available under Medicare Part D for these immunizations. Benefits available only at participating pharmacies. Pays at 100% of allowed amount with no member cost share at pharmacy.
HPV (Human papillomavirus) *Adults ages 19 through 26 years*	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 *Ages 19 years and up*	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) *Ages 19 years and up*	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 *Ages 19 years and up*	Pays at 100% of allowed amount with no member cost share amounts.	Medicare benefits are available under Medicare Part B for these immunizations. **Medicare supplement members:** Your medical plan will pay remaining Medicare deductible and coinsurance if Medicare pays. **Medicare carve-out members:** Your medical plan will coordinate with Medicare to determine if any secondary benefits are available.
Polio *Ages 19 years and up*	Pays at 100% of allowed amount with no member cost share amounts.	Medicare benefits are available under Medicare Part D for these immunizations. Benefits available only at participating pharmacies. Pays at 100% of allowed amount with no member cost share at pharmacy.

Continued on next page

Immunization[1]	Primary coverage	
	State Health Plan[2]	Medicare[3]
Tetanus, Diphtheria, Pertussis *Ages 19 years and up*	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 *Ages 19 years and up*	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) *Ages 60 years and up*	Pays at 100% of allowed amount with no member cost share amounts.	Medicare benefits are available under Medicare Part D for these immunizations. **Medicare supplement and carve-out members:** If you receive this vaccine at your pharmacy, Medicare Part D will cover the cost. If you receive this vaccine at your medical provider's office, the State Health Plan will cover the vaccine at 100% of the allowed amount with no member cost share.

[1]Benefits are available only when performed by a medical or pharmacy network provider. Any associated office visit costs are not covered.
[2]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.
[3]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.

Supplemental Plan members at participating providers. To learn which vaccinations are covered, contact your network physician or go to www.cdc.gov/vaccines/schedules and select "Adults (19 years and older)."

A coverage schedule is available above.

Additional information about Zostavax, the shingles vaccine

Some network pharmacies administer Zostavax, the shingles vaccine. Coverage includes the fee for giving the shot; however, the vaccination requires a prescription. 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.

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
- 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. If you do not have Internet access, contact your provider or call BCBSSC 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 *Medicare and You* handbook for information about coverage. The State Health Plan is primary for a woman covered as active employee or as the spouse of an active employee regardless of Medicare eligibility.

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.

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.

Who is eligible?

Covered children are eligible for Well Child Care check-ups until they turn age 19.

How does it work?

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 (IVP)	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

Additional benefit for Savings Plan participants

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
- A preventive lipid panel once every five years for testing cholesterol and triglycerides.

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

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

Natural Blue℠ and Member Discounts

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

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

- Discount network
- Vitamins and supplements
- TruHearing Digital Hearing Aid
- Bosley Hair Restoration
- Walking Works®
- Cosmetic and restorative dentistry
- Vision One EyeCare Program
- Cosmetic surgery
- Allergy relief
- Jenny Craig
- Doctors Wellness Center
- Blue 365
- Fitness centers
- Healthy products
- My Gym Children's Fitness Center

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

Companion Global Healthcare is offered through BCBSSC, but it is not a State Health Plan benefit. It assists with providing lower-cost medical care in countries ranging from Costa Rica to Ireland to Thailand. All care is

offered at facilities accredited by the Joint Commission International. Members also may be able to save money on major dental work through Companion Global Dental. For more information, call 800.906.7065 or go to www.companionglobalhealthcare.com.

Members may use their Medical Spending Account funds tax free for contacts, eyeglasses, hearing aids and many other services. For more information, see Internal Revenue Service Publication 969, "Health Savings Accounts and Other Tax-Favored Health Plans" on the IRS website, www.irs.gov.

Prescription drug benefits

State Health Plan Prescription Drug Program

Prescription drugs are a major benefit to you and a major part of the cost of our self-insured health plan. Using generic drugs saves you and the plan money. You also can save money and receive the same FDA-approved drugs when you refill prescriptions through the plan's Retail Maintenance Network or mail-order prescription service. **Benefits are paid only for prescriptions filled at network pharmacies or through Express Scripts mail-order pharmacy, in the United States.** Limited coverage is offered outside the United States. For more information, see Pages 193-194.

Prescription drugs, including insulin or other self-injectable drugs (drugs administered at home), are covered subject to plan exclusions and limitations, if you use a participating pharmacy. Drugs in FDA Phase I, II or III testing are not covered. Prescription drugs associated with infertility treatments have a different coinsurance rate. See Pages 57-58 for more information.

You will receive one pharmacy benefits card from Express Scripts, the State Health Plan pharmacy benefits manager. Please present your card when you fill a prescription, particularly the first time you use your card, and any time you fill a prescription at a different pharmacy.

Standard Plan

Under the Standard Plan, you show your pharmacy benefits card the first time you purchase a prescription from a participating retail pharmacy and pay a copayment. Copayments are $9 for Tier 1 (generic – lowest cost), $38 for Tier 2 (brand – higher cost) or $63 for Tier 3 (brand – highest cost) for up to a 31-day supply. The prescription drug copayment is a fixed total amount a subscriber must pay for a covered drug. The insurance plan pays the cost beyond the copayment, up to the allowed amount. Prescription drug benefits are payable without an annual deductible and there are no claims to file.

The prescription drug benefit has a separate annual copayment maximum of $2,500 per person. This means that after you spend $2,500 in prescription drug copayments, the plan will pay 100 percent of the allowed amount for your covered prescription drugs for the rest of the year. Drug expenses do not count toward your medical annual deductible or coinsurance maximum.

Savings Plan

Under the Savings Plan, you show your pharmacy benefits card the first time you purchase a prescription from a participating retail pharmacy. There are no copayments under the Savings Plan. You pay the full allowed amount for your prescription drugs,

and a record of your payment is transmitted electronically to BCBSSC. If you have not met your annual deductible, the full allowed amount for the drug will be credited to it. If you have met your annual deductible, you will pay 20 percent of the allowed amount for the drug. This amount will be credited to your coinsurance maximum. Non-sedating antihistamines and drugs for erectile dysfunction are not covered under the Savings Plan.

Express Scripts Medicare®

If you are enrolled in the State Health Plan as an active employee, there are no changes in your prescription drug coverage when you or your covered dependents become eligible for Medicare. PEBA automatically enrolls Medicare-eligible retirees and their Medicare-eligible dependents in Express Scripts Medicare®, the State Health Plan's Medicare Part D program. However, you have the option to return to the SHP Prescription Drug Program, which covers members who are not eligible for Medicare. For information about Express Scripts Medicare®, see the 2016 *When You Become Eligible for Medicare* handbook, which is available online or from PEBA.

Features of the Prescription Drug Program

Step Therapy Programs

This program is designed to encourage use of generics and over-the-counter drugs that are alternatives to some high-volume, high-priced brand-name drugs. For example, omeprazole is a less expensive alternative to Aciphex.

If you or your doctor thinks you should not use the lower-cost drug, your prescription may require preauthorization or it may be covered at the Tier 3 (highest cost) rate. You or your doctor may request a coverage review by calling Express Scripts. As part of the process, you may be required to have tried and failed to successfully use the lower-cost drug. If as a result of the review, the drug is approved,

The examples below show how pay-the-difference works in the Standard Plan and, if you are covered by the State Health Plan Prescription Drug Program, the Medicare Supplemental Plan:

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

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

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

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

it will be covered at the appropriate tier. If approval is denied, your health plan will not cover the drug. For more information, call Express Scripts at 855.612.3128.

Tiers determine prescription drug cost

Members covered by the Standard Plan and Express Scripts Medicare® pay copayments for drugs.

Tier 1 (Generic — $9 copayment)

Generic drugs may differ in color, size or shape, but the FDA requires that the active ingredients be the chemical equivalent of the brand-name alternative and have the same strength, purity and quality. Because generic drugs have a lower copayment, you typically get the same health benefits for less. You may wish to ask your doctor to mark "substitution permitted" on your prescription. If he does not, your pharmacist will have no choice but to give you the brand-name drug if that is the drug your doctor wrote on the prescription.

Tier 2 (Brand — $38 copayment)

These are drugs Express Scripts' Pharmacy and Therapeutics Committee has determined to be safe, effective and available at a lower cost than Tier 3 drugs. The list may be updated during the year. It is available online at www.Express-Scripts.com. You may also reach the Express Scripts website through the PEBA insurance benefits website by clicking on "Links" and then "Prescription Drugs (Express Scripts)."

Tier 3 (Brand — $63 copayment)

These medications carry a higher copayment or higher price. **Tier 3 contains drugs that may be considered preferred or non-preferred on the formulary,** the list of prescription drugs approved by your plan.

Pay-the-difference policy

The State Health Plan has a "pay-the-difference" policy. If you purchase a brand-name drug when an FDA-approved generic equivalent is available, the payment will be limited to what the plan would have paid for the generic equivalent. This policy will apply even if the doctor prescribes the drug as "Dispense as Written" or "Do Not Substitute."

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

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

Savings Plan members do not pay copayments; however, they usually save money by buying generic drugs because these drugs typically cost less. With the **Savings Plan**, if you purchase a Tier 2 or Tier 3 (brand) drug over a Tier 1 (generic) drug, only the allowed amount for the generic drug will apply toward your deductible. After you have met your deductible, only the patient's 20 percent share of the allowed amount for the generic drug will apply toward your coinsurance maximum. If you are taking a Tier 2 or Tier 3 drug, you may wish to ask your doctor about using a generic drug, if one is available. If appropriate, the doctor may note on the prescription that substitution is permitted.

Compound prescriptions

A compound prescription is a medication that requires a pharmacist to mix two or more drugs, based on a doctor's prescription, when such a medication is not available from a manufacturer. The prescription must be medically necessary and studied for use in this type of preparation. It must also be purchased from a participating pharmacy.

In order to be sure that your compound is covered under your plan, the pharmacist should submit this to ESI electronically. If one ingredient in the compound is not covered, the preparation is not covered by the plan and will have no reimbursement. The pharmacist will receive information on coverage of ingredients and in some situations can substitute other covered items to create your preparation. If your compound is not covered, you should discuss commercially available products with your physician.

If a network pharmacy does not file your claim, you must pay the entire cost of the prescription and then submit a claim to Express Scripts. Information on how to file a claim to Express Scripts is on Pages 193-194. Claims must be accompanied by an itemized list of the ingredients. This information allows Express Scripts to process your claim based on the actual ingredients in the medication. Ask your pharmacist to provide you with this list when you fill your prescription. Please be sure it includes:

- The name of each ingredient
- The valid National Drug Code for each ingredient
- The quantity of each ingredient

When you file your own claim, your reimbursement may be less than what you paid for the drug because it will be limited to the plan's allowed amount minus the copayment for the actual ingredients in the compound prescription. Prescriptions filled at out-of-network pharmacies will not be reimbursed. If the prescription is not covered by the plan, there will be no reimbursement. The way to avoid this is for the pharmacist to submit the compound electronically and collect the appropriate copayment at the time of dispensing.

Prior authorization

Some medications will be covered by the plan only if they are prescribed for certain uses. These drugs must be authorized in advance, or they will not be covered under the plan. If the prescribed medication requires prior authorization, you, your doctor or your pharmacist may begin the review process by contacting Express Scripts at 855.612.3128.

Retail pharmacies

You must use a participating pharmacy and you must show your health plan identification card when purchasing medications. Most major pharmacy chains and independent pharmacies participate in the network. If you are enrolled in the State Health Plan, you may get a list of network pharmacies from the PEBA insurance benefits website, www.eip.sc.gov, by selecting "Online Directories" and then "State Health Plan Pharmacy Locator." You will need to register and sign in. You may also get a list of network pharmacies from your benefits administrator.

Retail Maintenance Network – save money locally

If you are enrolled in the SHP Prescription Drug Program or Express Scripts Medicare®, you may buy up to 90-day supplies of prescription drugs at mail-order prices at local pharmacies belonging to the Retail

Maintenance Network. You pay the same copayment as you would pay through mail order. The discount applies only to prescriptions filled for a 63-90 day supply. Copayments for prescriptions filled for a 0-62 day supply at these retail pharmacies remain the same. The copayments also remain the same at all other network pharmacies. A list of the pharmacies is on the PEBA insurance benefits website, www.eip.sc.gov, under "Online Directories." If you do not have Internet access, ask your benefits administrator to print the list for you or contact Express Scripts at 855.612.3128.

Mail-order: another way to save time and money

The State Health Plan Prescription Drug Program and Express Scripts Medicare® offer home delivery for 90-day supplies of prescriptions through Express Scripts Pharmacy. By using this service, you receive a discount on the same FDA-approved prescription drugs that you would buy at a retail pharmacy. Mail order is an ideal option for anyone with a recurring prescription, such as birth control medicine, or a chronic condition, such as asthma, high cholesterol or high blood pressure. Some controlled substances may not be available by mail. Please call Express Scripts before submitting your prescription. You can also get a 90-day supply of your maintenance medications at mail-order prices through the Retail Maintenance Network, which allows you to use a network pharmacy near you. Be sure to ask your physician to write your prescription for a 90-day supply. If you have any questions before you order a 90-day supply of a medication, call Express Scripts at 855.612.3128.

Standard Plan and the Medicare Supplemental Plan

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

- Tier 1 (generic) – $22
- Tier 2 (brand) – $95
- Tier 3 (brand) – $158

Savings Plan

You pay the full allowed amount when you order prescription drugs through the mail; however, the cost for a 90-day supply will typically be less than you would pay at a retail pharmacy unless you use the Retail Maintenance Network.

How to order drugs by mail

Here is how fill a prescription through Express Scripts Pharmacy by mail:

- Ask your doctor to write a new prescription for a 90-day supply of the medication with refills, as appropriate. You may also want to ask him to write a prescription for 31-day supply of the drug, which you can fill at a retail pharmacy and use until you receive your drugs in the mail.
- Complete a home delivery prescription form, or have your physician e-prescribe the prescription to ESI mail order. If you have set up an online profile, the method of payment can be selected in advance and ESI will send you an email on the receipt of your new prescription and begin dispensing. You may pay by check, money order or major credit card. If you prefer to pay by credit card, you may want to sign up for Express Scripts' automatic payment program.
- Mail the prescription, the order form and the payment to Express Scripts in

the return envelope provided in your welcome kit.

- Additional home delivery forms are available from Express Scripts Customer Service or at www.Express-Scripts.com.

Here is how to fill a prescription by fax:

- Ask your doctor to write a new prescription for a 90-day supply of the medication with refills, as appropriate. Give your doctor your member identification number, which is on the front of your pharmacy benefits card.
- If your doctor asks how to fax your prescription to Express Scripts, suggest he call 888.327.9791.
- Ask your doctor to fax your prescription to 800.837.0959.

Your mail order prescription(s) will be sent to your home, typically within 10-14 business days.

Coordination of benefits

The State Health Plan coordinates prescription drug benefits as well as medical benefits. This ensures that if you are covered by more than one health plan, both plans pay their share of the cost of your care. See Pages 38-40 for more information.

Exclusions

Some prescription drugs are not covered under the plan. See Page 59 for more information.

Mental health and substance abuse benefits

For customer service and information about claims for mental health and/or substance abuse care, call BCBSSC at 800.868.2520.

How are mental health/substance abuse claims filed?

Claims for mental health and substance abuse are subject to the same copayments, deductibles, coinsurance and coinsurance maximums as medical claims. There is no limit on the number of provider visits allowed as long as the care is medically necessary under the terms of the plan. There is not an annual or lifetime maximum for mental health and substance abuse benefits.

If you use a network provider, the provider is responsible for submitting claims. If you receive care from a provider that is not a member of the network, see Page 192 for information about how to file a claim. Your mental health and substance abuse provider will be required to conduct periodic medical necessity reviews (similar to Medi-Call for medical benefits).

The mental health/substance abuse provider network

Medically necessary mental health and substance abuse services are covered when rendered by network and out-of-network providers. Just like benefits for medical services, a higher percentage of the cost of your care is covered if you use network services.

The most up-to-date list of providers is on the state BCBSSC website, StateSC.SouthCarolinaBlues.com. Click on the “Find a Provider” link in the “Find a Doctor” box and follow the instructions. To see a printable directory of network providers in South Carolina and surrounding counties in Georgia and North Carolina, go to provider.bcbs.com and follow the instructions. To learn more

about how to use these directories, see Page 40 and Page 43.

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

For preauthorization and case management – 800.868.1032

Preauthorization and case management of mental health and substance abuse benefits are handled by Companion Benefit Alternatives, the State Health Plan's mental health/substance abuse benefits manager. Office visits to a mental health or substance abuse provider, such as a psychologist, a clinical social worker or a professional counselor, do not require preauthorization unless they are one of the services listed below.

These services must be preauthorized by Companion Benefit Alternatives:

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

To preauthorize services, your provider must call Companion Benefit Alternatives at 800.868.1032 before you are admitted or, in an emergency situation, within 48 hours or the next working day. For professional services listed above, your provider must call before services are rendered. To assess medical necessity, Companion Benefit Alternatives will require clinical information from the mental health or substance abuse provider treating you. Although your provider may make the call for you, **it is your responsibility to see that the call is made and the preauthorization has been granted.** A determination by Companion Benefit Alternatives does not guarantee payment. Other conditions, including eligibility requirements, other limitations and exclusions, payment of deductibles and other provisions of the plan must be satisfied before BCBSSC makes payment.

What are the penalties for not calling Companion Benefit Alternatives for preauthorization?

Mental health professional services

If mental health and substance abuse outpatient services that require preauthorization (i.e., Applied Behavior Analysis Therapy and Psychological/ Neuropsychological Testing) are not preauthorized, they will not be covered.

Facility services

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

Case management

Case management is designed to support members with catastrophic or chronic illnesses. Participants are assigned a case manager, who will help educate them on the options and services available to meet their

mental health and substance abuse needs and assist in coordinating services.

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

Quit For Life® Program

The research-based Quit For Life® Program is brought to you by the American Cancer Society® and Alere Wellbeing. It is available at no charge to State Health Plan subscribers, their covered spouses and covered dependents age 13 or older.

One of the most successful programs of its kind, the Quit For Life Program helps participants stop using cigarettes, cigars, pipes and smokeless tobacco. A professionally trained Quit Coach® works with each participant to create a personalized quit plan. As part of the 12-month program, participants receive a complete Quit Guide and five telephone calls from a Quit Coach. Participants may call the toll-free support line as often as they wish. For members age 18 and older, the program also provides free nicotine replacement therapy, such as patches, gum or lozenges, if appropriate.

Your Quit Coach may also recommend that your doctor prescribe a smoking cessation drug, such as bupropion or Chantix, which is available through your prescription drug coverage. Prescription drugs for smoking cessation, including Chantix and bupropion, are provided to Savings Plan and Standard Plan primary members at no cost to the member. The drugs must be obtained from a network provider.

Registration is available 24 hours a day, seven days a week. Quit Coaches also are available 24 hours a day, seven days a week (except on certain holidays). If you still need help after the 12-month program ends, you may re-enroll. Call 866.QUIT.4.LIFE (866.784.8454) or visit www.quitnow.net/ScStatehealthPlan to enroll in the Quit For Life Program. After your eligibility is verified, you will be transferred to a Quit Coach for your first call.

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Exclusions: services not covered

There are some medical expenses the State Health Plan does not cover. The Plan of Benefits (available in your benefits office or on the PEBA website) contains a complete list of the exclusions.

1. Services or supplies that are not medically necessary within the terms of the plan
2. Routine procedures not related to the treatment of injury or illness, except for those specifically listed in the Preventive Benefits section
3. Routine physical exams, checkups (except Well Child Care and Preventive Benefits according to guidelines), services, surgery (including cosmetic surgery) or supplies that are not medically necessary. (The

Savings Plan covers an annual physical by a network physician for each participant age 19 and older.)

4. Routine prostate exams, screenings or related services are not covered under the plan. A diagnostic prostate exam, screening and laboratory work will be covered when medically necessary but not as part of the Savings Plan annual physical exam. The diagnostic exam will be subject to the State Health Plan's usual deductibles and coinsurance.
5. Routine Prostate-Specific Antigen tests
6. Eyeglasses
7. Contact lenses, unless medically necessary after cataract surgery and for the treatment of keratoconus, a corneal disease affecting vision
8. Routine eye examinations
9. Refractive surgery, such as radial keratotomy, laser-assisted in situ keratomileusis (LASIK) vision correction, and other procedures to alter the refractive properties of the cornea
10. Hearing aids and examinations for fitting them
11. Dental services, except for removing impacted teeth or treatment within one year of a condition resulting from an accident
12. TMJ splints, braces, guards, etc. (Medically necessary surgery for TMJ is covered if preauthorized by Medi-Call.) TMJ, temporo mandibular joint syndrome, is often characterized by headache, facial pain and jaw tenderness caused by irregularities in the way joints, ligaments and muscles in the jaws work together.
13. Custodial care, including sitters and companions or homemakers/caretakers
14. Admissions or portions thereof for custodial care or long-term care, including:
    - Respite care
    - Long-term acute or chronic psychiatric care
    - Care to assist a member in the performance of activities of daily living, i.e., custodial care (including, but not limited to: walking, movement, bathing, dressing, feeding, toileting, continence, eating, food preparation and taking medication)
    - Psychiatric or substance abuse long-term care, including: therapeutic schools, wilderness/boot camps, therapeutic boarding homes, half-way houses and therapeutic group homes
15. Any item that may be purchased over the counter, including but not limited to medicines and contraceptive devices
16. Surgery to reverse a vasectomy or tubal ligation if elective and not medically necessary to treat a pre-existing condition
17. Diagnosis or treatment of infertility for a subscriber or a spouse if either member has had a tubal ligation or vasectomy
18. Assisted reproductive technologies (fertility treatment) except as noted on Pages 57-58 of this chapter
19. Diet treatments and all weight loss surgery, including, but not limited to: gastric bypass, gastric banding or stapling; intestinal bypass and any related procedures; the reversal of such procedures; and conditions and complications as a result of such procedures or treatment

20. Equipment that has a nontherapeutic use (such as humidifiers, air conditioners, whirlpools, wigs, artificial hair replacement, vacuum cleaners, home and vehicle modifications, fitness supplies, speech augmentation or communication devices, including computers, etc.), regardless of whether the equipment is related to a medical condition or prescribed by a physician
21. Air quality or mold tests
22. Supplies used for participation in athletics (that are not necessary for activities of daily living), including but not limited to, splints or braces
23. Physician charges for medicine, drugs, appliances, supplies, blood and blood derivatives, unless it is a covered medical benefit under the Plan
24. Medical care by a doctor on the same day or during the same hospital stay in which you have surgery, unless a medical specialist is needed for a condition the surgeon could not treat
25. Physician's charges for clinical pathology, defined as services for reading any machine-generated reports or mechanical laboratory tests. Interpretation of these tests is included in the allowance for the lab service.
26. Fees for medical records and claims filing
27. Food supplements, including but not limited to, formula, enteral nutrition, Boost/Ensure or related supplements
28. Services performed by members of the insured's immediate family
29. Acupuncture
30. Chronic pain management programs
31. Transcutaneous (through the skin) electrical nerve stimulation (TENS), whose primary purpose is the treatment of pain
32. Biofeedback
33. Complications arising from the receipt of noncovered services
34. Psychological tests to determine job, occupational or school placement or for educational purposes; milieu therapy; or to determine learning disability
35. Any service or supply for which a covered person is entitled to payment or benefits pursuant to federal or state law (except Medicaid), such as benefits payable under workers' compensation laws
36. Charges for treatment of illness or injury or complications caused by acts of war or military service
37. Cosmetic goods, procedures or surgery or complications resulting from such procedures or services
38. Smoking cessation or deterrence products or services, with the exception of provisions established in the Prescription Drug Program or as authorized by the behavioral health manager for eligible participants in its tobacco cessation program.
39. Sclerotherapy (treatment of varicose veins), including injections of sclerosing solutions for varicose veins of the leg, unless a prior-approved ligation (tying off of a blood vessel) or stripping procedure has been performed within three years and documentation submitted to Medi-Call with a preauthorization request establishes that some varicosities (twisted veins) remained after the procedure
40. Services performed by service or therapy animals or their handlers

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

Additional limits in the Standard Plan

- Chiropractic benefits in the Standard Plan are limited to $2,000 per person per year.
- Chiropractic benefits for manual therapy are limited to one per visit per person.

Additional limits and exclusions in the Savings Plan

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

Helpful information may be found on the Internet

StateSC.SouthCarolinaBlues.com

BCBSSC has a website designed to give State Health Plan subscribers quick access to information about their plan. You can go directly to the site at www.StateSC.SouthCarolinaBlues.com. On the site, you will find direct links to:

- The 2016 *Insurance Benefits Guide*
- Frequently used forms and publications
- A service for finding network doctors, hospitals and other providers
- Information about the No-Pay Copay program, including how to enroll, which generic drugs are covered by the waiver and frequently asked questions.
- The login for MyHealth Toolkit.

You need to register and log in to access MyHealth Toolkit information and resources, which include:

- See how much of your deductible and coinsurance maximum you have satisfied
- Check the status of claims, preauthorizations and bills
- Choose to view your Explanation of Benefits online rather than receiving a paper copy in the mail. You will be notified by email when an Explanation of Benefits is ready.
- Request a benefits identification card
- Create a Personal Health Record
- Take a Personal Health Assessment
- Enroll in the "Coming Attractions" maternity program
- Ask Customer Service a question.

www.CompanionBenefitAlternatives.com

The Companion Benefit Alternatives' (CBA) website offers a variety of ways to learn more about mental health and health in general. Go to www.CompanionBenefitAlternatives.com and select "Members." You can sign up for an email newsletter and use tools that include:

A description of CBA's case management program

- A printable provider directory
- Links to other resources, including phone numbers for financial assistance hot lines.

www.Express-Scripts.com

To get the most out of Express Scripts' website, you must register. You will need the information on your prescription drug card to register. It may be helpful to have a copy of a recent prescription at hand as well. The website offers a variety of information and tools with which you can:

- View a list of your medications
- Refill prescriptions
- Find network pharmacies near you
- View a summary of your prescription expenses
- Print your prescription history, which will be useful to your doctor
- View up-to-date coverage information
- Print forms

Appeals

PEBA contracts with third-party claims processors, BCBSSC and Express Scripts, to handle claims for State Health Plan benefits, and Companion Benefit Alternatives to manage mental health and substance abuse benefits. A subscriber has the right to appeal these third-party claims processors' decisions.

If all or part of a request for preauthorization or a claim for benefits is denied, the subscriber will be informed of the decision promptly and told why it was made. If he has questions about the decision, he may contact the deciding third-party claims processor for an explanation.

Appeals to third-party claims processors

First-level appeals: preauthorizations and claims

You may appeal an initial denial of a preauthorization (to Medi-Call or Express Scripts) or a claim (to BCBSSC) within 180 days of the decision. If you would like for someone else to appeal on your behalf, you may make

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

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

Procedures to appeal preauthorization decisions by National Imaging Associates are different from other appeal procedures. If National Imaging Associates denies a procedure on the grounds that it is not medically necessary, you have three days to file an appeal with National Imaging Associates if the services have not been received. If three days have passed, you may request Medi-Call review the decision.

Appeals to PEBA: preauthorizations and services that have been provided

If you are still dissatisfied after your appeal decision is re-examined, you may request a second-level appeal by writing to PEBA within 90 days of notice of the denial. Please include a copy of the denial with the appeal. Appeals are processed in the order in which they are received. If the denial is upheld by the PEBA Insurance Benefits Health Appeals Committee, you have 30 days to seek judicial review as provided by Sections 1-11-710 and 1-23-380 of the S.C. Code of Laws, as amended.

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

GEA TRICARE Supplement Plan

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

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

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

Eligibility

PEBA does not confirm eligibility for the TRICARE Supplement Plan. Eligible individuals must be registered with the Defense Enrollment Eligibility Reporting System (DEERS) and must not be eligible for Medicare. You

must drop your State Health Plan coverage to enroll in the TRICARE Supplement Plan.

You should confirm your eligibility for TRICARE with DEERS before enrolling in the TRICARE Supplement. If a dependent's Military identification card has expired or if information has changed (i.e., address corrections), call DEERS at 800.538.9552. The TRICARE Supplement Plan is available to:

Eligible employees, retirees and survivor subscribers and spouses who are under age 65 and not eligible for Medicare:

- Military retirees receiving retired, retainer or equivalent pay
- Spouse/surviving spouse of a military retiree
- Retired reservists between the ages of 60 and 65 and spouses/surviving spouses of retired reservists
- Retired reservists younger than 60 and enrolled in TRICARE Retired Reserve ("Gray Area" retirees) and spouses/surviving spouses of retired reservists enrolled in TRICARE Retired Reserve.
- Qualified National Guard and Reserve Members (TRICARE Retired Reserve).

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

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

Eligible dependent children

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

How to enroll

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

To enroll:

1. Membership in the Government Employees Association is required for enrollment in the TRICARE Supplement Plan. Information about the Government Employees Association is provided in the TRICARE Supplement Plan welcome packet. Dues are included in the plan's monthly premium. For more information, contact the Government Employees

Association at 800.446.7600 or www.geausa.org.

2. Complete a Notice of Election, and check "TRICARE Supplement Plan" in the health plan section. Return the Notice of Election to your benefits administrator along with a copy of your military identification or TRICARE identification card. Also, if you are an active employee, your benefits administrator can enroll you using the online Employee Benefits System. As a subscriber, you can enroll through MyBenefits during open enrollment. See Page 15 for more information. If you are a retired employee of a state agency, public school district or a higher education institution, submit a Retiree Notice of Election to PEBA. If you are a local subdivision retiree, submit a Retiree Notice of Election to your former employer's benefits office. See Pages 171-172 for more information. Coverage is not automatic.
3. If you are an eligible subscriber, complete the TRICARE Other Health Insurance form if you were previously enrolled in the State Health Plan. The TRICARE Other Health Insurance form for each region is on the TRICARE website, www.tricare.mil. Fax the completed forms to TRICARE at the number on the form. Remember, the TRICARE Supplement Plan is not considered other health insurance.

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

In addition to enrolling in the TRICARE Supplement Plan, during open enrollment, if you're an eligible subscriber, you may drop TRICARE Supplement Plan coverage for yourself or your dependents, or add dependents. See Page 15 for more information.

Plan features

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

- No deductibles, coinsurance or out-of-pocket expenses for covered services
- You may choose any TRICARE-authorized provider, including network, non-network, participating and nonparticipating providers. For more information, see the *TRICARE Supplement Plan Member Handbook*.
- Reimbursement of prescription drug copayments.

Premiums

The monthly premiums for the TRICARE Supplement Plan for active employees, retirees and survivors are:

- Employee: $62.50
- Employee/spouse: $121.50
- Employee/children: $121.50
- Full family: $162.50

You pay the entire premium. There is no employer contribution; however, your premiums may be paid before taxes are deducted from your paycheck through the MoneyPlus Pretax Group Insurance Premium Feature.

Filing claims

Most providers submit TRICARE Supplement Plan claims. If a provider does not, you

may submit the claims to Selman & Company. Detailed information about filing doctor/hospital and pharmacy claims is included in the welcome packet and on the Selman & Company website, www.selmantricareresource.com/SC. The claim form is in the welcome packet and on the website, www.selmantricareresource.com, in "Member Resources."

Portability

The TRICARE Supplement Plan is portable. If you leave your job, you can continue coverage by paying the premiums directly to Selman & Company.

Medicare eligibility and the TRICARE Supplement Plan

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

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

Loss of TRICARE eligibility

The TRICARE Supplement Plan pays after TRICARE pays. Therefore, if an employee, spouse or dependent child loses TRICARE eligibility, TRICARE Supplement Plan coverage ends. Dependents who lose TRICARE eligibility are not eligible for continued TRICARE Supplement Plan coverage through COBRA or on portability. Loss of TRICARE eligibility is a special eligibility situation that permits an eligible employee or retiree and his dependents, if the dependents are otherwise eligible for PEBA insurance coverage, to enroll in health, dental and vision coverage. Basic Life Insurance and Basic Long Term Disability Insurance are provided free to active employees who enroll in the State Health Plan or the TRICARE Supplement Plan.

Loss of a spouse's TRICARE eligibility

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

Loss of a dependent child's TRICARE eligibility

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

For more information

For more information about the Government Employees Association TRICARE Supplement Plan, contact the Selman & Company Call Center at 866.637.9911 and select option 1, email memberservices@selmanco.com or log on to www.selmantricareresource.com/SC. For more information about TRICARE for Life, call

866.773.0404 or go to www.tricare4u.com.

Dental insurance

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

- During initial enrollment in PEBA's insurance benefits coverage
- During open enrollment in an odd-numbered year. The next opportunity will be October 2017.
- Within 31 days of a special eligibility situation, which is also referred to as a "change in status" in the dental plan. Special eligibility situations are explained on Pages 16-23.

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

State Dental Plan

The State Dental Plan offers these levels of treatment: diagnostic and preventive; basic; prosthodontics; and orthodontics. They are described on the next page. The lifetime orthodontics payment is $1,000 for each covered child age 18 and younger. State Dental Plan benefits are paid based on the allowed amounts for each dental procedure listed in the plan's Schedule of Dental Procedures and Allowed Amounts. Be aware that your dentist's charge may be greater than the allowed amount.

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

Dental Plus

Dental Plus covers the first three levels of treatment at the same percentage as the State Dental Plan. However, the allowed amount is higher. Dental Plus does not cover orthodontics. However, members enrolled in Dental Plus must also be covered by the State Dental Plan. That plan offers a $1,000 lifetime orthodontics benefit for each covered child age 18 and younger. See the chart on Page 98 for more information.

Under Dental Plus, payment for a covered service is based on the lesser of the dentist's charge and the Dental Plus allowed amount. The allowances may differ for services rendered by a network dentist versus a non-network dentist. You are only responsible for any deductibles and coinsurance, plus any non-covered services, that apply for services rendered by a network dentist. **You will be responsible for the difference (plus deductibles and coinsurance) between the payment and charge for all services rendered by a non-network dentist.**

Premiums are on Pages 184-190.

BCBSSC offers dentists in South Carolina agreements to accept the lesser of their usual charge or the Dental Plus allowed amount. For a list of network dentists, go to StateSC.SouthCarolinaBlues.com and select "Find a Dentist" under the "Find a Doctor" section. Enter your location. Select "Advanced Search" on the main screen and follow the prompts.

If your dentist has not accepted BCBSSC's

agreement, your benefits under Dental Plus will not be reduced. However, you will be responsible for the difference between your dentist's charge and the Dental Plus allowed amount plus deductibles and coinsurance.

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

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

Not all dental procedures are covered. Reimbursement is based on the lesser of the dentist's actual charge or the plan's allowed amount, the most the plan allows for a covered service. Please see Page 92-93 for more information.

How to file a dental claim

The easiest way to file a claim is to assign benefits to your dentist. Assigning benefits means that you authorize your dentist to file claims for you and to receive payment from the plan(s). To do this, show a staff member in your dentist's office your dental identification card and ask that the claim be filed for you. Be sure to sign the payment authorization block of the claim form. Your dentist will be paid directly.

If your dentist will not file your claims, see Page 193 for information about how to file a claim.

If you are covered under Dental Plus, BCBSSC will process your claims under the State Dental Plan and then under Dental Plus. You do not have to submit additional claims. If you are covered under the State Dental Plan and Dental Plus, you will receive an Explanation of Benefits (EOB) from each plan. State Dental Plan EOBs have "State Dental Plan" on the front page, and the claim number normally begins with a "T." "Dental Plus Plan" is printed in the same place on the Dental Plus EOBs, and the claim number normally begins with a "V." The numbers after the letter, or first digit, should be the same for both claims.

Special provisions of the State Dental Plan

Alternate forms of treatment

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

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

Dental benefits at a glance

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

[1]A subscriber must submit a letter from his provider for a covered child, age 18 and younger, stating that the child's orthodontic treatment is not for cosmetic purposes for it to be covered by the State Dental Plan.
[2]$2,000 is the maximum yearly payment for benefits when a member is enrolled in both the State Dental Plan and Dental Plus.

Pretreatment estimates

Although it is not required, PEBA suggests that you obtain a Pretreatment Estimate of your non-emergency treatment for major dental procedures. To do this, you and your dentist should fill out a claim form before any work is done. The form should list the services to be performed and the charge for each one. Mail the claim form to BlueCross BlueShield of South Carolina, State Dental Claims Department, P.O. Box 100300, Columbia, SC 29202-3300. Emergency treatment does not need a Pretreatment Estimate.

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

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

If the State Dental Plan is your secondary insurance, the Pretreatment Estimate will not reflect the estimated coordinated payment, because BCBSSC will not know what your primary insurance will pay.

Exclusions: Dental benefits not offered

There are some dental benefits that the State Dental Plan and Dental Plus do not offer. The dental plan document lists all exclusions. The list below includes many of them. You may wish to take it with you when you discuss treatment with your dentist.

General benefits not offered

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

charge is made or no payment would be required if the person did not have this benefit, including non-billable charges under the person's primary insurance plan.

- Services or supplies not recognized as acceptable dental practices by the American Dental Association.

Benefits covered by another plan

- Treatment for which the covered person is entitled under any workers' compensation law.
- Services or supplies that are covered by the armed services of a government.
- Dental services for treatment of injuries as a result of an accident that are received during the first 12 months from the date of the accident. These services are covered under the member's health plan.

Specific procedures not covered

- Space maintainers for lost deciduous (primary) teeth if the covered person is age 19 or older.
- Experimental services or supplies.
- Onlays or crowns, when used for preventive or cosmetic purposes or due to erosion, abrasion or attrition.
- Services and supplies for cosmetic or aesthetic purposes, including charges for personalization or characterization of dentures, except for orthodontic treatment as provided for under this plan.
- Myofunctional therapy (i.e., correction of tongue thrusting).
- Appliances or therapy for the correction or treatment of temporo mandibular joint (TMJ) syndrome.
- Services to alter vertical dimension and/or for occlusion purposes or due to erosion, abrasion or attrition.
- Splinting or periodontal splinting, including extra abutments for bridges.
- Services for tests and laboratory examinations, including but not limited to, bacterial cultures for determining pathological agents, caries (tooth or bone destruction) susceptibility tests, viral cultures, saliva samples, genetic tests, diagnostic photographs and histopathologic exams.
- Pulp cap, direct or indirect (excluding final restoration).
- Provisional intracoronal and extracoronal (crown) splinting.
- Tooth transplantation or surgical repositioning of teeth.
- Occlusal adjustment (complete). Occlusal guards are covered for certain conditions. The provider should file office records with the claim for review by the dental consultant.
- Temporary procedures, such as temporary fillings or temporary crowns.
- Rebase procedures.
- Stress breakers.
- Precision attachments.
- Procedures that are considered part of a more definitive treatment (i.e., an X-ray taken on the same day as a procedure).
- Inlays (cast metal and/or composite, resin, porcelain, ceramic). Benefits for inlays are based on the allowance of an alternate amalgam restoration.
- Gingivectomy/gingivoplasty in conjunction with or for the purpose of placement of restorations.

- Topical application of sealants per tooth for patients age 16 and older.

Limited benefits

- More than two of these procedures during any plan year: oral examination, consultations (must be provided by a specialist) and prophylaxis (cleaning of the teeth). Four oral examinations will be allowed for patients requiring four cleanings a year.
- More than two periodontal prophylaxes. (Periodontal prophylaxes, scaling or root planing are available only to patients who have a history of periodontal treatment/surgery.) Four cleanings a year (a combination of prophylaxes and periodontal prophylaxes) are allowed for patients with a history of periodontal treatment/surgery.
- Bitewing X-rays more than twice during any plan year or more than one series of full-mouth X-rays or one panoramic film in any 36-month period, unless a special need for these services at more frequent intervals is documented as medically necessary by the dentist and approved by BSBSSC.
- More than two topical applications of fluoride or fluoride varnish during any plan year.
- Topical application of sealants for patients age 15 and younger; payment is limited to one treatment every three years and applies to permanent unrestored molars only.
- More than one root canal treatment on the same tooth. Additional treatment (retreatment) should be submitted with the appropriate American Dental Association procedure code and documentation from your dentist.
- More than four quadrants in any 36-month period of gingival curettage, gingivectomy, osseous (bone) surgery or periodontal scaling and root planing.
- Bone replacement grafts performed on the same site more than once in any 36-month period.
- Full mouth debridement for treatment of gingival inflammation if performed more than once per lifetime.
- Tissue conditioning for upper and lower dentures is limited to twice per denture in any 36-month period.
- The application of desensitizing medicaments is limited to two times per quadrant per year, and the sole purpose of the medication used must be for desensitization.
- No more than one composite or amalgam restoration per surface in a 12-month period.
- Replacement of cast restorations (crowns, bridges, implants) or prosthodontics (complete and partial dentures) within five years of the original placement unless evidence is submitted and is satisfactory to the third-party claims administrator that: 1) the existing cast restoration or denture cannot be made serviceable; or 2) the existing denture is an immediate temporary denture and replacement by a permanent denture is required, and that such replacement is delivered or seated within 12 months of the delivery or seat date of the immediate temporary denture.
- Addition of teeth to an existing removable partial or fixed bridge unless evidence is submitted and is satisfactory to the

third-party claims processor that the addition of teeth is required for the initial placement of one or more natural teeth.

Prosthodontic and orthodontic benefits

Benefits are not payable for prosthodontics (ie., crowns, crowns seated on implants, bridges, partial or complete dentures) until they are seated or delivered. Other exclusions and limitations for these services include:

- Prosthodontics (including bridges, crowns and implants) and their fitting that were ordered while the person was covered under the plan, but were delivered or seated more than 90 days after termination of coverage.
- Replacement of lost or stolen prosthodontics, space maintainers or orthodontic appliances or charges for spare or duplicate dentures or appliances.
- Replacement of broken orthodontic appliances or occlusal guards.
- Replacement of existing cast prosthodontics unless otherwise specified in the dental plan document.
- Orthodontic treatment for employees, retirees, spouses or covered children age 19 and older.
- Payment for orthodontic treatment over the lifetime maximum.
- Orthodontic services after the month a covered child becomes ineligible for orthodontic coverage.

Please note: Dental Plus does not provide additional benefits for orthodontic services.

Coordination of benefits

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

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

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

Website

StateSC.SouthCarolinaBlues.com

Information about the State Dental Plan and Dental Plus is now included in the BCBSSC

website designed for PEBA subscribers. At the site, you can:

- Sign up for paperless Explanations of Benefits (EOB)
- Find Dental Plus network providers through the "Find a Dentist" section
- Visit the Dental Resource Center (click on "Dental" in the carousel on the home page)
- Review your eligibility and benefits
- Check claims and view EOBs
- Check pretreatment estimates
- Report other dental coverage.

Appeals

If BCBSSC denies all or part of your claim or proposed treatment, you will be informed promptly. If you have questions about the decision, check the information in this book or call for an explanation. If you believe the decision was incorrect, you may ask BCBSSC to re-examine its decision. The request for review should be made in writing within six months after notice of the decision by writing to BCBSSC, Attn: State Dental Appeals, AX-B15, P.O. Box 100300, Columbia, SC 29202.

If you are still dissatisfied after BCBSSC has reviewed the decision, you have 90 days to request, in writing, that PEBA review the decision. Please include a copy of the denial with your appeal. If the decision is upheld by the PEBA Health Appeals Committee, you have 30 days to seek judicial review at the Administrative Law Court as provided by Sections 1-11-710 and 1-23-380 of the S.C. Code of Laws, as amended.

Claim example (using Class III procedure)

Under the State Dental Plan and Dental Plus, Class III dental benefits (prosthodontics) are paid at 50 percent of the allowed amount after the $25 deductible is met. The table below shows how the plans work together using a crown (porcelain with predominantly base metal) as an example. The example assumes the $25 deductible has been met. The Dental Plus payment is based on the current allowed amount for the Columbia area and may differ slightly depending on where your dentist is located. The Dental Plus allowed amounts are updated yearly.

State Dental Plan only	
Dentist's charge	$1,150
Allowance	$409.60
State Dental Plan payment (50% of the allowed amount)	$204.80
You pay	$945.20

2016 Dental Plus reimbursement

What is the incentive for you to seek dental treatment from a network provider beginning in 2016?

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

The network and non-network allowances may vary by dentist and/or location.

Adult cleaning rendered by a network dentist	
Charge	$82
Allowance	$61 (average)
Payment	$61
You pay	$0
You save	$21 of your annual benefits

Adult cleaning rendered by an out-of-network dentist	
Charge	$82
Allowance	$82 (average)
Payment	$82
You pay	$0
You lose	$21 of your annual benefits

Crown rendered by a network dentist	
Charge	$1,150
Allowance	$800 (average)
Payment	$400
You pay	$400
You save	$200 out of pocket, plus $150 of your annual benefits

Crown rendered by an out-of-network dentist	
Charge	$1,150
Allowance	$1,100 (average)
Payment	$550
You pay	$600 (50% coinsurance, plus difference in charge and allowance)
You lose	$200 out of pocket, plus $150 of your annual benefits

How coordination of benefits works with dental coverage

Example one

This example uses an adult cleaning, a Class I procedure, which has no deductible and is payable at 100 percent of the allowed amount. The Dental Plus payment is based on the current allowed amount for the Columbia area and may differ slightly based on where your dentist is located. Dental Plus allowed amounts are updated yearly.

Example one	
Dentist's charge	$100
Benefit payable under primary plan (assuming $60 is the allowed amount and payable at 100%)	$60
Benefit payable if the State Dental Plan were primary ($30.10, the allowed amount, is payable at 100%)	$30.10
State Dental Plan's secondary payment	$0 No benefit is payable under the State Dental Plan, since the sum of total benefits paid under all dental plans cannot exceed the State Dental Plan allowed amount of $30.10.
You pay if you have primary coverage and State Dental Plan coverage	$40
Dental Plus allowed amount	$82
Dental Plus secondary payment	$22 An additional $22 is payable if you have Dental Plus, due to higher Dental Plus allowed amount of $82.
You pay if you have primary coverage, State Dental Plan coverage and Dental Plus coverage	$18

We coordinate up to the primary plan's allowance if your dentist is a network dentist with that plan. So, the secondary payment would be $0 in the above example if your dentist is in that plan's network because that plan's allowance would be paid at 100% and the dentist writes off the difference in his charge and the allowance.

Example two

This example uses a porcelain crown fused to a predominantly metal base, a Class III procedure for which the deductible has been paid and which is payable at 50 percent of the allowed amount. The Dental Plus payment is based on the current out of network allowed amount for the Columbia area and may differ based on where your dentist is located. Dental Plus will coordinate up to the allowed amount and that amount is determined by where the dentist is located and whether he is in or out of network.

Example two	
Dentist's charge	$1,100
Benefit payable under primary plan (assuming $1,100 is the allowed amount and payable at 50%)	$550
Benefit payable if State Dental Plan were primary ($409.60, the allowed amount, is payable at 50%)	$204.80
State Dental Plan's secondary payment	$0 No benefit is payable under the State Dental Plan, since the sum of total benefits paid under all dental plans cannot exceed the State Dental Plan allowed amount of $409.60.
You pay if you have primary coverage and State Dental Plan coverage	$550
Dental Plus allowed amount	$1,090
Dental Plus secondary payment	$545 An additional $500 is payable if you have Dental Plus, due to the higher Dental Plus allowed amount of $1,000.
You pay if you have primary coverage, State Dental Plan coverage and Dental Plus coverage	$5

For more information about coordination of benefits, including how to determine which plan pays first, see page 20 and page 54. If your state dental coverage is secondary, you must send the Explanation of Benefits you receive from your primary plan with your claim to BCBSSC.

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

Vision care

Good vision is crucial for work and play. It is also a significant part of your overall health. A yearly eye exam can help detect serious illnesses, such as high blood pressure, heart disease and diabetes. That is why the South Carolina Public Employee Benefit Authority (PEBA) offers vision care benefits through the State Vision Plan, which is a fully-insured product provided through EyeMed Vision Care®.

State Vision Plan

The State Vision Plan is available to eligible employees, retirees, survivors, permanent, part-time teachers and COBRA subscribers and their covered family members. Subscribers pay the premium without an employer contribution. Premiums are listed on Pages 184-190.

The program covers comprehensive eye examinations, frames, lenses and lens options, and contact lens services and materials. It also offers discounts on additional pairs of eyeglasses and contact lenses. A discount of 15 percent on the retail price and 5 percent on a promotional price is offered on LASIK and PRK vision correction through the U.S. Laser Network. Medical treatment of your eyes, such as eye diseases or surgery, is covered by your health plan. Discounts on services may not be available at all participating providers. Before your appointment, please check with your provider to determine whether discounts are offered.

Please note: A benefit may not be combined with any discount, promotional offering or other group benefit plan.

The sales tax on any benefit, such as eyeglasses or contact lenses, is not covered by the State Vision Plan.

The importance of eye exams

Eye exams are important for good health. A comprehensive eye exam not only detects the need for vision correction, but it can also reveal early signs of many medical conditions, including diabetes and high blood pressure. A comprehensive exam is covered as part of your EyeMed benefit once a year with a $10 copay.

Some providers may offer an optional retinal imaging exam for up to $39. It provides high-resolution pictures of the inside of the eye. This is a discount, not a covered benefit.

Note: To assure you are only charged the $10 vision exam copay, tell your provider you want only the services the State Vision Plan defines as a “comprehensive eye exam.”

Frequency of benefits

The State Vision Plan covers:

- A comprehensive eye exam once a year
- Standard plastic lenses for eyeglasses or contact lenses, instead of eyeglass lenses, once a year
- Frames once every two years
- Members with Type 1 or Type 2 diabetes are eligible for office service visits and diagnostic testing once every six months to monitor for signs of diabetic changes in the eye.
- $50 savings on non-prescription sunglasses through SunPerks.

Vision benefits at a glance*

Service	In-network member cost	Out-of-network reimbursement
Comprehensive exam with dilation, as necessary (limited to once per year)	$10 copay	Reimbursed up to $35
Retinal imaging (covered for members with Type 1 or Type 2 diabetes only)	$0 copay	Reimbursed up to $50
Retinal imaging discount (optional; not a covered benefit)	No more than $39	N/A

*Plan exclusions and limitations may apply. Please refer to Page 100 for details.

Eyeglasses

Service	In-network member cost	Out-of-network reimbursement
Frames (limited to once every two years; this applies to any frames available at the provider's location)	$0 copay Member receives $150 allowance and pays 80% of balance over $150 (This benefit cannot be used with any promotion)	Reimbursed up to $75
Standard plastic lenses* (limited to once per year)		
Single vision	$10 copay	Reimbursed up to $25
Bifocal	$10 copay	Reimbursed up to $40
Trifocal	$10 copay	Reimbursed up to $55
Lenticular	$10 copay	Reimbursed up to $55
Standard, premium progressive lenses	See chart on Page xx	See chart on Page xx
Lens add-ons		
UV treatment, tint (solid, gradient); standard scratch coating; and standard polycarbonate lens (under age 19 only)	$0 copay for each option	Reimbursed up to $5 for each option
Standard polycarbonate lens (adults)	$30 copay	Reimbursed up to $5
Standard anti-reflective coating	$45	N/A
Premium anti-reflective coating	See chart on Page xx	N/A
Polarized	20% off retail price	N/A
Transition plastic lenses	$60 copay	Reimbursed up to $5
Other add-ons	20% off retail price	N/A
Additional savings		
Additional pairs of eyeglasses	40% off complete pairs of prescription eyeglasses after the funded benefit has been used	N/A

*Glass eyeglass lenses are not covered under the Plan. As a non-covered item, glass lenses are offered at a 20 percent discount.

Contact lenses*

Available in place of eyeglass lens benefit; limited to once per year

Service	In-network member cost	Out-of-network reimbursement
Contact lens fit and follow-up (available after a comprehensive eye exam has been completed)	**Standard[1]:** $0 copay, paid in full fit and two follow-up visits **Premium[2]:** 10% off retail price, then $55 allowance is applied	**Standard[1]:** Reimbursed up to $40 **Premium[2]:** Reimbursed up to $40
Conventional	$0 copay Member receives $130 allowance and pays 85% of balance over $130	Reimbursed up to $104
Disposable	$0 copay Member receives $130 allowance and pays balance over $130	Reimbursed up to $104
Medically necessary contact lenses	$0 copay, paid in full	Reimbursed up to $200
Additional savings		
Additional contact lenses	15% off conventional contact lenses after the funded benefit has been used	N/A

*The contact lens allowance includes materials only. Your allowance for disposable contact lenses is $130. You do not need to use this allowance all at once. For example, you can use $50 of the allowance when you purchase your first supply of disposable contacts and the remainder of the allowance later.
[1]A standard contact lens fitting includes clear, soft, spherical, daily wear contact lenses for single-vision prescriptions. It does not include extended/overnight wear lenses.
[2]A premium contact lens fitting is more complex and may include fitting for bifocal/multifocal, cosmetic color, post-surgical and gas-permeable lenses. It also includes extended/overnight wear lenses.

Progressive lens and anti-reflective coating*

Service	In-network member cost	Out-of-network reimbursement
Progressive lens		
Standard progressive lenses	$35	Reimbursed up to $55
Premium progressives (scheduled)	$55-80 copay	Reimbursed up to $55
Other premium progressives (non-scheduled)	$35 copay, 80% of charge less $120 allowance	Reimbursed up to $55
Anti-reflective coating		
Standard anti-reflective coating	$45	N/A
Premium anti-reflective coatings (scheduled)	$57-$68	N/A
Other premium anti-reflective coatings (non-scheduled)	80% of charge	N/A
Add-ons		
Other add-ons and services	20% off retail price	N/A

*Products listed as premium progressives and premium anti-reflectives are subject to annual review by EyeMed's medical director and may change based on market conditions. The copay listed applies to particular brand names of lenses. Providers are not required to carry all brands at all levels. Providers can give members names and prices of specific products upon request. For a complete list of brands, go to http://www.eyemedvisioncare.com/theme/pdf/microsite-template/eyemedlenslist.pdf.

Using the EyeMed provider network

The EyeMed network includes private practitioners and optical retailers in South Carolina and nationwide. Retailers include LensCrafters®, Sears Optical℠, Target Optical®, JCPenney® Optical and participating Pearle Vision® locations. When you use a network provider, you are only responsible for copays and any charges that remain after allowances and discounts have been applied to your bill. Also, the network provider will file your claim.

To find a network provider:

- Check network providers in or near your ZIP code on the list that comes with your membership card.
- To review the online directory, which is the most up-to-date, go to the PEBA Insurance Benefits website, www.eip.sc.gov. Select "Online Directories," and then click on "State Vision Plan – State of South Carolina Insight Network (EyeMed)." That will take you to the provider directory on the EyeMed website. You may enter your ZIP code or address and select "Insight" network from the drop-down list to find a network provider near you.
- Use the Interactive Voice Response system or speak with a representative at the Customer Care Center at 877-735-9314. To speak with a customer service representative, choose your language ("1" is for English) and then say, "Provider Locator."
- You may also ask your provider if he accepts EyeMed coverage.

When you make an appointment, tell the office staff you are covered by EyeMed. It is best to bring your State Vision Plan identification card to your appointment. However, you are not required to do so.

How to order contact lenses online

You can typically save money by using your State Vision Plan network benefit to order contact lenses through ContactsDirect.com. Click on "Insurance" in the bar at the top of the home page. Register at the site and follow the instructions. You will need a prescription from your doctor and information about your vision insurance. Your contacts will be mailed to your home at no charge.

Out-of-network benefits

Your benefits are lower when you use a provider outside the network. To learn what you will be reimbursed if you use an out-of-network provider for covered services and supplies, see the charts on Pages 97-98.

To receive out-of-network services:

- Request an out-of-network claim form from EyeMed's Customer Care Center. You may also print one from PEBA's insurance benefits website, www.eip.sc.gov. Select "Forms." The out-of-network claim form is listed under "Vision Care."
- When you receive services, pay for them and ask your provider for an itemized receipt.
- Send the claim form and a copy of your receipt to: First American Administrators/ EyeMed Vision Care, Attn: OON Claims, P.O. Box 8504, Mason, Ohio 45040-7111. Your reimbursement will be sent to you.

First American Administrators "FAA" is a wholly-owned subsidiary of EyeMed Vision Care.

For information about out-of-network services, call the Customer Care Center at 877.735.9314. Please have your State Vision Plan ID card handy.

Exclusions and limitations

Some services and products are not covered by your vision care benefits. They include:

- Orthoptic (problems with the use of eye muscles) or vision training, subnormal vision aids and any associated supplemental testing
- Aniseikonic lenses (lenses to correct a condition in which the image of an object in one eye differs from the image of it in the other eye)
- Medical and/or surgical treatment of the eye, eyes or supporting structures
- Any eye or vision examination, or any corrective eyewear required by an employer as a condition of employment; safety eyewear
- Services that would be provided by the government under any workers' compensation law, or similar legislation, whether federal, state or local
- Plano (non-prescription) lenses and/or contact lenses
- Non-prescription sunglasses
- Two pairs of glasses instead of bifocals
- Services provided by any other group benefit plan offering vision care
- Services provided after the date the enrollee is no longer covered under the policy, except when vision materials ordered before coverage ended are delivered and the services are provided to the enrollee within 31 days from the date the materials were ordered
- Lost or broken lenses, frames, glasses or contact lenses will not be replaced until they are next scheduled to be replaced under Frequency of Benefits
- A benefit may not be combined with any discount, promotional offering or other group benefit plans.

Access to information about your vision benefits

On EyeMed's website, www.EyeMed.com, you can search for a provider, find answers to commonly asked questions and sign up for a newsletter. After you register and log in, you can:

- Check your benefits, including which family members are covered and when you are next eligible for service.
- Monitor the status of your claim.
- Print an I.D. card or an out-of-network claim form.
- Go paperless and receive Explanations of Benefits (EOBs) and information about benefits electronically.
- Order replacement contact lenses and learn about LASIK vision correction.

Under "Vision Wellness" you can learn more about eye exams, eye diseases, vision and aging and selecting eyewear. Among the videos available is one about a child's first visit to an eye doctor.

Contacting EyeMed

You can reach EyeMed's Customer Care Center

at 877.735.9314 or by logging in on EyeMed's home page and then selecting "Contact us" under "Help and Resources." Be sure to have this information ready:

EyeMed has an app that provides the same access as EyeMed's member website. Visit your app store and search for "EyeMed Members." The app is free. It is now available only for iPhone, iPad, iPod Touch and android devices.

- The first and last name of the subscriber
- The subscriber's Benefits ID number or Social Security number
- The group number for the State Vision Plan: 9925991
- A fax number or address, if you are asking for information by fax or mail.

Appeals

If a claims question cannot be resolved by EyeMed's Customer Care Center, the subscriber may write to the Quality Assurance Team at EyeMed Vision Care, Attn: Quality Assurance Dept., 4000 Luxottica Place, Mason, OH 45040. Information may also be faxed to 513.492.3259. This team will work with the subscriber to resolve the issue within 30 days. If the subscriber is dissatisfied with the team's decision, he may appeal to an appeals subcommittee, whose members were not involved in the original decision. All appeals are resolved within 30 days of the date the subcommittee receives the appeal.

Vision Care Discount Program

This program offers discounted vision care services. Providers throughout the state have agreed to charge no more than $60[1] for a routine, comprehensive eye exam. If you are fitted for contact lenses, you may pay more because it can require additional services. Providers, including opticians, also have agreed to give a 20-percent[1] discount on all eyewear except disposable contact lenses.

Full-time and part-time employees, retirees, survivors and COBRA subscribers, as well as their family members, are eligible. You do not have to be enrolled in a health plan. You may need to show employment-related identification to prove you are eligible for the program.

Please note: Discounts on services may not be available at all State Vision Plan participating providers. Before your appointment, please check with your provider to determine whether discounts are offered.

[1]These amounts can change yearly. Contact your benefits office, provider or PEBA for the current amounts.

A member may not use the discount program and State Vision Plan benefits at the same time. However, if he is enrolled in the vision plan and wants a second eye exam during the year, he can have one for $60 through the discount program.

Visions Care Discount Program providers are available statewide

There are participating providers in South Carolina, Georgia and North Carolina. If you are interested in a discount through the program, call your provider and ask if he gives discounts through the state's Vision

Care Discount Program. If he would like to participate, he should call PEBA.

No claims to file

With the Vision Care Discount Program, you do not file claims and will not receive reimbursement for vision examinations or eyewear, including contacts. Active employees who have a MoneyPlus Medical Spending Account or a Limited-use Medical Spending Account can file for reimbursement for vision care expenses. If you have questions about this program, please contact your benefits office or PEBA.

Listed below are some examples of what you might pay for services under the State Vision Plan.

Example one

Service	Average retail price[1]	State Vision Plan benefits	In-network cost (member out-of-pocket)
Eye examination	$109	$10 copay	$10
Frames	$200	$150 allowance, plus 20% off balance	$40
Lenses			
Single vision	$72	$10 copay	$10
Polycarbonate (adults)	$62	$30 copay	$30
Premium anti-reflective (Crizal Alize)	$97	$68 copay	$68
Total	**$540**		**$158**

Example two

Service	Average retail price[1]	State Vision Plan benefits	In-network cost (member out-of-pocket)
Eye examination	$109	$10 copay	$10
Frames	$150	$150 allowance, plus 20% off balance	$0
Lenses			
Premium progressive (Tier 2)	$230	$65 copay	$65
Premium anti-reflective (Crizal Alize)	$97	$68 copay	$68
Total	**$586**		**$143**

Example three

Service	Average retail price[1]	State Vision Plan benefits	In-network cost (member out-of-pocket)
Eye examination	$109	$10 copay	$10
Contact lens fit and follow-up (standard)	$71	$0 copay	$0
Disposable contact lenses	$130	$130 allowance	$0
Total	**$310**		**$10**

[1]Based on industry averages. Prices and costs will vary by market and provider type. Premiums are not included.

Life insurance

The contract

The South Carolina Public Employee Benefit Authority's life insurance program, term life insurance with accidental death and dismemberment coverage, is underwritten by Minnesota Life, a Securian Financial Group Affiliate.

The contract for the life insurance program consists of the policy, which is issued to PEBA Insurance Benefits; PEBA Insurance Benefits' application and your application, if required. The policy is held by PEBA Insurance Benefits. This section of the *Insurance Benefits Guide* is the summary of your coverage.

Changes in the insurance contract

The insurance contract may be changed at any time as long as Securian and PEBA agree on the change. No one else has the authority to change the contract. Changes in the contract may affect any class of insured people and do not require your or your beneficiary's consent. All changes must be in writing, made a part of the policy and signed by an official of Securian and of PEBA.

Applications

The Notice of Election (NOE) and/or Evidence of Insurability form that you complete to be covered by this plan are considered your application for life insurance coverage. Securian may use misstatements or omissions in your application to contest the validity of insurance or to deny a claim. Securian will not use your application to contest insurance that has been in force for two years or more during your lifetime. The two-year period can be extended for fraud or as otherwise allowed by law.

Except for fraud or the non-payment of premiums, after the insured's insurance has been in force during his lifetime for two years from the effective date of his coverage, Securian cannot contest the insured's coverage. However, if there has been an increase in the amount of insurance for which the insured was required to apply or for which Securian required evidence of insurability, then, to the extent of the increase, any loss that occurs within two years of the effective date of the increase will be contestable.

Life insurance offered through PEBA is term life insurance. Term life provides coverage for a specific period of time. **The policy has no cash value.**

Any statements that the insured makes in his application will, in the absence of fraud, be considered representations (true at the time) and not warranties (true at the time and will remain true in the future). Also, any statement an insured makes will not be used to void his insurance, nor defend against a claim, unless the statement is contained in the application.

Cafeteria Plan (MoneyPlus) election restrictions

This policy is part of a cafeteria plan (MoneyPlus) sponsored by your employer and governed by the requirements of Sections 105, 125 and 129 of the Internal Revenue Code. The rules of the cafeteria plan will supersede any parts of the policy that are in conflict with them. By law, cafeteria plans are subject to these restrictions: The benefits you elect during the enrollment period will remain in

effect until the next enrollment period. Section 125 allows exceptions to this rule only in specified situations, including change in family status and commencement or termination of employment as described in the MoneyPlus section of this handbook. Active employees can pay Optional Life insurance premiums for coverage up to $50,000 before taxes through the MoneyPlus Pretax Group Insurance Premium Feature (see Page 138). Retired employees are not eligible.

Eligibility

To be eligible to enroll in life insurance, a person must be classified as a full-time employee who receives compensation from a department, agency, board, commission or institution of the state; public school districts; county governments (including county council members); local subdivisions; and other eligible employers approved by state law and participating in the state insurance program. Members of the South Carolina General Assembly, clerical and administrative employees of the General Assembly, and judges in the state courts also are considered employees eligible for coverage.

An employee is classified for insurance purposes as full-time if he works at least 30 hours per week. Active employees who work at least 20 hours per week may also be eligible if the covered employer has elected, and PEBA Insurance Benefits has approved, an irrevocable option to elect the definition of full-time to mean at least 20 hours per week. Employees must be citizens or legal residents of the United States, its territories and its protectorates, excluding temporary, leased or seasonal employees.

Basic Life Insurance

To be eligible for Basic Life Insurance a person must be an active, full-time employee who is enrolled in the State Health Plan or the TRICARE Supplement Plan. When your health coverage ends, you will be able to convert your Basic Life coverage.

Optional Life Insurance

To be eligible for Optional Life Insurance, you must be an active, full-time employee.

Dependent Life Insurance

You may enroll your eligible dependents in Dependent Life Insurance, a term life insurance program, even if you have not enrolled in Optional Life coverage or state health insurance coverage, as long as you are eligible for life coverage.

Your eligible dependents include:

- Your lawful spouse who is not legally separated from you. If your spouse is eligible for coverage as an employee or retiree of a participating employer, you cannot cover him as a dependent.
- Your children must be:
  - Your natural children, legally adopted children, children placed for adoption (from the date of placement with the adopting parents until the legal adoption), stepchildren or children for whom you have legal guardianship, provided the child lives with you and is supported by you.
  - Unmarried.
  - From live birth to age 19, or 19 years old but younger than age 25, who attend school on a full-time basis (as defined by the institution) as their principal activity and are primarily dependent on you for financial

support. A child cannot be employed on a full-time basis.

Insurance eligibility changes made by the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, do not apply to the Dependent Life-Child insurance. When you file a claim for a dependent child, age 19-24, you will be required to show the child was a full-time student at the time of enrollment and at the time of the claim. For information about how to file a claim for a dependent child, age 19-24, see Page 10.

Children of any age are eligible if they are physically or mentally incapable of self-support, were incapable of self-support before age 25 and are financially dependent on you for more than one-half of their support and maintenance.

For more information about covering an incapacitated child see Pages 10-11. Please also see your benefits administrator.

A person who is eligible as an employee or retiree under the policy or insured under continuation, is not eligible as a dependent. Only one person can insure an eligible dependent child.

PEBA Insurance Benefits may conduct an audit of the eligibility of an insured dependent. If the dependent is found to be ineligible, no benefits will be paid.

If both husband and wife work for a PEBA insurance participating employer, only one can carry dependent coverage for eligible dependent children, and the spouses cannot cover each other.

Excluded dependents

Any dependent who is eligible as an employee for life insurance coverage, or who is in full-time military service, will not be considered a dependent.

A former spouse and former stepchildren cannot be covered under Dependent Life through PEBA Insurance Benefits, even with a court order.

A foster child is not eligible for Dependent Life coverage.

Basic Life Insurance

The Basic Life Insurance program with Accidental Death and Dismemberment (AD&D) coverage provides $3,000 in term life insurance to all eligible employees younger than age 70 and $1,500 to eligible employees age 70 or older. The AD&D coverage matches the amount of Basic Life Insurance. This benefit is provided at no charge to eligible employees enrolled in the State Health Plan or the TRICARE Supplement Plan.

Enrollment

Enrollment in Basic Life Insurance is automatic with enrollment in the State Health Plan or the TRICARE Supplement Plan.

Your coverage begins on the first day of the month if you are actively at work on that day as a full-time employee. If you become eligible on the first working day of the month (the first day that is not a Saturday, Sunday or observed holiday), and it is not the first calendar day, you may choose to have your coverage start on the first day of that month or the first day of the next month.

If you become eligible on a day other than the first calendar day or first working day of the month, your coverage starts on the first day of the next month.

All effective dates of coverage are subject to the Actively at Work requirement (see Page 120).

Optional Life Insurance

Participation in the Optional Life Insurance Program with Accidental Death and Dismemberment Coverage is on a voluntary, employee-pays-all basis. All premiums are paid by the participants with no contribution by PEBA Insurance Benefits or the state of South Carolina.

Initial enrollment - active employees

If you are an eligible employee of a participating employer of the state of South Carolina, you can enroll in Optional Life Insurance within 31 days of the date you are hired. To enroll, you must complete the required forms, including a *Notice of Election* form. Coverage is not automatic. You can elect coverage, in $10,000 increments, up to the lesser of three times your basic annual earnings (rounded down to the nearest $10,000) or $500,000 without providing evidence of good health. You can apply for a higher benefit level, in increments of $10,000, up to a maximum of $500,000, by providing evidence of insurability.

A transfer is not a new hire for insurance purposes. He must remain enrolled in the same insurance benefits in which he was enrolled with his former employer. For more information, see Page 15.

Your coverage begins on the first day of the month if you are actively at work on that day as a full-time employee.

If you become eligible on the first working day of the month (the first day that is not a Saturday, Sunday or observed holiday), and it is not the first calendar day, you may choose to have your coverage start on the first day of the month in which you became eligible or the first day of the next month.

If you become eligible on a day other than the first calendar day or first working day of the month, your coverage starts on the first day of the next month.

If you enroll for an amount of coverage that requires evidence of insurability, your coverage effective date for the amount requiring evidence of insurability will be the first of the month after approval.

All effective dates of coverage are subject to the Actively at Work provision (see Page 120).

Special eligibility situation

A special eligibility is an event that allows an eligible subscriber to enroll in or drop coverage for himself and/or eligible family members outside an open enrollment period. Examples include: birth, marriage, adoption or divorce. Enrollment changes must be requested within 31 days of the qualifying event. A salary increase does not constitute a special eligibility situation.

Late entry with the Pretax Group Insurance Premium

If you participate in the MoneyPlus Pretax Group Insurance Premium Feature and do not enroll within 31 days of the date you begin employment, you can enroll only within 31 days of a special eligibility situation (see Pages 16-23) or during an enrollment period. In certain special eligibility situations, you may

purchase coverage, in $10,000 increments, up to a maximum of $50,000 without providing evidence of insurability. Coverage elected as a result of special eligibility situation will be effective the first of the month after you complete and file the NOE. Otherwise, you must complete a *Notice of Election* form and an Evidence of Insurability form during an open enrollment period, which occurs yearly in October and return these forms to your benefits administrator. If approved, your coverage will be effective on the first day of January after the enrollment period or, if approved after Jan. 1, coverage will be effective the first of the month after approval as long as you are actively at work on that day as a full-time employee. All effective dates of coverage are subject to the Actively at Work provision (see Page 120).

Changing coverage amount with Pretax Group Insurance Premium Feature

If you participate in the MoneyPlus Pretax Group Insurance Premium Feature, you can increase, decrease or drop your coverage only during each open enrollment period, which occurs yearly in October, or within 31 days of a special eligibility situation (see above).

To increase your coverage during open enrollment, you must provide evidence of insurability and be approved by Securian. If approved, coverage will be effective on January 1 following the enrollment period as long as you are actively at work on that day as a full-time employee. All effective dates of coverage are subject to the Actively at Work provision (see Page 120). If you are increasing your coverage due to a special eligibility situation, you can increase, in increments of $10,000, up to $50,000 ($500,000 maximum coverage amount) without providing evidence of insurability. If you are enrolling in Optional Life for the first time due to a special eligibility situation, you may enroll, in $10,000 increments, up to a maximum of $50,000 without providing evidence of insurability.

Late entry without the Pretax Group Insurance Premium Feature

If you do not participate in the MoneyPlus Pretax Premium Feature and do not enroll within 31 days of the date you begin employment, you can enroll throughout the year as long as you provide evidence of insurability and it is approved by Securian. To enroll, you must complete a *Notice of Election* form and an Evidence of Insurability form and return these forms to your benefits administrator for processing. Your coverage will be effective on the first day of the month coinciding with, or the first of the month following, approval as long as you are actively at work on that day as a full-time employee. In certain special eligibility situations, you may purchase coverage, in $10,000 increments, up to a maximum of $50,000 without providing evidence of insurability. Coverage will be effective the first of the month after you complete and file the *Notice of Election* form. All effective dates of coverage are subject to the Actively at Work provision (see Page 120).

Changing coverage amount without the Pretax Group Insurance Premium Feature

If you do not participate in the MoneyPlus Pretax Group Insurance Premium Feature, you can apply to increase your amount of coverage at any time during the year by providing evidence of insurability and being approved by Securian. Your coverage at the new level will be effective on the first day of

the month following the date of approval as long as you are actively at work on that day. In certain special eligibility situations, you may purchase coverage, in $10,000 increments, up to a maximum of $50,000 without providing evidence of insurability. Coverage will be effective the first of the month after you complete and file the *Notice of Election* form. All effective dates of coverage are subject to the Actively at Work provision (see Page 120). You can decrease or cancel your coverage at any time. However, if you later want to increase coverage or re-enroll in the plan, you must provide evidence of insurability and be approved.

Dependent Life Insurance

Enrollment

Within 31 days of the date you are hired you can enroll in Dependent Life-Spouse Insurance up to a limit of $20,000 without providing evidence of insurability. Enrollment in Optional Life is required to enroll in Dependent Life-Spouse coverage for more than $20,000.

Eligible children may be added at initial enrollment and throughout the year without providing evidence of insurability. You are not allowed to cover an ex-spouse.

To enroll in Dependent Life insurance, you must complete a *Notice of Election* form and return it to your benefits administrator. Each dependent you wish to cover must be listed on the *Notice of Election* form.

Your dependent's coverage begins on the first day of the month if you are actively at work on that day as a full-time employee. If you become eligible on the first working day of the month (the first day that is not a Saturday, Sunday or observed holiday), and it is not the first calendar day, you may choose to have coverage start on the first day of that month or the first day of the next month.

If you become eligible on a day other than the first calendar day or first working day of the month, coverage starts on the first day of the next month.

At any time during the year, a subscriber can enroll in or add additional Dependent Life-Spouse coverage by submitting evidence of insurability. The additional coverage is effective the first of the month after approval of evidence of insurability.

All effective dates are subject to the Actively at Work requirement (see Page 120) and the Dependent Non-Confinement Provision (see Page 110).

Adding your new spouse

If you wish to add a spouse because you marry, you can add coverage of $10,000 or $20,000 for your new spouse without providing evidence of insurability by completing an NOE within 31 days of the date of marriage. Coverage becomes effective the first of the month after you complete and file the NOE. You cannot cover your spouse as a dependent if your spouse is or becomes an employee of an employer that participates in the plan. If you divorce, you must drop your spouse from your coverage by completing a *Notice of Election* form within 31 days of the date of divorce. After 31 days, you will forfeit premiums. You can continue to cover your children if they meet the requirements on Pages 105-106.

Spouse's loss of employment

If your spouse's employment with a PEBA

Insurance Benefits covered employer ends, you can enroll your spouse in Dependent Life coverage for up to $20,000 within 31 days of his termination without providing evidence of insurability. If your spouse loses life insurance through an employer that does not participate in PEBA Insurance Benefits, he can enroll throughout the year with evidence of insurability.

Late entry

If you do not enroll within 31 days of the date you begin employment or when you acquire an eligible dependent, you can enroll your spouse throughout the year as long as you provide evidence of insurability and it is approved by Securian. To do so, you must complete an Evidence of Insurability form. Coverage will be effective on the first day of the month after approval if the employee is actively at work. All effective dates of coverage are subject to the Actively at Work requirement and the Dependent Non-confinement provision.

Adding children

Eligible children may be added throughout the year, without providing evidence of insurability, by completing a *Notice of Election* form. Coverage will be effective the first of the month after you complete and file the NOE.

An employee's eligible child is automatically covered for 31 days from the child's live birth. To continue coverage of the child, the employee must list each child on his *Notice of Election* form within 31 days of birth; otherwise the child's coverage will terminate at the end of the 31-day period.

You must list each child on your *Notice of Election* form within 31 days of birth, even if you have Dependent Life Insurance coverage when you gain a new child.

All effective dates of coverage are subject to the Dependent Non-Confinement provision.

What is the Dependent Non-Confinement Provision?

If a dependent is hospitalized or confined because of illness or disease on the date his insurance would otherwise become effective, his effective date shall be delayed until he is released from such hospitalization or confinement. This does not apply to a newborn child. However, in no event will insurance on a dependent be effective before the subscriber's insurance is effective.

Dependent Life benefits

Dependent Life-Spouse coverage and Dependent Life-Child coverage are separate programs for which a subscriber pays separate premiums.

Dependent Life-Spouse coverage

If you are enrolled in Optional Life for more than $30,000, you may cover your spouse in increments of $10,000 for up to 50 percent of your Optional Life coverage or $100,000, whichever is less.

However, an employee who is not enrolled or is enrolled for $10,000, $20,000 or $30,000 of Optional Life coverage can only enroll his spouse for $10,000 or $20,000.

Evidence of insurability is required for all amounts of more than $20,000 and for coverage not elected when the dependent first becomes eligible under the plan or due to a special eligibility situation.

Premiums for Dependent Life-Spouse coverage are the same as the Optional Life

premiums, which are based on the employee's age. Your spouse's coverage will be reduced at ages 70, 75 and 80 based on the employee's age. Premiums are paid entirely by you, with no contribution from the state, and are payable through payroll deduction.

Spouses enrolled in Dependent Life are covered for Accidental Death and Dismemberment benefits. They are eligible for the Seat Belt benefit, Air Bag benefit, Child Care benefit and Child Education benefit (see Pages 113-114).

Dependent Life-Child coverage

You can cover your eligible dependent children. For information, see pages 118-119. The benefit is $15,000. The monthly premium for Dependent Life-Child coverage is $1.10 regardless of the number of children covered. Premiums are paid entirely by you, with no contribution from the state, and are payable through payroll deduction.

Beneficiaries

Beneficiaries are the person(s) to whom insurance will be paid if you die. You may change your beneficiaries at any time. If there is no eligible beneficiary, or if you do not name one, death benefits will be paid to:

1. You lawful spouse if living: otherwise
2. Your natural or legally adopted child (children) in equal shares, if living; otherwise
3. Your parents in equal shares, if living; otherwise
4. Your siblings in equal shares, if living, otherwise
5. Your estate.

How to change your beneficiary

You can change your beneficiary at any time (unless you have given up that right). You may make the change online through MyBenefits or by notifying your benefits administrator and completing a *Notice of Election* form. When processed, the change will be effective on the date the request is signed. However, the change will not apply to any payments or other action taken before the request was processed. Note: Securian will allow beneficiary changes by power of attorney only if the documents specifically state an attorney-in-fact has the power to change beneficiary designations.

Assignment

You may assign your insurance (transfer ownership rights to a third party). However, Securian will not be bound by an assignment of the certificate or of any interest in it unless it is made as a written statement, and you file the original instrument or a certified copy with Securian's home office, and Securian sends you an acknowledged copy.

Securian is not responsible for the validity of any assignment. You are responsible for ensuring that the assignment is legal in your state and that it accomplishes your intended goals. If a claim is based on an assignment, Securian may require proof of interest of the claimant. A valid assignment will take precedence over any claim of a beneficiary.

Premiums

Optional Life

Optional Life premiums are determined by your age on the preceding December 31 and the amount of insurance you select. Active employees can pay premiums for coverage up to $50,000 before taxes through MoneyPlus

(see Page 138). Retired employees are not eligible for the Pretax Group Insurance Premium Feature.

What if my age category changes?

If your age category changes, your premium will change on January 1 of the next calendar year. Your coverage will be reduced at age 70, 75 and 80. For Optional Life premiums, see Page 189.

Dependent Life

Premiums for Dependent Life-Spouse are determined by the subscriber's age. For premiums, see Page 189.

The premium for Dependent Life-Child coverage is the same, $1.10, regardless of the number of children covered. The benefit for a covered child is $15,000.

Accidental Death and Dismemberment Benefits

This section does not apply to retirees or dependent children.

Schedule of accidental losses and benefits

In addition to any life insurance benefit, Securian will pay Accidental Death and Dismemberment (AD&D) benefits equal to the amount of Basic and Optional life insurance for which the employee is insured and an amount equal to the amount of Dependent Life – Spouse insurance for which the spouse is insured, according to the schedule below, if:

1. You suffer accidental bodily injury while your insurance is in force;
2. A loss results directly from such injury, independent of all other causes, and is unintended, unexpected and unforeseen; and
3. Such a loss occurs within 365 days after the date of the accident causing the injury.

Loss of a hand or foot, means actual and permanent severance from the body at or above the wrist or ankle joint. Loss of sight, speech or hearing, means entire and irrecoverable loss. Loss of both a thumb and index finger of same hand, means actual and permanent severance from the body at or above the metacarpophalangeal joints.

The amount of the benefit shall be a percentage of the amount of Basic, Optional and Dependent Life – Spouse insurance. The percentage is determined by the type of loss, as shown in the table on the following page.

Description of loss	Percent of amount of insurance
Life	100 percent
Both hands, both feet, or sight of both eyes	100 percent
One hand and one foot	100 percent
Speech, and hearing in both ears	100 percent
Either hand or foot, and sight of one eye	100 percent
Movement of both upper and lower limbs (quadriplegia)	100 percent
Movement of both lower limbs (paraplegia)	75 percent
Movement of both legs and one arm, or both arms and one leg	75 percent
Movement of the upper and lower limbs of one side of body (hemiplegia)	50 percent
Either hand or foot	50 percent
Sight of one eye	50 percent
Speech, or hearing in both ears	50 percent
Movement of one limb (uniplegia)	25 percent
Thumb and index finger of same hand	25 percent

What is not covered?

Securian will not pay Accidental Death and Dismemberment Benefits under this section for any loss caused or contributed to by:

- Intentionally self-inflicted injury; or
- Suicide or attempted suicide; or
- Committing or attempting to commit a felony; or
- Bodily or mental infirmity, illness or disease; or
- Alcohol in combination with any drug, medication, or sedative; or
- The voluntary use of prescription drugs, nonprescription drugs, illegal drugs, medications, poisons, gases, fumes or other substances taken, absorbed, inhaled, ingested or injected unless it is taken upon the advice of a licensed physician in the verifiable prescribed manner and dosage; or
- Motor vehicle collision or accident where you are the operator of the motor vehicle and your blood alcohol level meets or exceeds the level at which intoxication is defined in the state where the collision or accident occurred, regardless of any legal proceedings thereto; or
- Infection, other than infection occurring simultaneously with, and as a direct and independent result of, the accidental injury; or
- Medical or surgical treatment or diagnostic procedures or any resulting complications, including complications from medical misadventure; or
- War or any act of war, whether declared or undeclared; or
- Service in the military of any nation, except the United States National Guard.

Additional AD&D benefits

Seat Belt and Air Bag Benefit (Basic, Optional and Dependent Spouse AD&D only)

The Seat Belt benefit is an additional 25 percent of your accidental death benefit. As an example, if your amount of life insurance is $20,000 and you die in an accident, an additional $20,000 accidental death benefit will be payable (according to the Accidental Death provision explained above). The Seat Belt benefit increases this accidental death

benefit by 25 percent, or $5,000. The total accidental death benefit will then be $25,000, which means the entire death benefit will be $45,000.

The Air Bag benefit is an additional 5 percent, or $5,000, whichever is less, of your accidental death benefit. As an example, if your amount of life insurance is $20,000 and you die in an accident, an additional $20,000 accidental death benefits will be payable (according to the Accidental Death provision explained above). The Seat Belt benefit increases the accidental death benefit by $5,000, and the Air Bag benefit increases the accidental death benefit by $1,000 (5 percent of $20,000 = $1,000), which means the entire death benefit will be $46,000.

To be eligible for these benefits, the following must apply:

1. The seat in which the insured was seated was equipped with a properly installed air bag at the time of the accident; and
2. The private passenger car is equipped with seat belts; and
3. The seat belt was in proper use by the insured at the time of the accident as certified in the official accident report or by the investigating officer; and
4. At the time of the accident, the driver of the private passenger car was a licensed driver and was not intoxicated, impaired or under the influence of alcohol of drugs.

Child Care Benefit (Optional and Dependent Spouse AD&D only)

A child care benefit will be paid to each dependent who is younger than age 7 (at the time of the insured's death) and who is enrolled in a day care program. The benefit is for each child per year will be the lesser of:

1. Five percent of your amount of AD&D insurance; or
2. $10,000; or
3. Actual incurred child care expenses.

It will be paid for each dependent who qualifies for no more than two years. If this benefit is in effect on the date that the employee or the spouse dies and there is no dependent child who could qualify for this benefit, Securian will pay $1,000 to the beneficiary.

Dependent Child Education Benefit (Optional and Dependent Spouse AD&D only)

An education benefit is paid for each dependent who qualifies as a student. A qualified dependent must be either a post-high school student who attends a school for higher learning on a full-time basis at the time of the insured's death or in the 12th grade and will become a full-time post-high school student in a school for higher learning within 365 days after the insured's death. The benefit is a maximum of $5,000 per academic year with a maximum overall benefit of five percent of the value of the policy. The benefit will be payable at the beginning of each school year for a maximum of four consecutive years but not beyond the date the child turns age 25.

If this benefit is in effect on the date an employee dies or an employee's spouse dies and there is no child who could qualify for it, Securian will pay $1,000 in one sum to the employee's beneficiary.

Felonious Assault Benefit (Optional AD&D, Employee only)

A felonious assault benefit is paid if the

employee is injured in a felonious assault and the injury results in a loss for which benefits are payable under the Accidental Death and Dismemberment (AD&D) benefit. The benefit is the lesser of one times the employee's annual earnings, $25,000, or the employee's amount of Optional AD&D insurance.

A felonious assault is a physical assault by another person resulting in bodily harm to you. The assault must involve the use of force or violence with intent to cause harm and must be either a felony or a misdemeanor.

No benefit is payable if the assault is committed by an immediate family member. Immediate family members include the employee's spouse and the employee's and employee's spouse's children, parents, siblings, grandparents and grandchildren.

Repatriation Benefit (Basic and Optional AD&D, Employee only)

A Repatriation Benefit will be paid if you die in a way that would be covered under the Accidental Death and Dismemberment Benefit and if the death occurs more than 100 miles from your principal residence.

The Repatriation Benefit will be the lesser of:

1. The actual expenses incurred for:
   - Preparation of the body for burial or cremation; and
   - Transportation of the body to the place of burial or cremation;
2. The amounts resulting from multiplying the amount of your Maximum Benefit by the Repatriation
3. Benefit percentage (5 percent) or
4. The maximum amount for this benefit ($5,000).

Public Transportation (Common Carrier) Benefit (Basic, Optional AD&D, Employee only)

If an insured dies as a result of a covered accident that occurs while the insured is a fare-paying passenger on a public transportation vehicle, Securian will pay an additional benefit equal to the insured's full amount of AD&D insurance.

Public transportation vehicle means any air, land or water vehicle operated under a license for the transportation of fare-paying passengers.

Value Added Services

Travel Assistance Services (active employees)

Travel Assistance Services is offered to all active employees covered under group life insurance offered through PEBA. It is available for personal or business travel 100 or more miles from home. Included is help replacing lost or stolen luggage, prescriptions or other critical items; medical or security evacuation; medically necessary repatriation; and repatriation of mortal remains.

For service terms and conditions and pre-trip information go to www.LifeBenefits.com/travel or call 855.516.5433 in the U.S. and Canada. Elsewhere, call collect 415.484.4677.

Legal, Financial and Grief Resources (active employees, spouse and families)

Legal, Financial and Grief Resources is available to all active employees, their spouse and dependent children covered under Basic and/or Optional Life insurance offered through PEBA. It includes guidance

and consultation with professionals over the telephone, comprehensive web and mobile resources, and a 30-minute face-to-face consultation with an attorney for each unique legal issue.

Go to LifeWorks.com and sign in with the user name "lfg" and the password "resources." For more information, call 877.849.6034.

Legacy Planning Resources (active employees, retirees and their families)

Legacy Planning Resources is available to active employees and retirees and their families covered under group life insurance offered through PEBA. It provides information related to end-of-life planning that can be useful in preparing for one's own death or in dealing with the loss of loved one. These resources are available at LegacyPlanningResources.com.

Beneficiary Financial Counseling (beneficiaries who receive $25,000 or more)

Beneficiary Financial Counseling will be offered to beneficiaries of group life insurance who will receive proceeds of $25,000 or more. The beneficiary has the option to participate in the program. Services are provided by PricewaterhouseCoopers LLP and are designed to provide independent, objective financial counseling at a time when it is needed most.

Services provided by Ceridian HCM, Inc., RedpointWTP LLC, PricewaterhouseCoopers LLP are their sole responsibility. The services are not affiliated with Securian or its group contracts and may be discontinued at any time. Certain terms, conditions and restrictions may apply when utilizing the services. To learn more, visit the appropriate website.

When your coverage ends

Termination of coverage

Your insurance will end at midnight on the earliest of:

- The last day of the month you terminate your employment
- The last day of the month you go on unapproved leave of absence
- The last day of the month you enter a class of employees not eligible for coverage (for example, a change from full-time to part-time status)
- The date PEBA Insurance Benefits' policy ends
- The last day of the month you do not pay the required premium for that month, or

If you are a retiree:

January 1 after the day you become age 70, if you continued coverage and retired before January 1, 1999; January 1 after the day you become age 75, if you continue coverage and retired January 1, 1999, and later.

Claims incurred before the date insurance ends will not be affected by coverage termination.

Termination of Dependent Life Insurance coverage

Your dependent's coverage will terminate at midnight on the earliest of:

- The day PEBA Insurance Benefits' policy ends

- The day you, the employee, die
- The day you, the employee, are no longer eligible to purchase the Dependent Life Insurance Plan
- The last day of the month in which the dependent no longer meets the definition of a dependent
- The day any premiums for Dependent Life Insurance coverage are due and unpaid for a period of 31 days.

Claims incurred before the date insurance ends will not be affected by coverage termination.

Extension of benefits

An extension of benefits is provided according to the requirements below. Securian is not required by contract to provide these benefits unless you meet these requirements.

Leave of absence

If you are on leave of absence approved by your employer and you remain eligible for active benefits, you can continue your group Optional Life Insurance for up to 12 months from the first of the month after the last day worked, as long as you pay the required premiums. Securian may require written proof of your leave of absence approval before any claims are paid.

Military leave of absence

If you enter active military service and are granted a military leave of absence in writing, your coverage (including Dependent Life coverage) may be continued for up to 12 months from the first of the month after the last day worked, as long as you pay the required premiums. If the leave ends before the agreed-upon date, this continuation will end immediately. If you return from active military duty after being discharged and you qualify to return to work under applicable federal or state law, you may be eligible for the coverage you had before the leave of absence began, provided you are rehired by the same employer and request reinstatement within 31 days of returning to work.

Disability

If you become disabled, your life insurance can be continued for up to 12 months from your last day worked as long as you remain eligible for active benefits and:

- You continue to pay the premiums; and
- The group Optional Life Insurance policy does not end.

When you lose eligibility for active benefits:

- If you are eligible for retiree insurance, you can convert your coverage to an individual whole life policy or continue your Optional Life Insurance until age 75. Securian must receive the form requesting conversion or continuation within 31 days of termination of your active employee coverage.
- If you are not eligible for retiree insurance, you can convert your coverage to an individual whole life policy. Securian must receive the form requesting conversion within 31 days of termination of your active employee coverage.
- If you are later approved for disability retirement benefits, and therefore are eligible for retiree insurance, you may enroll in up to the same amount of Optional Life coverage you had when your eligibility for active benefits ended. To do so, contact Securian within 31 days of your disability retirement approval

date. Coverage would begin the first of the month after your approval for disability retirement.

For more information about retiree insurance eligibility, see Pages 174-176.

Continuing or converting your life insurance

The PEBA Coverage Verification Notice of Group Life Insurance must be completed and accompany your request for continuation or conversion. The form is available from your benefits administrator.

Note: Accidental Death and Dismemberment coverage may not be continued or converted.

Continuation

If you are eligible for retiree insurance, you may be able to continue your term life insurance coverage and pay premiums directly to Securian. To continue your coverage, complete the Retiree Life Continuation Election form, which is available on PEBA's insurance benefits website, www.eip.sc.gov, or from your benefits administrator. Coverage must be elected within 31 days of the date of coverage is lost due to approved retirement or approved disability retirement.

If you have questions about your options for continuing your group term life insurance coverage or would like to request continuation forms, please contact Securian at 866.365.2374. A complete application must be received within 31 days of your benefit termination.

Conversion

If your Basic, Optional or Dependent life insurance ends because your employment or eligibility for coverage ends, you may apply to convert your coverage to an individual whole life insurance policy, a permanent form of life insurance, without providing evidence of insurability. To apply for an individual conversion policy, contact Securian at 866.365.2374. Securian will review the conversion option with you and will provide a Conversion of Group Life Insurance Enrollment Form. Complete the form and mail it with your coverage application and first premium payment to Securian.

When applying for coverage, remember these rules:

1. You may not apply for more than the amount of life insurance you had under your terminated group life insurance.
2. Your new premium for the conversion policy will be set at Securian's standard rate for the amount of coverage that you wish to convert and your age.

The forms must be received by Securian within 31 days of the date your group life insurance coverage ends.

Group policy is terminated

If your group life insurance ends because of termination by the state of the group life insurance policy or termination as a class, you may be eligible for a conversion policy. For more information, see the Securian certificate under the Conversion Right section.

Death benefit during conversion period

If you die within 31 days of the date your group insurance terminates and meet the conversion eligibility requirements, Securian will pay a death benefit regardless of whether or not an application for coverage under an individual policy has been submitted. The

death benefit will be the amount of insurance you would have been eligible to convert under the terms of the Conversion Right section.

Claims

To pay benefits, Securian must be given a written proof of loss. This means a claim must be filed as described below.

Your Accelerated Benefit

If an employee or a covered dependent is diagnosed by a physician as having a terminal illness, you may request that Securian pay up to 100 percent of your life insurance prior to your death. Any remaining benefits will be paid to your beneficiary upon your death. A terminal illness means that you have a life expectancy of 12 months or less.

To file a claim, notify your employer. Then the employer, the insured and the attending physician will each complete his section of Securian's Notice of Claim for Accelerated Benefit form.

How to file a claim

When an active employee or his dependent dies, the employer should be notified. This should be done as soon as reasonably possible. The benefits administrator will complete and submit Securian's Notice of Death form. Securian will send the beneficiary a beneficiary statement and a condolence letter, which requests an original certified death certificate.

When Securian receives acceptable proof of a covered dependent's death, Securian will pay the life Insurance benefit to the employee. If the employee is no longer living, it will be paid to the employee's estate.

When a retiree dies, the beneficiary, or the employer on his behalf, should notify Securian of the death by calling 888.658.0193.

Retired employees: For questions about coverage, conversion, etc., call Securian Customer Service at 866.486.5298. For questions about claims, call Securian Claim Department Customer Service at 888.658.0193.

Suicide provision

No Optional Life or Dependent Life-Spouse benefit will be payable if death results from suicide, whether the covered person is sane or insane, within two years of the effective date. If suicide occurs within two years of a coverage increase, the death benefit payable is limited to the amount of coverage in force prior to the increase.

How AD&D claims are paid

In the case of accidental death, your employer should be notified. The benefits administrator will complete and submit Securian's Notice of Death form. Securian will pay the accidental death benefit to the person or persons entitled to receive your death benefits.

If you sustained other losses covered under AD&D, you, your employer and your physician must complete the Notice of Accidental Dismemberment and Loss of Sight Claim and submit it to Securian. The benefit for other losses you sustained will be paid to you, if you are living. Otherwise, it will be paid to your estate.

A dependent's AD&D benefit will be paid to you, if you are living. Otherwise, it will be paid to your estate.

Examinations and autopsies

Securian retains the right to have you medically examined at its expense when and so often as it may reasonably require whenever a claim is pending and, where not forbidden by law, Securian reserves the right to have an autopsy performed in case of death.

Terms to know

These terms apply to your Life and Accidental Death and Dismemberment (AD&D) coverage:

Actively at Work requirement

To be eligible to become insured or to receive an increase in the amount of insurance, you must be actively at work. This means you must be fully performing your customary duties for your regularly scheduled number of hours at the employer's normal place of business or at other places the employer's business requires you to travel.

If you are not working due to illness or injury, you do not meet the actively at work requirement. If you are receiving sick pay, short-term disability benefits or long-term disability benefits, you do not meet the actively at work requirement.

If you are not actively at work on the date coverage would otherwise begin, or on the date an increase in your amount of insurance would otherwise be effective, you will not be eligible for the coverage or the increase until you return to active work. However, if the absence is on a non-work day, coverage will not be delayed provided you were actively at work on the work day immediately preceding the non-work day. Except as otherwise provided for in the insurance certificate, you are eligible to continue to be insured only while you remain actively at work.

Any insurance or increase in insurance that is elected or put in force while you are not actively at work will not be eligible for claim payment. You will receive a refund of premium for any contributory insurance (insurance you paid for) for which you were not eligible.

Basic salary

The actual amount you are compensated by your employer per year, including merit and longevity increases. It does not include commissions, annuities, bonuses, overtime or incentive pay. If you are a teacher, it does not include compensation for summer school.

Evidence of Insurability form

The form used to provide medical evidence of good health to Securian.

Injury

Injury means resulting directly and independently from all other causes, from an accidental bodily injury which was unintended, unexpected and unforeseen. The bodily injury must be evidenced by a visible contusion or wound, except in the case of accidental drowning. The bodily injury must be the sole cause of death or dismemberment. The injury and accidental loss, death or dismemberment must occur while your coverage is in force. Infection, other than infection occurring simultaneously with, and as a direct and independent result of, the accidental injury is not considered an injury.

Maximum amount of Optional Life Insurance

Medical evidence of good health, which is provided on the Evidence of Insurability form, may be required for the amount of coverage

that you select. The maximum eligible amount of Optional Life Insurance for all eligible employees is $500,000.

Physician

A physician is an individual who is licensed to practice medicine or treat illness in the state in which the treatment is received. The physician cannot be you or your spouse, children, parent, grandparent, grandchild, brother or sister; or the spouse of any such individual.

Pretax Group Insurance Premium Feature

This feature allows you to pay your Optional Life insurance premiums for coverage up to $50,000 before taxes are taken out of your paycheck. Retirees are not eligible to participate in the Pretax Group Insurance Premium Feature.

Sickness

A disease, disorder or condition that requires treatment by a physician.

You

A person insured under the policy.

Long term disability

Basic Long Term Disability

The Basic Long Term Disability (BLTD) Plan, administered by Standard Insurance Company (The Standard), is an employer-funded disability plan provided by the state. It helps protect a portion of your income if you become disabled as defined by the Plan. This benefit is provided at no cost to you.

If you have questions or need more information, please contact The Standard at 800.628.9696 or at www.standard.com/mybenefits/southcarolina.

Eligibility

You are eligible for BLTD if you are covered under the State Health Plan or the TRICARE Supplement Plan and are an active, full-time employee as defined by the Plan or a full-time academic employee and you are employed by: a department, agency, board, commission or institution of the state; a public school district; a county government (including county council members); or another group participating in the state's insurance program. BLTD is provided at no cost to you.

Members of the General Assembly and judges in the state courts are also eligible for coverage. BLTD is provided at no cost to you.

If you become disabled, you may be eligible, through PEBA, for additional benefits, which are separate from the benefits described here. Call 803.737.6800 or 888.260.9430, or visit www.retirement.sc.gov for more information.

You must be actively employed when the disability occurs.

Benefit waiting period

The benefit waiting period is the length of time you must be disabled before benefits are payable. No benefits are paid during this period. The BLTD plan has a 90-day benefit waiting period.

Certificate

The BLTD certificate is available through your benefits administrator and is on PEBA's insurance benefits website, www.eip.sc.gov, under "Forms." The contract contains the controlling provisions of this insurance plan. Neither the certificate nor any other material can modify those provisions.

Claims

As soon as it appears you will be disabled for 90 days or more or your employer is modifying your duties due to a health condition, ask your benefits administrator for a claim form packet, which is on PEBA's insurance benefits website. The packet contains these forms:

- Employee's Statement
- Authorization to Obtain Psychotherapy Notes
- Authorization to Obtain Information
- Attending Physician's Statement
- Employer's Statement

You are responsible for making sure these forms are completed and returned to The Standard. You may fax the forms to 800.437.0961; original forms must follow by mail. If you have questions, contact The Standard at 800.628.9696.

You should provide these completed claim forms to The Standard within 90 days of the end of the benefit waiting period. If you cannot meet this deadline, you must submit these forms as soon as reasonably possible, but no later than one year after that 90-day period. If you do not provide these forms within this time, barring a court's determination of legal incapacity, The Standard may deny your claim.

Active work requirement

If physical disease, mental disorder, injury or pregnancy prevent you from working the day before the scheduled effective date of your coverage, your coverage will not become effective until the day after you are actively at work for one full day.

Pre-existing conditions

A pre-existing condition is a mental or physical condition for which you have done of the following at any time during the Pre-existing Condition Period:

- Consulted a physician
- Received medial treatment or services
- Taken prescribed drugs or medications

No benefits will be paid for a disability caused or contributed to by a pre-existing condition unless on the date you become disabled:

- You have been continuously covered under the plan for at least 12 months (Exclusion Period) or
- If your date of disability falls within 12 months after your BLTD coverage became effective, you must demonstrate you have not consulted a physician, received medical treatment or services, or taken prescribed drugs during the six-month period preceding your coverage effective date. (Treatment Free Period).

Exclusions and limitations

- Disabilities resulting from war or any act of war are not covered.
- Intentional self-inflicted injuries are not covered.
- No BLTD benefits are payable when you are not under the ongoing care of a physician in the appropriate specialty.
- No BLTD benefits are payable for any period when you are not participating, in good faith, in a course of medical treatment, vocational training or education approved by The Standard, unless your disability prevents you from participating.
- No BLTD benefits are payable for any period of disability when you are confined for any reason in a penal or correctional institution.
- No BLTD benefits are payable after you have been disabled under the terms of the BLTD plan for 24 months during your entire lifetime, excluding the benefit waiting period, for a disability caused or contributed to by:
  - A mental disorder, unless you are continuously confined to a hospital solely because of a mental disorder at the end of the 24 months.
  - Your use of alcohol, alcoholism, use of any illicit drug, including hallucinogens, or drug addiction.
  - Chronic pain, musculoskeletal or connective tissue conditions.
  - Chronic fatigue or related conditions.
  - Chemical and environmental sensitivities.
- During the first 24 months of disability, after the 90-day benefit waiting period,

no BLTD benefits will be paid for any period of disability when you are able to work in your own occupation and you are able to earn at least 20 percent of your predisability earnings, adjusted for inflation, but you choose not to work. Thereafter, no BLTD benefits will be paid for any period of disability when you are able to work in any occupation and able to earn at least 20 percent of your predisability earnings, adjusted for inflation, but choose not to work.

- While living outside the United States or Canada, payment of LTD benefits is limited to 12 months for each period of continuous disability.

BLTD plan benefits summary

- Benefit waiting period: 90 days
- Monthly BLTD benefit* percentage: 62.5 percent of your predisability earnings, reduced by deductible income
- Maximum benefit: $800 per month
- Maximum benefit period: To age 65 if you become disabled before age 62. If you become disabled at age 62 or older, the maximum benefit period is based on your age at the time of disability. The maximum benefit period for age 69 and older is one year.

*BLTD benefits are subject to federal and state income taxes. Check with your accountant or tax advisor regarding your tax liability.

Predisability earnings

Predisability earnings are the monthly earnings, including merit and longevity increases, from your covered employer as of the January 1 preceding your last full day of active work, or on the date you became a member if you were not a member on January 1. It does not include your bonuses, commissions, overtime or incentive pay. If you are a teacher, it does not include your compensation for summer school, but it does include compensation earned during regular summer sessions by university staff.

When are you considered disabled?

You are considered disabled and eligible for benefits if you cannot fulfill the requirements of your occupation due to a covered injury, physical disease, mental disorder or pregnancy. You also will need to satisfy the benefit waiting period and meet the following definitions of disability during the period to which they apply.

Own Occupation Disability

You are unable to perform, with reasonable continuity, the material duties* of your own occupation during the benefit waiting period and the first 24 months of disability.

"Own Occupation" means any employment, business, trade, profession, calling or vocation that involves material duties* of the same general character as your regular and ordinary employment with the employer. Your own occupation is not limited to your job with your employer, nor is your own occupation limited to when your job is available.

Any Occupation Disability

You are unable to perform, with reasonable continuity, the material duties* of any occupation.

"Any Occupation" means any occupation or employment you are able to perform, due to education, training or experience, which is available at one or more locations in the national economy and in which you can be expected to earn at least 65 percent of your predisability earnings (adjusted for inflation)

within 12 months following your return to work, regardless of whether you are working in that or any other occupation. The any occupation period begins at the end of the own occupation period and continues to the end of the maximum benefit period.

Partial Disability

- During the benefit waiting period and the own occupation period you are working while disabled, but you are unable to earn more than 80 percent of your predisability earnings, adjusted for inflation, while working in your own occupation.
- During the any occupation period you are working while disabled but you are unable to earn more than 65 percent of your predisability earnings, adjusted for inflation, while working in any occupation.

*"Material duties" means the essential tasks, functions and operations, and the skills, abilities, knowledge, training and experience generally required by employers from those engaged in a particular occupation.

Deductible income

Your BLTD benefits will be reduced by your deductible income – income you receive, or you are eligible to receive – from other sources. Deductible income includes: sick pay or other salary continuation (including sick-leave pool); primary Social Security benefits; workers' compensation; other group disability benefits (except SLTD benefits, which are described on page 144); maximum plan retirement benefits; etc. In addition, TERI funds, at the time you receive them, are deductible income back to the time you began receiving disability benefits. For example, your BLTD benefit, before reduction by deductible income, is 62.5 percent of your covered pre-disability earnings, with a maximum monthly amount of $800. The benefit will then be reduced by the amount of any deductible income you receive or are eligible to receive. The total of the reduced benefit, plus the deductible income, will provide at least 62.5 percent of your covered predisability earnings, but no more than $800 a month.

You are required to meet deadlines for applying for all deductible income you are eligible to receive. PEBA Retirement Benefits has different requirements for disability retirement. Please contact PEBA for more information.

When other benefits are awarded, they may include payments due to you while you were receiving BLTD benefits. If the award includes past benefits, or if you receive other income before notifying The Standard, your BLTD claim may be overpaid. This is because you received benefits from the plan and income from another source for the same period of time. You will be required to repay the plan for this overpayment.

When benefits end

Your benefits end automatically on the earliest of these dates:

- The date you are no longer disabled under the terms of the BLTD plan
- The date your maximum benefit period ends (refer to "Exclusions and Limitations" on Pages 129-130)
- The date benefits become payable under any other group long term disability insurance policy under which you became insured during a period of temporary recovery
- The date of your death.

If you are an employee of a local subdivision, your employer becomes responsible for your

BLTD benefit payments if your employer stops participating in the state insurance program.

When BLTD coverage ends

Your coverage ends automatically on the earliest of:

- The date the plan ends
- The date you no longer meet the requirements noted in the "Eligibility" section of this chapter
- The date your health coverage as an active employee ends
- The date your employment ends.

Appeals

If Standard Insurance Company denies your claim for long term disability benefits, you can appeal the decision by writing to Standard Insurance Company, P.O. Box 2800, Portland, OR 97208, within 180 days of receipt of the denial letter. If the company upholds its decision after a review by its Administrative Review Unit, you may appeal that decision by writing to PEBA Insurance Benefits within 90 days of the notice of denial. If the PEBA Insurance Benefits Appeals Committee denies your appeal, you have 30 days to seek judicial review as provided by Sections 1-11-710 and 1-23-380 of the S.C. Code of Laws, as amended. Please retain copies of all submissions and medical records.

Supplemental Long Term Disability

Many people think they will never become disabled. Consider these statistics:

- Just over 1 in 4 of today's 20-year-olds will become disabled before they retire.[1]
- More than 37 million Americans are classified as disabled; about 12 percent of the total population. More than 50 percent of those disabled Americans are in their working years, from age 18 to age 64.[2]
- 65 percent of working Americans say they could not cover normal living expenses even for a year if their employment income were lost; 38 percent could not pay their bills for more than three months.[3]

As noted above, many people would not be able to meet their financial obligations if they became disabled and could not work for an extended period of time. PEBA Insurance Benefits offers an optional disability insurance plan that provides additional protection for you and your family. This program, Supplemental Long Term Disability Insurance (SLTD), is fully-insured by Standard Insurance Company (The Standard) and is not under PEBA's administration.

[1]U.S. Social Security Administration, Fact Sheet February 7, 2013.
[2]U.S. Census Bureau, American Community Survey, 2011.
[3]Council for Disability Awareness, Disability Divide Consumer Disability Awareness Study, 2010.

What SLTD insurance provides

- Competitive group rates
- Survivors benefits for eligible dependents
- Coverage for injury, physical disease, mental disorder or pregnancy
- A return-to-work incentive
- SLTD conversion insurance
- A cost-of-living adjustment
- Lifetime security benefit

Eligibility

You are eligible for SLTD insurance if you are an active, full-time employee as defined under

the plan, or a full-time academic employee, and you are employed by: a department, agency, board, commission or institution of the state; a public school district; a county government (including county council members); or another eligible employer approved by law and participating in the state insurance program; or you are a member of the General Assembly or a judge in the state courts.

You are not eligible for this coverage if you are an employee of an employer that is covered under any other group long term disability plan that insures any portion of your predisability earnings (other than the BLTD Plan); if you are receiving retirement benefits from PEBA Retirement Benefits and you have waived active employee coverage; if you are a temporary or seasonal employee; or if you are a full-time member of the armed forces of any country.

Enrollment

You can enroll in the SLTD program within 31 days of eligibility. You may choose from one of two benefit waiting periods. If, however, you do not enroll within 31 days after you first become eligible for SLTD, you must provide The Standard with medical evidence of good health and be approved to become insured. You may enroll with medical evidence of good health throughout the year.

Benefit waiting period

The benefit waiting period is the length of time you must be disabled before benefits are payable. You may choose a 90-day or a 180-day benefit waiting period.

You may change from one benefit waiting period to the other at any time.

To change from a 90-day to a 180-day benefit waiting period, you must complete a Notice of Election (NOE) form and return it to your benefits administrator.

To change from a 180-day to a 90-day benefit waiting period, you must complete an NOE and provide medical evidence of good health, which The Standard will consider in determining whether to approve your application.

Certificate

The SLTD certificate is available through your benefits administrator and is on PEBA's insurance benefits website, www.eip.sc.gov, under "Forms." Please read it carefully. The contract contains the controlling provisions of this insurance plan. Neither the certificate nor any other material can modify those provisions.

Physical exam

If you fail to enroll within 31 days of your hire date, you must complete a medical history statement. The Standard may require you to undergo a physical examination and blood test. You also may be required to provide any additional information about your insurability that The Standard may reasonably require, at your own expense.

Claims

As soon as it appears you will be disabled for 90 days or more, ask your benefits administrator for a claim form packet. The packet is also on PEBA's insurance benefits website, www.eip.sc.gov, under "Forms." It contains these forms: Employee's Statement; Authorization to Obtain Psychotherapy Notes; Authorization to Obtain Information; Attending Physician's Statement; and Employer's

Statement. You are responsible for making sure these forms are completed and returned to The Standard. If you have BLTD coverage, only one claim packet must be completed. The forms may be faxed to 800.437.0961; original forms must follow. If you have questions, contact The Standard at 800.628.9696.

You should provide these completed claim forms to The Standard within 90 days of the end of the benefit waiting period. If you cannot meet this deadline, you must submit the forms as soon as reasonably possible, but no later than one year after that 90-day period. If you do not provide the forms within this period, barring a court's determination of your legal incapacity, The Standard may deny your claim.

Salary change

Your SLTD premium will be recalculated based on your age as of the preceding January 1. Any change in your predisability earnings after you become disabled will have no effect on the amount of your SLTD benefit.

Active work requirement

If physical disease, mental disorder, injury or pregnancy prevents you from working the day before the scheduled effective date of your insurance coverage, your coverage will not become effective until the day after you are actively at work for one full day.

Pre-existing conditions

A pre-existing condition is a mental or physical condition for which you have done of the following at any time during the Pre-existing Condition Period:

- Consulted a physician
- Received medial treatment or services
- Taken prescribed drugs or medications

No benefits will be paid for a disability caused, or contributed to, by a pre-existing condition unless on the date you become disabled:

- You have been continuously covered under the plan for at least 12 months (Exclusion Period) or
- If your date of disability falls within 12 months after your SLTD coverage became effective, you must demonstrate you have not consulted a physician, received medical treatment or services, or taken prescribed drugs during the six-month period preceding your coverage effective date. (Treatment Free Period).

The Pre-existing Condition Exclusion also applies when you change from the plan with the 180-day benefit waiting period to the plan with the 90-day benefit waiting period. The Pre-existing Condition Period, Treatment Free Period and Exclusion Period for the new plan will be based on the effective date of your coverage under the 90-day plan. However, if benefits do not become payable under the 90-day plan because of the Pre-existing Condition Exclusion, your claim will be processed under the 180-day plan as if you had not changed plans.

Exclusions and limitations

- Disabilities resulting from war or any act of war are not covered.
- Intentional self-inflicted injuries are not covered.
- No SLTD benefits are payable when you are not under the ongoing care of a physician in the appropriate specialty.
- No SLTD benefits are payable for any period when you are not participating, in good faith, in a course of medical treatment, or vocational training, or

education approved by The Standard, unless your disability prevents you from participating.

- No SLTD benefits are payable for any period of disability when you are confined for any reason in a penal or correctional institution.
- No SLTD benefits are payable after you have been disabled under the terms of the SLTD plan for 24 months during your entire lifetime, excluding the benefit waiting period, for a disability caused, or contributed to, by:
  - A mental disorder, unless you are continuously confined to a hospital solely because of a mental disorder at the end of the 24 months.
  - Your use of alcohol, alcoholism, use of any illicit drug, including hallucinogens, or drug addiction.
  - Chronic pain, musculoskeletal or connective tissue conditions.
  - Chronic fatigue or related conditions.
  - Chemical and environmental sensitivities.
- During the first 24 months of disability, after the benefit waiting period, no SLTD benefits will be paid for any period of disability when you are able to work in your own occupation and you are able to earn at least 20 percent of your predisability earnings, adjusted for inflation, but you choose not to work. Thereafter, no SLTD benefits will be paid for any period of disability when you are able to work in any occupation and able to earn at least 20 percent of your predisability earnings, adjusted for inflation, but choose not to work.
- Generally, no SLTD benefits are payable for any period of disability when you are not also receiving disability benefits under the state of South Carolina Basic Long Term Disability (BLTD) plan. However, this may not apply if:
  - You receive or are eligible to receive other income that is deductible under the BLTD plan and the amount of that income equals or exceeds the amount of the benefits that would otherwise be payable to you under that plan.
  - Benefits that would otherwise be payable to you under the BLTD plan are being used to repay an overpayment of any claim, or
  - You were not insured under the BLTD plan when you become disabled.
- While living outside the United States or Canada, payment of LTD benefits is limited to 12 months for each period of continuous disability.

SLTD plan benefits summary	
Benefit waiting period	Plan one: 90 days Plan two: 180 days
Maximum SLTD-covered predisability earnings	$12,307 per month
Monthly benefit[1] percentages	65 percent of the first $12,307 of your monthly predisability earnings, reduced by deductible income
Minimum benefit	$100 per month
Maximum benefit	$8,000 per month
Cost-of-living adjustment	After 12 consecutive months of receiving SLTD benefits, effective on April 1 of each year thereafter; based on the prior year's Consumer Price Index up to 4 percent. This cost-of-living adjustment does not apply when you are receiving the minimum monthly benefit or a monthly benefit of $25,000 as a result of these adjustments.
Maximum benefit period	To age 65 if you become disabled before age 62. If you become disabled at age 62 or older, the maximum benefit period is based on your age at the time of disability. The maximum benefit period for age 69 and older is one year. In certain circumstances, benefits may continue after the maximum benefit period. See "Lifetime Security Benefit" on Page 133 for more information.
Monthly premium[2] rate	Multiply the premium factor for your age and plan selection by your monthly earnings.

[1]These benefits are not taxable provided you pay the premium on an after-tax basis.
[2]Premium must be an even amount (amount is rounded up to next even number).

Age on preceding January 1	90-day waiting period	180-day waiting period
Under 31	.00056	.00045
31-40	.00078	.00060
41-50	.00154	.00117
51-60	.00311	.00239
61-65	.00374	.00287
66 and older	.00457	.00351

Example one

John is 52 years old, earns $2,250 per month and selected plan one. John's monthly premium is $2,250 x .00311,or $7.00 per month. (The premium was rounded up because it was an uneven amount.)

Example two

Mary is 38 years old, earns $3,000 per month and selected plan two. Mary's monthly premium is $3,000 x .00060, or $1.80 per month.

How does SLTD insurance work?

SLTD insurance is designed to provide additional financial assistance if you become disabled. Your benefit will be based on a percentage of your predisability earnings. This program is customized for you. The SLTD plan benefits summary will provide more information about your plan, including:

- Your level of coverage
- How long benefits payments would continue if you remain disabled
- The maximum benefit amount
- Your choice of benefit waiting periods
- Your premium schedule

You can apply for SLTD if you are:

- An active, full-time employee as defined by the plan or
- A full-time academic employee, and
- You receive compensation from:
  - A department, agency, board, commission or institution of the state
  - A public school district
  - A county government (including county council members) or
  - Another group participating in the state's insurance program.

Members of the General Assembly and judges in the state courts are also eligible. If your group offers other supplemental long term disability coverage, you must choose one or the other.

Predisability earnings

Predisability earnings are the monthly earnings, including merit and longevity increases, from your covered employer as of the January 1 before your last full day of active work, or on the date you became a member if you were not a member on January 1. It does not include your bonuses, commissions, overtime pay or incentive pay. If you are a teacher, it does not include your compensation for summer school, but it does include compensation earned during regular summer sessions by university staff.

When are you considered disabled?

You are considered disabled and eligible for benefits if you cannot work due to a covered injury, physical disease, mental disorder or pregnancy. You will also need to satisfy the benefit waiting period and meet the following definitions of disability during the period to which they apply.

Own Occupation Disability

You are unable to perform, with reasonable continuity, the material duties[1] of your own occupation during the benefit waiting period and the first 24 months SLTD benefits are payable.

"Own occupation" means any employment, business, trade, profession, calling or vocation that involves material duties* of the same general character as your regular and ordinary employment with the employer. Your "own occupation" is not limited to your job with your employer, nor is it limited to when your job is available.

Any Occupation Disability

You are unable to perform, with reasonable continuity, the material duties* of any occupation.

*"Material duties" means the essential tasks, functions and operations, and the skills, abilities, knowledge, training and experience generally required by employers from

those engaged in a particular occupation.

"Any occupation" means any occupation or employment you are able to perform, due to education, training or experience, which is available at one or more locations in the national economy and in which you can be expected to earn at least 65 percent of your predisability earnings (adjusted for inflation) within 12 months following your return to work, regardless of whether you are working in that or any other occupation. The any occupation period begins at the end of the own occupation period and continues to the end of the maximum benefit period (see Page 133).

Partial Disability

- During the benefit waiting period and the own occupation period, you are working while disabled but you are unable to earn more than 80 percent of your predisability earnings, adjusted for inflation, while working in your own occupation.
- During the any occupation period, you are working while disabled but you are unable to earn more than 65 percent of your predisability earnings, adjusted for inflation, while working in any occupation.

Deductible income

Your SLTD benefits will be reduced by your deductible income – income you receive, or you are eligible to receive – from other sources. Deductible income includes: sick pay or other salary continuation (including sick leave pool), primary and dependent Social Security benefits, workers' compensation, BLTD benefits, other group disability benefits, maximum plan retirement benefits, etc. In addition, TERI funds, at the time you receive them, are deductible income back to the time you began receiving disability benefits. For example, your SLTD benefit before reduction by deductible income is 65 percent of your covered predisability earnings. The benefit will then be reduced by the amount of any deductible income that you receive or are eligible to receive, so the total of the reduced SLTD benefit plus the deductible income will provide at least 65 percent of your covered predisability earnings. The guaranteed minimum SLTD benefit is $100, regardless of the amount of deductible income.

You are required to meet deadlines for applying for all deductible income you are eligible to receive. PEBA Retirement Benefits has different requirements for disability retirement. Please contact PEBA Retirement Benefits for more information. When other benefits are awarded, they may include payments due to you while you were receiving LTD benefits. If the award includes past benefits, or if you receive other income before notifying The Standard, your SLTD claim may be overpaid. This is because you received benefits from your plan and income from another source for the same period of time. You will be required to repay the plan for this overpayment.

Lifetime security benefit

This coverage provides lifetime long term disability benefits if, on the last day of the regular maximum benefit period, the disabled person is unable to perform two or more activities of daily living and/or suffers from a severe cognitive impairment that is expected to last 90 days or more, as certified by a physician in the appropriate specialty as determined by The Standard. The benefit will be equal to the benefit that was being paid on the last day of the regular long term disability period.

Conversion

When your insurance ends, you may buy SLTD conversion insurance if you meet all of these criteria:

1. Your insurance ends for a reason other than:
   - Termination or amendment of the group policy
   - Your failure to pay a required premium
   - Your retirement
2. You were insured under your employer's long term disability insurance plan for at least one year as of the date your insurance ended.
3. You are not disabled on the date your insurance ends.
4. You are a citizen or resident of the United States or Canada.
5. You apply in writing and pay the first premium for SLTD conversion insurance within 31 days after your insurance ends.

If you have questions about converting your SLTD policy, call The Standard at 800.378.4668. You will need to know the state of South Carolina's group number, which is 621144.

Death benefits

If you die while SLTD benefits are payable,The Standard will pay a lump-sum benefit to your eligible survivor. This benefit will be equal to three months of your SLTD benefit, not reduced by deductible income. Eligible survivors include your surviving spouse; surviving, unmarried children younger than age 25; or any person providing care and support for any of them.

This benefit is not available to any eligible survivors if your SLTD benefits and claim have reached the Maximum Benefit Period before your death. Also, this benefit is not available if you have been approved for and/or you are receiving the Lifetime Security Benefit.

When benefits end

Your benefits end automatically on the earliest of:

- The date you are no longer disabled
- The date your Maximum Benefit Period ends, unless SLTD benefits are continued by the Lifetime Security Benefit
- The date of your death
- The date benefits become payable under any other group LTD policy for which you become insured during a period of temporary recovery.

When SLTD coverage ends

Your insurance ends automatically on the earliest of:

- The last day of the month for which you paid a premium
- The date the group policy ends
- The date you no longer meet the requirements noted in the "Eligibility" section of this chapter

Appeals

If Standard Insurance Company denies your claim for supplemental long term disability benefits, you can appeal the decision by writing to Standard Insurance Company, P.O. Box 2800, Portland, OR 97208, within 180 days of the receipt of the denial letter. If the company upholds its decision, the claim will receive an independent review by The Standard's Administrative Review Unit.

Please note: Because Supplemental Long

Term Disability is fully insured by The Standard, you may not appeal SLTD decisions to PEBA.

MoneyPlus

Your tax-favored accounts program

What is MoneyPlus?

MoneyPlus offers tax-favored accounts, IRS-approved, tax-free benefits. If you are an active employee, these accounts save you money on eligible medical and dependent care costs by enabling you to pay these expenses with funds deducted from your salary before it is taxed.

For more information, see the *Tax-Favored Accounts Guide* on PEBA's insurance benefits website, www.eip.sc.gov.

MoneyPlus is governed by Sections 105, 125, 129 and 223 of the Internal Revenue Service code. WageWorks, Inc., is the program's third-party claims processor. Each account has an administrative charge, which is designed to be minimal compared to your tax savings.

Pretax premiums

The Pretax Group Insurance Premium Feature allows you to pay premiums for the State Health Plan (including the tobacco-use surcharge), the TRICARE Supplement Plan, the State Dental Plan, Dental Plus, the State Vision Plan, and Optional Life (for coverage up to $50,000) before taxes are taken from your paycheck.

Flexible Spending Accounts

Through MoneyPlus you can pay eligible medical and dependent care expenses with money you set aside before it is taxed. You authorize deposits to your MoneyPlus account, which occur every pay period. As you have eligible expenses, you request tax-free withdrawals from your account to reimburse yourself. There are three Flexible Spending Accounts: a Dependent Care Spending Account (DCSA), a Medical Spending Account (MSA) and a Limited-use Medical Spending Account, which can accompany a Health Savings Account (HSA). (Members enrolled in the Savings Plan are eligible for an HSA.) If you have dependent care and medical expenses, you can establish a DCSA and an MSA (or a Limited-use MSA, if you contribute to an HSA.)

You must enroll annually to be covered by a DCSA, an MSA or a Limited-use MSA.

A retiree who returns to work in an insurance-eligible position under the active group is eligible for the Pretax Group Insurance Premium Feature, a DCSA and an MSA.

Health Savings Accounts

A Health Savings Account (HSA) is available to employees enrolled in the Savings Plan and can be used to pay health care expenses. The funds do not have to be spent in the year they are deposited. Money in the account accumulates tax free, so the funds can be used to pay qualified medical expenses in the future. An important advantage of an HSA is that you own it. If you leave your job, you can take the account with you and continue to use it for qualified medical expenses.

For more information about the State Health Plan's Savings Plan, see Page 37.

Administrative fees per month	
Pretax Group Insurance Premium feature[1]	$0.28
Dependent Care Spending Account[1]	$3.14
Medical Spending Accounts (full and limited-use)[1]	$3.14
Health Savings Account (WageWorks fee)[2]	$1.50
Health Savings Account (Wells Fargo fee)[3, 4]	$1.75

[1]This fee is deducted from your paycheck before taxes.
[2]This fee is deducted from your paycheck.
[3]This fee, for HSAs established with Wells Fargo Bank, is deducted from your account. The fee is waived for accounts with balances of $2,500 or more.
[4]There is no fee for processing checks. There is a $15 one-time fee for a basic order of checks. There is no charge if you use your Visa® debit card. There may be additional fees for other services. All fees are deducted from your HSA.

Pretax Group Insurance Premium Feature

Optional Life Insurance premiums for coverage up to $50,000 are tax exempt.

With this feature, you can pay your State Health Plan, TRICARE Supplement Plan, State Dental Plan, Dental Plus, State Vision Plan and Optional Life premiums before taxes are taken out of your paycheck. You may also pay the tobacco-use surcharge. This feature is beneficial to all employees who pay these premiums.

Eligibility

You are enrolled in this feature automatically if you pay a health, TRICARE Supplement Plan, dental, vision care or Optional Life premium, unless you decline on your Notice of Election form. If you declined the Pretax Group Insurance Premium Feature in the past, you can enroll during open enrollment, which occurs yearly in October, or within 31 days of an approved change in status. See "Changing Your Flexible Spending Account Coverage," Pages 151-152. For additional information, see "Special Eligibility Situations," Pages 16-23.

Please note: Effective January 1, 2016, an employee who covers an ex-spouse on any benefit is not eligible for the Pretax Group Insurance Premium Feature. This does not affect the employee's eligibility to participate in an MSA or a DCSA.

Flexible Spending Accounts

IRS guidelines for Flexible Spending Accounts

1. The IRS does not allow you to pay any insurance premiums through any type of spending account.
2. You cannot transfer money between MoneyPlus accounts or pay a dependent care expense from your Medical Spending Account or vice versa. The dependent care account is for dependent child/adult day care only. It does not provide any medical benefits for your dependents.
3. The IRS gives you until March 15 to spend any remaining funds deposited in your Medical Spending Account or your Limited-use Medical Spending Account from January through December of the previous year. For example: You have until March 15, 2016, to spend funds deposited in your MSA or Limited-use MSA between January 1 and December 31, 2015.

   However, you must submit all reimbursement requests by March 31, 2016. Any money in your Medical Spending Account or your Limited-use Medical Spending Account after your reimbursable requests have been processed cannot be returned to you or carried over to the next year.
4. You have until March 31 after the end

of the year to submit for reimbursement eligible Dependent Care Spending Account expenses incurred during your period of coverage, January through December. Any money in your Dependent Care Spending Account after your reimbursable requests have been processed cannot be returned to you or carried over to the next year.

To learn if you qualify to enroll in a spending account or to make a change, call WageWorks Customer Care at 800.342.8017 or PEBA at 803.737.6800 (toll-free at 888.260.9430).

5. You may not be reimbursed through your MoneyPlus accounts for expenses paid by insurance or by any other source.
6. You cannot deduct reimbursed expenses from your income tax.
7. You may not be reimbursed for a service that you have not received.

Written certification

When enrolling in either or both MoneyPlus spending accounts, you must agree to the following in writing on your enrollment form:

- I will only use my MoneyPlus account to pay for IRS-qualified expenses eligible under my employer's plan and only for me and my IRS-eligible dependents.
- I will exhaust all other sources of reimbursement, including those provided under my employer's plan(s), before seeking reimbursement from my MoneyPlus spending account.
- I will not seek reimbursement through any additional source.
- I will collect and maintain sufficient documentation to validate the requirements above.

Deciding how much to contribute to your Flexible Spending Accounts

To estimate how much to deposit in your Dependent Care Spending Account or Medical Spending Account, complete the MoneyPlus Worksheets, which are at www.eip.sc.gov. Be conservative in your estimates.

- Money remaining in your Dependent Care Spending Account after the plan year ends cannot be returned to you or carried forward to the next plan year. However, you have until March 31, 2017, to submit requests for reimbursement for expenses incurred on or before December 31, 2016.
- Money remaining in your Medical Spending Account or in your Limited-use Medical Spending Account after the plan year and any grace period ends cannot be returned to you or carried forward to the next plan year. However, you have until March 31, 2017, to submit requests for reimbursement for expenses incurred on or before March 15, 2017, for either of the Medical Spending Accounts.

Earned Income Tax Credit

Contributions made before taxes to a Dependent Care Spending Account or a Medical Spending Account lower your taxable earned income. The lower your earned income, the higher the Earned Income Tax Credit (EITC). If you qualify for the EITC, contributions to one or both of these accounts will help. Taxpayers may consult IRS Publication 596 for additional information, use the services of a tax professional or get assistance from a Volunteer Income Tax

Assistance site. To find the closest site, call the IRS at 800.829.1040.

Dependent Care Spending Account vs. Child and Dependent Care Credit

If you pay for the care of a child or another dependent so you can work, you may be able to reduce your taxes by claiming those expenses on your federal income tax return through the Child and Dependent Care Credit. (Depending on a taxpayer's circumstances, participating in a Dependent Care Spending Account on a salary-reduction basis will generally produce the greater tax benefit.) However, it is important to look at your unique circumstances. Go to www.myFBMC.com, and select the Tax Savings Analysis link at the bottom of the home page. Follow the prompts. For more information about the Dependent Care Spending Account, go to the FAQs section on the same website.

In addition to the tax benefit of participating in a Dependent Care Spending Account, a partial Child and Dependent Care Credit may be available to you. For example, you may be able to claim an additional tax credit in an amount equal to a percentage of $1,000 if you have:

- Two or more qualifying individuals
- A maximum Dependent Care Spending Account tax filing status of $5,000 and
- $6,000 or more in eligible dependent care expenses.

Note:

- You cannot use the Child and Dependent Care Credit if you are married and filing separately. Dependent care expenses reimbursed through a Dependent Care Spending Account cannot be filed for the credit.
- In 2016, the Dependent Care Spending Account (DCSA) is capped at $1,500 for highly compensated employees. However, the $1,500 cap is subject to adjustment in mid-year if PEBA's DCSA does not meet the federal Average Benefit 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. For 2016, the Internal Revenue Code defines a highly compensated employee as someone who earned $120,000 or more in calendar year 2015.

For assistance, call the Customer Care Center at 800.342.8017.

For more information on the Child and Dependent Care Credit, refer to IRS Publication 503.

Note: If you participate in the Dependent Care Spending Account or if you file for the Child and Dependent Care Credit, you must attach IRS Form 2441 to your 1040 income tax return. If you do not, the IRS may not allow your pretax exclusion. To claim the income exclusion for dependent care expenses on IRS Form 2441, you must be able to list each dependent care provider's Social Security Number (SSN) or Employer Identification Number (EIN). If you are unable to obtain a dependent care provider's SSN or EIN, you must send with your IRS Form 2441 a written statement that explains the circumstances and states that you made a serious effort to get the information.

MoneyPlus Medical Spending Account vs. claiming expenses on IRS Form 1040

Unless your itemized medical and dental expenses exceed 10 percent of your adjusted gross income*, you cannot claim them on your IRS Form 1040. However, you can save taxes by paying for your uninsured, out-of-pocket medical expenses through a tax-free Medical Spending Account.

*Note: If you file a joint tax return, your adjusted gross income includes both your income and your spouse's.

With a Medical Spending Account, the money you set aside for medical expenses is deducted from your salary before it is taxed, so you save on taxes. For example, if your adjusted gross income were $45,000, the IRS would only allow you to deduct itemized expenses that exceed $4,500, or 10 percent of your adjusted gross income. But if you have $2,000 in eligible medical expenses, the MoneyPlus account saves you $656 on your medical expenses in federal income tax (15

percent), South Carolina state tax (7 percent) and Social Security taxes (7.65 percent).

For additional information about the tax credit, consult IRS Publication 502, use the services of a tax professional or get assistance from a Volunteer Income Tax Assistance site. To find the nearest site, call the IRS at 800.829.1040. For additional information on MSAs, check the FAQs at www.myFBMC.com.

Dependent Care Spending Account

Please note: This account is only for paying for day care for children and adults. It may not be used to pay for any medical care for your dependents. You will not be allowed to change this account to a Medical Spending Account after the January 1, 2016, plan year begins.

How the Dependent Care Spending Account works

1. Estimate the amount you will spend during the year on dependent care, up to $5,000, depending on your tax status. Don't forget to consider vacation and holiday time when you may not have to pay for dependent care. During the year, make sure you file all your claims for reimbursement. Remember, according to IRS guidelines, any money in your account after you have claimed all your expenses at the end of the year cannot be returned to you or be carried over into the next calendar year. You have until March 31 of the new plan year to file claims for services provided the previous year.
2. The annual amount you contribute to your account will be divided into equal installments and deducted from each paycheck before taxes. It is then credited to your Dependent Care Spending Account.
3. After incurring dependent care expenses, submit a MoneyPlus Claim Form and a copy of your expense documentation from your dependent care provider to WageWorks. The MoneyPlus Claim Form may serve as documentation if it includes the provider's signature. The provider's Tax ID Number or Social Security number is not requested on the claim form. However, you should be prepared to give it to the IRS if asked to do so.
4. Your claim will be processed within five working days of when WageWorks receives it, if it is properly completed and signed, and only if there are enough funds in your account. Then a direct deposit will be issued to your account, or a check will be mailed, up to your current account balance. You will be reimbursed for any remaining expenses when money is available in your account.

Note: In 2016, the Dependent Care Spending Account (DCSA) is capped at $1,500 for highly compensated employees. However, the $1,500 cap is subject to adjustment in mid-year if PEBA's DCSA does not meet the federal Average Benefit 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. For 2016, the Internal Revenue Code defines a highly compensated employee as someone who earned $120,000 or more in calendar year 2015.

Eligibility

You must be eligible for state group insurance benefits to participate in MoneyPlus. However, you are not required to be covered by an insurance program to participate in MoneyPlus, nor do you have to enroll in the Pretax Group Insurance Premium Feature to participate in the Dependent Care or Medical Spending Accounts.

Enrollment

You can enroll in the Dependent Care Spending Account within 31 days of your hire date through your benefits administrator. If you do not enroll then, you can enroll during the next enrollment period, October 1-31. You also can enroll in, or make changes to, this account within 31 days of an approved change in status (see "Special Eligibility Situations," Pages 16-23 and "Changing Your Flexible Spending Account Coverage," Pages 151-152). You must re-enroll each year during open enrollment, which occurs yearly in October, to continue your account the next year. The Dependent Care Spending Account allows you to pay dependent care expenses with your pretax income. Here are the limits on how much you may set aside

- If you are married and filing separately, your maximum is $2,500.
- If you are single and head of household, your maximum is $5,000.
- If you are married and filing jointly, your maximum is $5,000.
- If either you or your spouse earns less than $5,000 a year, your maximum is equal to the lower of the two incomes.
- If your spouse is a full-time student or incapable of self-care, your maximum is $3,000 a year for one dependent and $5,000 a year for two or more dependents.

You may use your Dependent Care Spending Account to receive reimbursement for eligible dependent care expenses for qualified individuals. A qualified individual includes a qualified child if he or she:

- Is a U.S. citizen, a U.S. national or a resident of the U.S., Mexico or Canada
- Has a specified family-type relationship to you
- Lives in your household for more than half of the tax year
- Is under age 13
- Has not provided more than one-half of his own support during the tax year

For more information, talk with your benefits administrator or a tax professional, or contact the Internal Revenue Service at 800.829.1040 or www.irs.gov.

Eligible expenses

Generally, child, adult and elder care costs that allow you and your spouse to work or actively look for work are eligible for reimbursement. If you are married, your spouse must work, be a full-time student or be mentally or physically incapable of self-care. Examples:

- Day care facility fees
- Local day camp fees
- Baby-sitting fees for at-home care while you and your spouse are working (you, your spouse or another tax dependent cannot provide the care)

Ineligible expenses

- Child support payments or child care if you are a non-custodial parent
- Payments for dependent care services provided by your dependent, your spouse's dependent or your child who is under age 19
- Health care costs or educational tuition
- Overnight care for your dependents (unless it allows you and your spouse to work during that time)
- Nursing home fees
- Diaper services
- Books and supplies

Although claims are processed in five working days, it may take as long as two weeks to get your check because of time in the mail and weekends. To receive your reimbursement faster, sign up for Direct Deposit. You may also file your DCSA and MSA claims online. To do so, go to www.myFBMC.com. Log in and select "My Account" and then "Online Claim Form." For more information, see Page 151.

- Activity fees
- Kindergarten tuition

Reimbursement of eligible DCSA expenses

To request reimbursement, you must complete and submit a MoneyPlus Claim Form, along with expense documentation showing the following:

- The dates your dependent received the care (for example, October 1-October 31), not the date you paid for the service
- The name and address of the facility
- The name, address and signature of the individual who provided the dependent care.

This information is required with each request for reimbursement. The MoneyPlus Claim Form may serve as documentation if it includes the provider's signature. The provider's Tax ID Number or Social Security number is not requested on the claim form. However, you should be prepared to give it to the IRS if asked to do so.

An approved expense will not be reimbursed until after the last date of service for which you are requesting reimbursement. For example, if you pay your dependent care provider on October 1 for the month of October, you can submit your reimbursement request for the entire month. However, payment will not be made until you receive the last day of care for that month.

An approved expense will not be reimbursed until enough funds are in your Dependent Care Spending Account to cover the expense. On your claim form, you may divide the dates of service into periods that correspond with your payroll cycle. This will allow you to be reimbursed for part of the amount on the documentation when there are enough funds in your account.

Medical Spending Account

How the Medical Spending Account Works

1. Estimate the amount you and your family want to set aside in your Medical Spending Account, up to $2,550 for 2016. This amount is indexed and may be updated yearly. If you are married and your spouse is eligible for coverage, you may each set aside up to $2,550. Consider only those expenses you and your family can expect to incur between January 1 and December 31.
    - According to IRS regulations, if you have money left in your MSA on December 31, you have until March 15 of the new year (a grace period) to spend funds deposited in the account during the previous year.
    - You have until March 31 to ask for reimbursement and submit documentation for eligible expenses incurred during the calendar year

and the grace period. This includes documentation for myFBMC Card® transactions. Check www.myFBMC.com for any outstanding transactions that may need documentation.

- Between January 1 and March 15, any myFBMC Card® swipes or paper claims filed will be paid from funds remaining in your MSA from the previous year. For example, if you have 2015 MSA funds you would like to use, submit all of your 2015 claims before you begin turning in claims for 2016 expenses. Once your 2015 funds are exhausted, you will begin to be reimbursed from your 2016 account.
- Remember, any money in your account after you have claimed all of your expenses cannot be returned to you or carried over beyond March 15 of the new year.
- If you had a myFBMC Card® during the old plan year, you can continue to use it to pay eligible expenses from your previous year's MSA until March 15. If you have not signed up for an MSA again, you cannot use your myFBMC Card® after December 31. However, you may submit paper claims until March 31 for expenses incurred until March 15 of the new plan year.

2. The yearly amount you elect to contribute to your account will be divided into equal installments and deducted from each paycheck before taxes. It is then credited to your Medical Spending Account.
3. After incurring medical or dental expenses, submit a MoneyPlus Claim Form and a copy of the expense documentation or the Explanation of Benefits for these expenses to WageWorks. File the claim only for your unreimbursed expenses. Approved claims will be paid until you have reached the annual amount you chose to have deducted. It will take five working days to process your claim after WageWorks receives it. Then a direct deposit will be issued to your account within 48 hours after your approved claim is processed, or a check will be mailed. Because of weekends and time in the mail, it may take up to two weeks for you to receive your check.
4. You may present your myFBMC Card® when you incur eligible medical expenses, including prescriptions or dental expenses. If the provider accepts the card, the funds will be automatically withdrawn from your account, and you will not have to wait for reimbursement. Instructions on when to submit expense documentation will be provided on your monthly statement, or you may check www.myFBMC.com.

Eligibility

You must be eligible for active group insurance to participate in MoneyPlus. However, you are not required to be enrolled in an insurance program to participate in MoneyPlus, nor do you have to enroll in the Pretax Group Insurance Premium Feature to participate in a Dependent Care or Medical Spending account.

Enrollment

To continue your Medical Spending Account each year, you must re-enroll during the enrollment period, October 1-31. If you have a myFBMC Card®, you must also re-enroll for it each year. You can enroll in, or make changes to, your MSA within 31 days of an approved change in status (see "Special Eligibility

Situations," Pages 16-23 and "Changing Your Flexible Spending Account Coverage," Pages 151-152).

You may enroll or re-enroll online at www.myFBMC.com during October enrollment. You also may complete a MoneyPlus Enrollment Form, available from your benefits administrator or on the PEBA insurance benefits website at www.eip.sc.gov. Submit the completed form to your benefits administrator. You may set aside up to $2,550 annually to pay your medical, vision and dental expenses that are not reimbursed by insurance. This figure may be adjusted yearly for inflation.

Your MoneyPlus MSA may be used to reimburse eligible expenses incurred by:

- Yourself
- Your spouse (even if he has a Medical Spending Account)
- Your qualifying child
- Your qualifying relative

An individual is a qualifying child if he is not someone else's qualifying child, and:

- Does not reach age 27 during the taxable year
- Has a specified family-type relationship to you: son/daughter, stepson/stepdaughter, eligible foster child, legally adopted child, or child placed for legal adoption
- Is a U.S. citizen, a U.S. national or a resident of the U.S., Mexico or Canada

An individual is a qualifying relative if he is a U.S. citizen, a U.S. national or a resident of the U.S., Mexico or Canada and:

- Has a specified family-type relationship to you, is not someone else's qualifying child and receives more than one half of his support from you during the tax year or
- If no specified family-type relationship to you exists, is a member of and lives in your household (without violating local law) for the entire tax year and receives more than one-half of his support from you during the tax year.

Note: There is no age requirement for a qualifying child if he is physically and/or mentally incapable of self-care. An eligible child of divorced parents is treated as a dependent of both, so either or both parents can establish a MoneyPlus MSA.

For more information, contact your benefits administrator or tax advisor or the Internal Revenue Service at 800.829.1040 or at www.irs.gov.

Eligible expenses —Medical Spending Account

Expenses eligible for reimbursement include your deductibles, coinsurance and copayments. In addition to these expenses, your MSA is an excellent way to help pay for:

- Annual physical exams
- Vision care
- Out-of-pocket dental fees (including orthodontia, if medically necessary, but not if cosmetic)
- Over-the-counter drugs, but only if prescribed by a physician
- Non-medicinal over-the-counter items, including diabetic supplies, are still reimbursable without a prescription
- Any other out-of-pocket medical expenses deductible under current tax laws, including travel to and from medical facilities.

Note: Orthodontia treatment designed to treat a specific medical condition can be reimbursed. However, you will have to submit additional documentation each year. For more information, call the Customer Care Center at

800.342.8017.

Eligible expenses — Limited-use Medical Spending Account

If you have a Health Savings Account (HSA), you are eligible for a Limited-use Medical Spending Account. This account may be used to pay expenses not covered by the Savings Plan, such as dental and vision care. You may use your HSA, but not your Limited-use MSA, for deductibles and coinsurance.

Over-the-counter medicine

Under the Patient Protection and Affordable Care Act, an MSA can only be used to pay for over-the-counter drugs if those drugs are prescribed by a physician. A list of categories of over-the-counter items that the IRS has approved for reimbursement is available at www.myFBMC.com.

Ineligible expenses

- Insurance premiums
- Vision warranties and service contracts
- Health or fitness club membership fees
- Cosmetic surgery not deemed medically necessary to alleviate, mitigate or prevent a medical condition.

Availability

Once you sign up for an MSA and decide how much to contribute, the entire amount will be available on January 1. You do not have to wait for the funds to accumulate in your account before being reimbursed for eligible medical expenses.

Medical Spending Account reimbursement

If you use a myFBMC Card®, funds will be transferred automatically from your MSA. You will not need to wait for reimbursement. The myFBMC Card® is discussed in detail below.

If you file by mail, your reimbursement will be issued within five business days from the time your properly completed and signed claim form is received. However, weekends and time in the mail may mean it will take longer to receive your check. The minimum reimbursement is $5, except for the last reimbursement, which brings your account balance to zero.

Direct Deposit

Your MoneyPlus reimbursement checks can be deposited automatically into your checking or savings account. There is no extra fee for this service, and you will still be notified that your claim has been processed. To apply, complete a MoneyPlus Direct Deposit Authorization Form available from your benefits office or on PEBA's insurance benefits website at www.eip.sc.gov. Processing your direct deposit application may take four to six weeks.

MoneyPlus spending accounts are tax-favored accounts and must follow the guidelines under Section 125 of the Internal Revenue Code. Your signature on the form submitted for reimbursement serves as a required certification that you are abiding by the plan rules. Your request cannot be processed without it.

Do not use a highlighter on any forms or other documents you send. It will make them impossible to read when they are photocopied or faxed.

Requesting manual reimbursement

Claims must first be filed for any health plan benefits, provided by your employer, for

which you are eligible. Any remaining out-of-pocket expenses may then be submitted for reimbursement from your MSA.

To request reimbursement from your MSA, fax or mail a completed MoneyPlus Claim Form (the fax number and address are on the form), along with one of these:

- An invoice or bill from your health care provider listing the date you received the service, the cost of the service, the type of service and the person for whom the service was provided
- An Explanation of Benefits (EOB) from your health insurance provider that shows the type of service you received, the date and cost of the service and any uninsured portion of the cost. In certain circumstances, a written statement from your health care provider that the service was medically necessary may be required. This Letter of Medical Need is available by calling 800.342.8017.

MoneyPlus MSA claims, as well as DCSA claims, also may be filed online. For information, see page 151.

MyFBMC Card® Visa® Card

Beginning in 2016, the myFBMC Card® is issued at no charge to all MoneyPlus MSA and Limited-use MSA participants. You may use the debit card to use funds from your MSA or Limited-use MSA to pay eligible, uninsured medical expenses for yourself and for your covered family members.

There is no risk of overspending. If you try to spend more than you will deposit into the account during the year, the transaction will be denied.

Enrollment

You will automatically receive the card if you sign up for an MSA. You will receive two cards; you can give one to your spouse or child.

Activating the card

You must activate your myFBMC Card® before you use it for the first time. To do so, log on to www.myFBMC.com. Be sure to sign the back of the card. If you continue to sign up for a MoneyPlus MSA from year to year, you will continue to use the same card until its expiration date.

Like any MSA expense, myFBMC Card® transactions must be documented for the IRS. See Pages 148-149 for more information.

Using the card

MSA participants may use the card for:

- Copayments and deductibles at physician, dentist and optometrist offices
- Vision and dental expenses
- Prescription copayments and uncovered prescriptions at participating pharmacies
- IRS-approved over-the-counter items
- Over-the-counter drugs with a prescription, if filled by the pharmacy
- Mail-order prescriptions.

Limited-use MSA participants may use the card for expenses not covered by the Savings Plan, such as dental and vision care.

They may not use the card to be reimbursed for:

- Out-of-pocket medical expenses, such as deductibles and coinsurance
- Over-the-counter items.

The myFBMC Card® may only be used for

eligible medical expenses not covered by your insurance. It may not be used for cosmetic dental costs and eyeglass warranties.

If you are enrolled in the Standard Plan, you may use your myFBMC Card® for mail-order prescriptions. No documentation is required for prescriptions with known copayments.

When you use the card to pay a health care provider, such as a physician or a stand-alone drug store, swipe it as you would a credit card. No PIN is needed. Please remember to keep documentation of your expenses, as stated in the IRS regulations.

The card will only be accepted at IIAS merchants. An up-to-date list of stores meeting the federal electronic coding requirements is at www.myFBMC.com. After you log in, click on the "My Account" tab at the top of the page and then select "My Account FAQ's." After that, select "Payment Card." Under that category, click on "What is IIAS?" On the website, you will also find a list of categories of over-the-counter items that the IRS has approved for reimbursement.

The pharmacy must also participate in your health plan's network. A list of pharmacies that are part of your network is on the PEBA insurance benefits website under "Online Directories." If you use a pharmacy that is not part of your plan's network, you will pay the full cost for the drug. The cost will not apply to your deductible.

When using your myFBMC Card® at a pharmacy, just swipe the card as you would any credit or debit card. A PIN is not needed. Your receipt will show the name of the drug and the amount of the copayment that was taken from your MSA.

If a provider does not accept the card, you must use a MoneyPlus Claim Form to file for reimbursement. The form is available on the PEBA insurance benefits website at www.eip.sc.gov.

Up to five prescriptions with fixed copayments (such as $9, $38 and $63 under the Standard Plan) on one card transaction will be auto-adjudicated. Auto-adjudicated means they will be verified and approved when you make the purchase without requiring documentation later. If you have more than five prescriptions on one card transaction, all of the prescriptions will require documentation.

Documentation will be required when you use the card for any transaction that does not have a fixed copayment.

If prescription drugs are purchased through your health plan's mail-order pharmacy, documentation will not be required for any prescriptions and IRS-approved over-the-counter items.

Documenting myFBMC Card® transactions

On Pages 143-144 you will find information about how the run-out period and grace period apply to the myFBMC Card®.

According to the IRS, it is not necessary to submit documentation for:

- Up to five prescriptions with fixed copayments on one card transaction. (These prescriptions will be auto-adjudicated, verified and approved when you make the purchase

without requiring documentation later.)

- Known copayments for services provided through the State Health Plan
- Eligible prescriptions purchased through your health plan's mail-order pharmacy
- IRS-approved over-the-counter items.

However, documentation is needed for other health care expenses. When you receive your quarterly statement, transactions requiring documentation will be highlighted in blue. If an expense appears in this section you must fax a copy of your documentation and a MoneyPlus Claim Form to WageWorks. No cover sheet is needed.

Documentation can be an Explanation of Benefits from your health plan or a statement or bill showing the name of the patient, the date of service, the type of service, the service provider and the cost of service. If the documentation is for a drug, be sure it includes the prescription number and the name of the drug. Most drug store receipts do not show the name of the drug. You may need to submit a print-out that includes the name of the drug. It may be from the pharmacy, from your prescription drug program's website or from the pharmacy's website. The name also may be on a note stapled to the bag from the pharmacy.

The claim form is available on the PEBA insurance benefits website at www.eip.sc.gov under "Forms." You may also get a copy from www.myFBMC.com, or from your benefits administrator. The claim form is necessary to process the documentation.

When an outstanding myFBMC Card® transaction has appeared in blue on two quarterly statements, the next time you submit an approved paper claim, enough money will be kept in your account to make up for the card transaction that you have not documented. You will be reimbursed for the difference between the new claim and the undocumented claim. This is called "automatic substitution." You may also satisfy any outstanding myFBMC Card® transactions by submitting a check to WageWorks, made out to your employer in the amount of the outstanding transaction.

Please submit documentation for items listed in blue on your quarterly statement. If you do not send in documentation after a transaction has appeared in blue on two quarterly statements, your card will be suspended on the last working day of the month.

If an undocumented transaction appears in blue on more than two consecutive quarterly statements and no automatic substitution has occurred, your myFBMC Card® will be suspended until:

- Your documentation is received and/or
- Automatic substitution occurs and/or
- You repay your account by check.

When the transaction in question is cleared by one of these methods, your card will be automatically reinstated. Any amounts from January 1, 2015, to March 15, 2016, that are not cleared by March 31, 2016, violate IRS guidelines and will be taxed as income.

You should keep all documents substantiating your claims for at least one year and submit them upon request.

Lost cards

If your myFBMC Card® is lost or stolen, call 888.462.1909 immediately.

Limited-use Medical Spending

Account

Savings Plan subscribers who contribute to an HSA also may be eligible to enroll in a Limited-use Medical Spending Account (MSA) to pay dental and vision care expenses, as these are not covered by the Savings Plan. Except for the restrictions regarding which expenses are reimbursable, a MoneyPlus Limited-use MSA works the same as a MoneyPlus MSA.

Using your Limited-use MSA

Since you can pay your out-of-pocket medical expenses with your MoneyPlus HSA, some MoneyPlus MSA features are not available with a MoneyPlus Limited-use MSA, including:

- No reimbursement of out-of-pocket medical expenses, such as deductibles and coinsurance.
- No reimbursement for over-the-counter items.

Remember, MoneyPlus Limited-use MSAs are available only to HSA participants. Dependent Care Spending Account eligibility is not affected by your HSA participation.

Access to information about your Flexible Spending Account

A word about your Interactive Voice Response PIN

To use the Interactive Voice Response (IVR) system, all you need is your Social Security number (SSN). When you call the IVR for the first time, you will be asked to use the telephone pad to key in your SSN. The last four digits of your SSN will be your first Personal Identification Number (PIN). Then you will be asked to select your own confidential PIN, which should be between four and eight digits. Please use numbers only. Once you have selected your new PIN, you have access to information about your benefits. Please keep your PIN in a safe place. This PIN has no connection with the myFBMC Card® .

If you have trouble registering, it may be because the information you entered does not match what is on file for you. During business hours, a customer care representative can help you register.

Website

The website, www.myFBMC.com, provides information about your tax-favored accounts. To register, enter your name, ZIP code, email address and Social Security number and then select a password. To log in to the site, enter your email address and password. After you log in, you will have access to this benefit information 24 hours a day:

- My Benefits. You may check your benefits, read Flexible Spending Account descriptions and other materials and much more.
- My Account. View your account summary, as well as an online statement, claims information and card transactions. The drop-down list includes access to an online claim form and other forms.
- My Profile. Change your email address, complete your online registration or select a new PIN.
- My Resources. Use the Tax Savings Analysis tool and find answers to many Frequently Asked Questions.
- Contact Us. Send a question to the Customer Care Center.

Filing Medical and Dependent Care Spending Account claims online

MoneyPlus claims may be filed online at www.myFBMC.com. Select "My Account" and then "Online Claim Form." Choose an account: "Dependent Care FSA" "Medical Expense FSA," or "Limited Medical FSA." Enter the total amount of the claim and click "Next." Then scan your completed claim form and supporting documents. Acceptable formats are .pdf, .jpg, .bmp and .gif. Individual claim forms may not exceed three megabytes. After you scan your claim form and documents, follow the directions on the screen to submit your claims.

Claims also may be submitted by mail and fax.

Email notification

You will be notified by email of a variety of events related to your Flexible Spending Accounts. They include receipt of claims, payment or rejection of claims, a need for myFBMC Card® documentation, suspension or reinstatement of your myFBMC Card® and more. To sign up, go to www.myFBMC.com, log in and click on "Go Green" in the box under "Account Access."

Telephone

The 24-hour automated phone system enables you to check a MoneyPlus claim, request forms and more. Getting connected to your benefits is easy. Call the Interactive Voice Response Line at 800.865.3262.

How to contact WageWorks

Customer Care Center
Monday – Friday, 7 a.m.-10 p.m., ET
800.342.8017 | 800.955.8771 (TDD)

Interactive Voice Response
24 hours a day, seven days a week
800.865.3262

Dispute line
Monday-Friday, 7 a.m.-10 p.m., ET
800.342.8017

Toll-free claims fax
888.800.5217

Changing your Flexible Spending Account coverage

You can start or stop your MoneyPlus Flexible Spending Accounts or vary the amounts you contribute to the account only under limited circumstances. MoneyPlus program and IRS regulations establish which "changes in status" allow you to change contributions to your account. The change you wish to make to your Dependent Care Spending Account (DCSA) or Medical Spending Account (MSA) must be consistent with the event that initiates the change. For example, you may wish to start a DCSA if you have a baby or adopt a child. You may want to decrease your MSA contribution if you get a divorce and will no longer be paying for your ex-spouse's out-of-pocket medical expenses.

Employees can enroll or reenroll in an MSA or a DCSA online during open enrollment, which occurs yearly in October. If you wish to open an HSA, which is associated with the Savings Plan, you must do so online.

Within 31 days of one of the events listed below, you must complete and submit a Change in Status Form to your benefits

administrator if you wish to make changes in your account. The form is available on the PEBA insurance benefits website at www.eip.sc.gov and from your benefits administrator.

Your benefits administrator must complete and review the form, along with any necessary documentation, authorize it and forward the form in a timely manner. Any related claims you submit in the interim will be held until WageWorks receives and processes the Change in Status Form. Birth, adoption and placement for adoption are effective on the date of the event. All other changes in status are effective the first of the month after the date of the request. Some changes in status that permit changes to your account are:

- Marriage, divorce
- Birth, placement for adoption, adoption
- Placement for custody
- Dependent loses eligibility
- Death of spouse or child
- Gain or loss of employment
- Begin or end unpaid leave of absence
- Change from full-time to part-time employment or vice versa
- Change in day-care provider.

You cannot change your MoneyPlus account because you are in the process of a divorce. When a divorce is final, it is a change-in-status event that does permit you to change your MoneyPlus account.

For more information, contact your benefits administrator or call the WageWorks Customer Care Center at 800.342.8017.

How changes affect your period of coverage

Your MoneyPlus spending account is set up for the entire calendar year (your period of coverage). However, if you are permitted to change it during the year (an approved, mid-plan-year election change), you have more than one period of coverage. Money you deposit during the original period of coverage may be combined with money you deposit after the mid-year change. However, expenses you incurred before the mid-year change cannot be reimbursed for more money than was in the MoneyPlus account before the change.

How leaving your job affects your Flexible Spending Account

Medical Spending Account

COBRA coverage under a MoneyPlus MSA will be offered only if you have an under-spent account. An account is under spent if the amount you elected to contribute to your account for the plan year, minus any reimbursable claims you have submitted up to the date of the COBRA qualifying event, is equal to or more than the amount you would have contributed to the account had you remained employed for the remainder of the plan year.

If you leave your job, your myFBMC Card® will be canceled.

COBRA coverage will consist of the amount you have in your MSA at the time of the qualifying event, plus additional contributions up to the annual amount you elected to contribute. You will be charged a 2 percent administrative fee. The use-it-or-lose-it rule will continue to apply. You will lose any funds remaining in your account at the end of the grace period, and COBRA coverage will end. WageWorks, the third-party

A MoneyPlus MSA, even a spouse's MSA, is considered other health insurance under HSA regulations. However, if you have no funds in your MSA on December 31, you may begin contributing to an HSA on January 1.

If you have a Limited-use MSA, you may begin making HSA contributions on January 1. A Limited-use MSA may only be used for dental and vision expenses, so it is not other health insurance.

claims processor, will contact you regarding continuation of coverage.

If you do not continue your MSA as permitted under COBRA, you have 90 days from your last day worked to submit eligible MSA expenses incurred before you left employment. Any funds still in your account will not be returned to you.

The Family and Medical Leave Act (FMLA) may affect your rights to continue coverage while on leave. Please contact your employer for further information.

Dependent Care Spending Account

If you leave your job permanently or take an unpaid leave of absence, you cannot continue contributing to your Dependent Care Spending Account. You can, however, request reimbursement for eligible expenses incurred while you were employed, until you exhaust your account or the plan year ends.

Health Savings Account

Subscribers enrolled in the State Health Plan Savings Plan can save money for qualified medical expenses tax free through a Health Savings Account (HSA).

Eligibility

To be eligible for the state's HSA, a subscriber must be covered by the Savings Plan, which is a High Deductible Health Plan (HDHP). He cannot be covered by any other health plan that is not a HDHP, including Medicare. However, he can be covered for specific injuries, accidents, disability, dental care, vision care and long-term care. He cannot be claimed as a dependent on another person's income tax return.

An eligible subscriber may establish an HSA offered through any qualified financial institution. However, to contribute to an HSA on a pretax basis through payroll deduction, he must enroll in the MoneyPlus HSA. Wells Fargo is the custodian for these accounts. The accounts are administered by WageWorks.

Retirees please note a retiree who is not enrolled in Medicare may be covered by the Savings Plan and contribute to an HSA.

If you are retired and eligible for and enrolled in Medicare, you may not contribute to an HSA.

Enrolling in an HSA

When you have met the eligibility requirements for an HSA, complete a MoneyPlus enrollment form choosing the HSA option. Give the form to your benefits administrator. If you would like to open an HSA with Wells Fargo go to the PEBA insurance benefits website, www.eip.sc.gov, and click on "Links." Under "MoneyPlus," select "Open HSA Bank Account with Wells Fargo." You will need to know your Employer HSA ID number (002470000000000) (00247 followed by 10

zeroes), your type of coverage (single or family) and your Social Security number.

If you don't have Internet access and want to open a MoneyPlus HSA, check with your benefits administrator.

Once you enroll in an HSA, you do not have to re-enroll in it as long as you remain eligible for it.

Active subscribers enrolled in the Savings Plan, upon turning 65, remain eligible to contribute to an HSA, if they delay enrollment in Medicare Part A by delaying receiving Social Security. (A person can delay enrolling in Social Security until age 70½.) Once this subscriber enrolls in Social Security (Part A of Medicare), usually at retirement, he can no longer make contributions to an HSA, including catch-up contributions. However, the funds already in the HSA can be withdrawn to pay Medicare premiums (not Medigap premiums), deductibles and coinsurance, which are qualified expenses.

Retirees enrolled in the Savings Plan are eligible to contribute to an HSA (although not through MoneyPlus). They may enroll in the HSA at Wells Fargo, or any other institution that offers an HSA, and make catch-up contributions. The retiree may claim his HSA contribution on his income tax return.

Limited-use Medical Spending Account

If you have an HSA, you also may be eligible for a Limited-use MSA. That account may be used for expenses not covered by your health insurance, the Savings Plan. Eligible expenses include dental and vision care. See page 159 for more information.

If you enrolled in a full MSA instead of an HSA, you cannot sign up for an HSA until the next enrollment period or until a special eligibility situation occurs that allows you to end your MSA within 31 days of the event.

Contributions

The maximum contribution to an HSA is indexed for inflation. In 2016, a subscriber with single coverage can contribute $3,350, and a subscriber who covers himself and any other family member can contribute $6,750. Total contributions for the entire year may not exceed these limits.

- For example, a subscriber with single coverage under the Savings Plan can contribute $3,350 to his HSA for the 12 months beginning January 1, 2016. Contributions may be paid in a lump sum, in equal amounts for 12 months (such as through payroll deduction with MoneyPlus) or in any combination of payments during the year, as long as the total does not exceed $3,350.
- A subscriber with the same coverage who enrolls by December 1, 2016, may also contribute $3,350. However, he must remain eligible for a full 12 months after the end of the plan year. Contributions may be paid in a lump sum, in equal amounts during the months he is eligible (such as through payroll deduction with MoneyPlus) or in any combination of payments during the year, as long as the total does not exceed $3,350.
- A subscriber who had funds in an MSA on December 31, 2015, may not

The Employer HSA ID number for an account at Wells Fargo is 002470000000000.

begin contributing to an HSA until the day after the end of the MSA run-out period, April 1, 2016. However, his maximum contribution would still be $3,350. Contributions may be paid in a lump sum, in equal amounts for nine months (such as through payroll deduction with MoneyPlus) or in any combination of payments during the year, as long as the total does not exceed $3,350. He must remain eligible for 12 months after the end of the plan year.

- A subscriber who had no funds in his MSA on December 31, 2015, may make the maximum contribution to his HSA in 2015 and may begin contributing on January 1, 2016. Contributions may be paid in a lump sum, in equal amounts for 12 months (such as through payroll deduction with MoneyPlus) or in any combination of payments during the year, as long as the total does not exceed $3,350.

Subscribers age 55 and older may make additional "catch-up" contributions to an HSA. The amount for 2016 is $1,000.

There is no minimum contribution, but remember that administrative fees will be deducted from your account. HSAs established at Wells Fargo through MoneyPlus include a WageWorks fee of $1.50 per month. You also pay a bank fee of $1.75 per month, until your account exceeds $2,500.

The HSA Custodial Account disclosure statement and funds availability disclosure agreement is available at www.eip.sc.gov, or by contacting WageWorks Customer Care at 800.342.8017 or www.myFBMC.com.

For information about a Wells Fargo HSA go to www.wellsfargo.com or call 866.884.7374.

General HSA information is available from the U.S. Dept. of the Treasury at www.treasury.gov/resource-center/faqs/Taxes/Pages/Health-Savings-Accounts.aspx.

Changing contributions

Unlike an MSA, you may enroll, change or stop your contributions to your MoneyPlus HSA through payroll deduction once a month. To make the change, fill out a new MoneyPlus Enrollment Form and complete Box A.

You may make regular and catch-up contributions to your HSA up to the time your federal income tax return is due, usually April 15.

Contributions over federal limits

WageWorks will monitor your HSA contributions and send an alert to your benefits administrator if you are exceeding your contribution limit.

However, the best way to avoid problems is to divide your annual contribution among the number of paychecks you receive. For example, if you have single coverage, you can deduct a maximum of $3,350 for 2016. If you receive 24 paychecks each year, you can deduct $139.58 (rounded down) each pay period. If you have family coverage, you can deduct a maximum of $6,750 for 2016. If you receive 24 paychecks a year, you can deduct $281.25 each pay period.

Using HSA funds

After you enroll in an HSA, you will receive a Visa® debit card from Wells Fargo. You may order additional cards by calling Wells Fargo at 866.884.7374 or by logging into your account at www.wellsfargo.com. You should receive the card within 10 business days. You can also order a supply of checks by calling this

number. You may use the card or the checks to reimburse yourself from your HSA. Using a check without sufficient funds in your account will result in additional fees.

One important difference between an HSA and an MSA is that on January 1, after open enrollment, which occurs yearly in October, you have immediate access to your full yearly contribution to an MSA. This is not true of an HSA. You can only withdraw HSA funds that are actually in your account. If you use your debit card for a transaction and you do not have enough money in your account, the transaction will not go through or you will be charged an overdraft fee. If you write a check and you do not have enough money in your account, you will be charged for writing a check with insufficient funds.

Availability of funds

Each contribution to your MoneyPlus HSA will be available after your employer's payroll is received and processed by WageWorks, transferred to Wells Fargo and deposited in your account. Deposits are sent to Wells Fargo twice a week. Funds should generally be available in your HSA no later than a week after your pay date. Remember, this depends on when your employer submits the deductions and payroll reports.

You will receive monthly statements from Wells Fargo. You may also check your balance by visiting any Wells Fargo banking location.

Through the online Wells Fargo Health Account Manager, you can check your balance, make online contributions, review monthly statements and annual tax reporting, transfer funds, set up your HSA investment account and more. After your account is open, go to wellsfargo.com and sign up for online access.

HSA administrative fees per month	
Health Savings Account (WageWorks fee)[1]	$1.50
Health Savings Account (Wells Fargo fee)[2, 3]	$1.75

[1]This fee is deducted from your paycheck.
[2]This fee, for HSAs established with Wells Fargo Bank, is deducted from your account. The fee is waived for accounts with balances of $2,500 or more.
[3]There is no fee for processing checks. There is a $15 one-time fee for a basic order of checks. There is no charge if you use your Visa® debit card. There may be additional fees, such as those for insufficient funds. All fees are deducted from your HSA.

Please note: If you are already registered with another Wells Fargo account, your user name and password will stay the same. You will see your HSA listed next to your other Wells Fargo accounts.

The $1.75 monthly service charge continues, even when your HSA balance reaches $0. As a result, your account will be overdrawn, and you will be subject to additional charges.

There is no charge for these services.

You can make deposits to, or withdrawals from, your account at any Wells Fargo banking location. You may also use your Wells Fargo Visa® HSA debit card at a Wells Fargo ATM to reimburse yourself for out-of-pocket expenses. Any withdrawals must be for medical expenses that qualify under IRS guidelines. If they do not qualify, they may be subject to taxes and penalties.

Eligible expenses

You may use the funds in your HSA, tax free, to pay for unreimbursed eligible medical expenses for yourself, your spouse and your tax dependents. Medical expenses include the costs of diagnosis, cure, treatment or prevention of physical or mental defects or illnesses, including dental and vision expenses. HSA funds can only be used tax-free to

pay for over-the-counter drugs if the drugs were prescribed by a physician. For more information, contact the IRS.

Documentation of eligible expenses

You should keep receipts for expenses paid from your HSA with your tax returns in case the IRS audits your tax return and requests copies.

If you use HSA funds for ineligible expenses, you will be subject to taxes on the amount you took from your HSA, as well as a 20-percent penalty if you are younger than age 65.

HSA fees

If you deposit funds to your HSA through payroll deduction, administrative fees will be deducted. There are no transaction fees for investing in mutual fund options.

If you will not contribute to your MoneyPlus HSA during the year but want to keep your account with Wells Fargo open, you must continue to pay the $1.75 monthly fee, until you have a minimum balance of $2,500. There is no WageWorks fee if you are not actively contributing.

Investment of HSA funds

One of the advantages of an HSA is that you do not have to spend all the funds during the year in which they are deposited, as you do with a MSA. The funds can accumulate and can be used for eligible medical expenses in the future.

Your funds will initially be held in an interest-bearing checking account with Wells Fargo. As the account grows, you may be eligible to place your funds over $2,000 into the Wells Fargo Advantage Funds options.

Unlike funds in an interest-bearing checking account, money invested in a mutual fund is not FDIC-insured. You have the opportunity to earn a higher rate of return on your investment, but that is not guaranteed. There is a possibility you will lose money, including the original amount invested.

Portability (Continuing your coverage)

If you leave your job, you can take your HSA with you and continue to use it for qualified medical expenses.

Tax reporting

After year end, Wells Fargo will send you tax filing information to use in reporting your HSA contributions and withdrawals when you file your taxes. It is important to save documentation, including receipts, invoices and explanations of benefits from your health insurance carrier, in case you are asked to show the IRS proof that your HSA funds were used for qualified expenses.

If you participate in MoneyPlus, pretax HSA contributions will appear on your W-2 Form as employer-paid contributions. This is because this money was deducted from your salary before it was taxed. Do not deduct this money on your return. Only after-tax contributions may be deducted. Consult your tax advisor for more information.

If you have questions about how your HSA contributions were reported on your W-2 Form, contact your benefits office.

Closing your HSA

If you are no longer eligible to contribute to an HSA, or no longer wish to do so, you must go to your benefits administrator and complete

a MoneyPlus Enrollment Form. Enter "$0" in Section A to stop contributions to the account. You and your benefits administrator must sign the form before your benefits administrator submits it.

If money remains in the account, you may continue to use it for qualified, unreimbursed medical expenses. To close the account, contact the Wells Fargo HSA Account Holder customer service line at 866.884.7374.

How death affects your MoneyPlus accounts

Flexible Spending Accounts

Medical Spending Accounts (MSA) and Dependent Care Spending Accounts (DCSA) end on the date the employee dies. They are not refunded to the survivor.

An IRS-qualified dependent/beneficiary may continue an MSA through the end of the plan year under COBRA. Contact WageWorks or your benefits administrator for more information. If the MSA is not continued through COBRA, the beneficiary has 90 days from the date of death to submit claims for eligible expenses incurred through the date of death.

DCSA claims incurred through the date of death may be submitted until the account is exhausted or through the end of the year.

The death of a spouse or child creates a "change in status" that makes it possible to stop, start or vary the amount contributed to an MSA or DCSA. You have 31 days from the date of death to make the change. See Page 152 for information about changing your contribution.

Health Savings Accounts

If the beneficiary of the Health Savings Account (HSA) is the account owner's spouse, the HSA can be transferred to an HSA in the spouse's name. If the beneficiary is not the spouse, the account will cease to be an HSA on the date of death. If the beneficiary is the account owner's estate, the fair market value of the account on the date of death will be taxable on the account owner's final return. For beneficiaries other than the spouse or the estate, the fair market value of the account is taxable to the beneficiary for the tax year in which the account owner died.

For more information, see Section VII of the Health Savings Account Custodial Agreement. A copy of the agreement is on the PEBA insurance benefits website, www.eip.sc.gov. To settle the account, contact the bank that is the custodian of the account.

Appeals

If your request for reimbursement, claim for benefits or mid-plan-year election change is denied, in full or in part, you have the right to appeal the decision by sending a written request within 30 days of the denial for review to WageWorks (Attn: Appeals Process), P.O. Box 14766, Lexington, KY 40512-4766). Please retain copies of claims and receipts for your records.

Your appeal must include:

- The name of your employer
- The date of the services for which your request was denied
- A copy of the denied request
- A copy of the denial letter you received
- Why you think your request should not have been denied and
- Any additional documents, information or

comments you think may have a bearing on your appeal.

Your appeal will be reviewed when it and its supporting documentation are received. You will be notified of the results of this review within 30 business days from receipt of your appeal. In unusual cases, such as when an appeal requires additional documentation, the review may take longer than 30 business days. If your appeal is approved, additional processing time is required to modify your benefit elections.

If you are still dissatisfied after the decision is re-examined, you may ask PEBA Insurance Benefits to review the matter by making a written request to PEBA Insurance Benefits within 90 days of notice of the denial. If the denial is upheld by the PEBA Insurance Benefits Appeals Committee, you have 30 days to seek judicial review as provided by Sections 1-11-710 and 1-23-380 of the S.C. Code of Laws, as amended.

Note: Appeals are approved only if the extenuating circumstances and supporting documentation are within your employer's, your insurance provider's and IRS' regulations governing the plan.

MoneyPlus example

This is how paying eligible expenses with a pretax payroll deduction may increase your spendable income. The figures used are monthly and for a single person covered under the S.C. Retirement System with two dependents.

There is an increase in spendable income of $187.33 per month, or $2,247.96 per year.

Note: "Spendable income" is your net pay, plus the reimbursement from your Medical Spending Account or Dependent Care Spending Account.

	Without MoneyPlus	With MoneyPlus
Gross monthly pay	$2,500.00	$2,500.00
State retirement	- 187.50	- 187.50
Pretax payroll deduction	- 0.00	- 614.40
Administrative fees		
Pretax Group Insurance Premium Feature	0.00	0.28
Dependent Care Spending Account	0.00	3.14
Medical Spending Account[1]	0.00	0.00
Taxable gross income	2,312.50	1,698.10
Payroll taxes (estimate)	- 696.78	- 513.50
Eligible expenses[2]	- 614.40	- 0.00
Spendable income	$1,001.32	$1,188.40

1A subscriber enrolled in both a DCSA and an MSA pays one administrative fee of $3.14 a month.
[2]In this illustration, these examples of monthly pretax payroll deductions and eligible, after-tax expenses were used:
Health premium - $143.86
Dental premium - $13.72
Dependent care expenses - $400.00
Out-of-pocket medical expenses - $56.82
Total - $614.40

Retirement and disability

Benefits for retirees

This chapter provides information for eligible participants in the state insurance program who are considering retirement or who have retired. For detailed information on specific programs, refer to the previous chapters in this guide.

If you are eligible for retiree insurance, you must enroll within 31 days of your eligibility date or of a special eligibility situation, or during open enrollment. See Pages 171-172 for more information.

If you have questions or need more information about your insurance, contact the South Carolina Public Employee Benefit Authority (PEBA) through its insurance benefits website at www.eip.sc.gov, write to 202 Arbor Lake Drive, Columbia, SC 29223 or call 803.737.6800 (toll-free at 888.260.9430).

If you or a family member you cover is eligible for Medicare, you will find helpful information in PEBA's *When You Become Eligible for Medicare* handbook, as well as in this chapter. A copy of the Medicare handbook is posted on PEBA's website. It is also available by contacting PEBA.

Planning for your retirement

PEBA cannot confirm eligibility or funding of your retirement insurance premiums over the telephone. If your anticipated retirement date is within 90 days, please submit an Employment Verification Record with a Retiree Notice of Election form. If your anticipated retirement date is three to six months away, you may submit a written request, which includes your anticipated retirement date and your Employment Verification Record, and PEBA Insurance Benefits will send you a written confirmation of your eligibility. PEBA will not confirm eligibility more than six months before your retirement date. Information about planning for insurance in retirement is offered on the PEBA's insurance benefits website, www.eip.sc.gov.

PEBA is the final authority on eligibility for retirement benefits and for insurance benefits. You must file applications with PEBA for retirement benefits and for insurance benefits in retirement. Neither benefit is automatic.

Are you eligible for retiree insurance?

Please note: Eligibility for retiree group insurance is not the same as eligibility for retirement. It is recommended that you review the requirements for retiree group insurance in this section and that you contact PEBA to confirm your eligibility for retirement and for retiree group insurance before you set your retirement date.

To determine what part of your insurance premium you will pay, see *Will Your Employer Pay Part of Your Premiums?* on Page 165-168.

You may be eligible for health, dental and vision coverage in retirement if you meet these criteria:

1. You retire from an employer that participates in the state insurance program.
2. You are eligible to retire when you leave employment.

3. Your last five years of employment were served consecutively in a full-time, permanent position with an employer that participates in the state insurance program.

Please note: If there is a break in your last five years of employment because you were on unpaid leave or were receiving Workers' Compensation benefits, please contact PEBA insurance benefits before making final arrangements for retirement.

For insurance purposes, members of a defined benefit plan administered by PEBA must meet the minimum retirement eligibility requirements established by the system in which they participate when they leave covered employment. Defined benefit plans administered by PEBA include the South Carolina Retirement System (SCRS), Police Officers Retirement System (PORS), General Assembly Retirement System (GARS) and Judges and Solicitors Retirement System (JSRS).

For more information about state retirement eligibility, call PEBA at 803.737.6800 or 888.260.9430, or go to the retirement benefits website, www.retirement.sc.gov.

Employees who started work before July 1, 2012

- SCRS members must have at least five years of earned service credit and be eligible to retire due to age (60) or years of service (28 years) or be approved for SCRS disability retirement. SCRS members are also eligible to retire at age 55 with at least 25 years of service.
- PORS members must have at least five years of earned service credit and be eligible to retire due to age (55) or years of service (25 years) or be approved for PORS disability retirement.
- Retirees of a local subdivision that does not participate in PEBA Retirement Benefits must have 28 years of service or have reached age 60 or be approved for disability through Standard Insurance Company. Their last five years of employment must be served consecutively in a full-time permanent position with an employer that participates in the state insurance program.

Exception:

- Former municipal and county council members who served on council for at least 12 years and were covered under the state insurance program by a participating employer when they left council may be eligible for retiree insurance if the county or municipal council on which they served allows coverage for former members.

Employees who started work on or after July 1, 2012

- SCRS members must have at least eight years of earned service credit and satisfy the Rule of 90 requirement (age plus years of service credit equals 90) or be approved for SCRS disability retirement.
- PORS members must have at least eight years of earned service credit and be eligible to retire due to age (55) or years of service (27 years) or be approved for PORS disability retirement.
- Retirees of a local subdivision that does not participate in PEBA Retirement

Benefits must have 28 years of service or have reached age 60 or be approved for disability through Standard Insurance Company. Their last five years of employment must be served consecutively in a full-time permanent position with an employer that participates in the state insurance program.

Exception:

- Former municipal and county council members who served on council for at least 12 years and were covered under the state insurance program by a participating employer when they left council may be eligible for retiree insurance if the county or municipal council on which they served allows coverage for former members.

Employees who participate in the State Optional Retirement Program

There is no minimum age or years of service requirement for State Optional Retirement Program (State ORP) participants. They become eligible to receive distributions when they leave employment or reach age 59 ½.

However, eligibility for retiree group insurance is not the same as eligibility for retirement. To be eligible for retiree group insurance, State ORP participants must:

- Have 28 years of service with a state insurance participating employer or
- Have five years of service with a state insurance participating employer and have reached age 60.

The employer must verify time worked as a State ORP participant.

Disability retirement

You may be eligible for retiree group insurance if you have been approved for disability retirement benefits through one of the defined benefit plans administered by PEBA Retirement Benefits: South Carolina Retirement System (SCRS), Police Officers Retirement System (PORS), General Assembly Retirement System (GARS) or Judges and Solicitors Retirement System (JSRS). For more information, see below or contact PEBA.

The State ORP does not provide disability protection. However, a State ORP participant may meet the retirement eligibility requirement for retiree group insurance through approval by the Standard Insurance Company for Basic Long Term Disability and/or Supplemental Long Term Disability.

Employees of local subdivisions that do not participate with PEBA's retirement benefits may meet the disability retirement eligibility requirement for retiree group insurance through approval by the Standard Insurance Company for Basic Long Term Disability and/or Supplemental Long Term Disability.

Eligibility for disability retirement

South Carolina Retirement System (SCRS) members

Disability retirement eligibility for SCRS members is based on entitlement to Social Security disability benefits. The member must have at least five years of earned service credit if he was hired before July 1, 2012, and at least eight years of earned service credit if he was hired on or after July 1, 2012, unless the disability is the result of an on-the-job injury.

Applications must be filed while the member is still "in service," even if he has not been approved for Social Security disability. A member is considered in service on the date the application is received by PEBA if:

1. The last day the member was employed by a covered employer was no more than 90 days before the date PEBA received the application; and
2. The member had not been retired on a service retirement allowance for more than 90 days at the time PEBA received the application.

A member must provide a copy of the Social Security Award Letter to PEBA Retirement Benefits. The benefit will be effective on the date the Social Security Administration (SSA) determines the disability began or the day after the member's termination date, whichever is later.

A member will not be eligible for SCRS disability benefits if the date the SSA determines the disability began is more than one year after the member's termination date.

Police Officers Retirement System (PORS) members

To be eligible for PORS disability retirement benefits, the member must have at least five years of earned service credit if he was hired before July 1, 2012, and at least eight years of earned service credit if he was hired on or after July 1, 2012, unless the disability is the result of an on-the-job injury. The member must be permanently incapacitated from performing job duties.

PORS disability retirement claims are evaluated by a disability determination provider and a medical board.

Insurance coverage for disability retirees

If you are approved for disability before you leave employment, you may apply for insurance coverage as a retiree within 31 days of notification by PEBA Retirement Benefits. State ORP participants and employees of local subdivisions that do not participate with PEBA Retirement Benefits may meet the disability retirement eligibility requirement for retiree group insurance through approval by Standard Insurance Company for Basic Long Term Disability and/or Supplemental Long Term Disability. Your coverage as a retiree will be effective the first of the month after you leave active employment.

If you leave employment before your application for disability is approved, you may enroll in continued coverage under COBRA for health, dental and vision benefits. Another option for health insurance is to enroll in coverage through the Health Insurance Marketplace.

If your disability application is later approved by PEBA Insurance Benefits, you may apply for coverage as a retiree within 31 days of notification. You may choose that your insurance coverage as a retiree be effective the first of the month after the date of notification or the first of the month after your date of retirement. You will be responsible for payment of all retroactive premiums.

How TERI participation affects retiree insurance

If you are a Teacher and Employee Retention Incentive (TERI) program participant in a permanent, full-time position, your insurance benefits as an active employee continue. When your TERI participation ends, you must

apply for continuation of your insurance as a retiree (if eligible) within 31 days of your date of termination. Your service as a TERI participant in a full-time, permanent position with a participating employer may be applied toward retiree insurance eligibility.

Will your employer pay part of your premiums?

As an active employee, your employer must pay part of the cost of your health and dental insurance. When you retire, the amount your employer contributes to your retiree insurance premiums is based on several factors, including the type of agency from which you retired.

State agency, higher education and public school district retirees

You may be eligible for a state contribution to your retiree insurance premiums based on when you began employment and on your number of years of earned service credit with an employer that participates in the state insurance program.

Local subdivision retirees

Retiree insurance eligibility guidelines are the same for local subdivision retirees as they are for state, higher education and public school district retirees. However, the funding may be different. Local subdivisions may or may not pay a portion of the cost of their retirees' insurance premiums. Each local subdivision develops its own policy for funding retiree insurance premiums for its eligible retirees. If you are a local subdivision employee, contact your benefits office for information about retiree insurance premiums.

Employees hired before May 2, 2008

If you worked in an insurance-eligible position before May 2, 2008, with an employer participating in the state insurance program, your health insurance premiums are based on the number of years of earned service with an employer participating in the state insurance program.

For insurance eligibility purposes, earned service credit is time earned and established with one of the plans administered by PEBA Retirement Benefits [South Carolina Retirement System (SCRS), Police Officers Retirement System (PORS), General Assembly Retirement System (GARS) or Judges and Solicitors Retirement System (JSRS)]. Insurance eligibility can also be earned through time worked while participating in the State Optional Retirement Program (State ORP) or time worked with a local subdivision that participates in PEBA Insurance Benefits but not with PEBA Retirement Benefits.

This includes time that you worked for an employer that participates in the state insurance program, even if you did not participate in any coverage offered through the program. Periods of non-qualified service, federal service, military service and out-of-state service purchased in the retirement systems, as well as sick leave and service with employers that do not participate in the state insurance program, do not count toward earned service with PEBA Insurance Benefits. State ORP participants cannot purchase time to meet eligibility. Service as a TERI participant in a full-time, permanent position with a participating employer may be applied toward earned service credit to determine retiree insurance eligibility.

Retirees hired before May 2, 2008, may be funded or non-funded. A funded retiree's former employer contributes to his retiree

insurance premiums. A non-funded retiree receives no contribution. He is responsible for the entire cost.

Funded retirees (Employer pays its part of the premium)

To be eligible for funded retiree insurance, you must be eligible to retire and meet one of these criteria:

- You left employment when you were eligible to retire and you have at least 10 years of state-covered entity service credit with an employer that participates in the state insurance program. The last five years of earned service credit must have been served consecutively in a full-time, permanent position with a state agency, a higher education institution or a public school district. You may enroll within 31 days of your retirement or of a special eligibility situation, or during open enrollment.
- You left employment before you were eligible to retire but when you left, you had at least 20 years of earned service credit with an employer that participates in the state insurance program. The last five years must have been served consecutively in a full-time, permanent position with a state agency, a higher education institution or a public school district.

If you are an SCRS member and you kept your contributions in your SCRS account, you may enroll within 31 days of your 60th birthday (when you become eligible to apply for a deferred retirement annuity*) or of a special eligibility situation, or during open enrollment.

*If you left employment before age 60, you may apply for a service retirement benefit when you turn age 60. You may also apply for a refund. However, if you do take your contributions from your account, your years of service credit will not count toward retiree insurance eligibility.

If you are a PORS member and kept your contributions in your account, you may enroll within 31 days of your 55th birthday, when you become eligible to apply for a deferred retirement annuity, or of a special eligibility situation or during open enrollment.

Non-funded retirees (You pay the entire premium)

To be eligible for non-funded retiree insurance, you must be eligible to retire and must meet one of these criteria:

- You left employment when you were eligible to retire and you have at least five years, but fewer than 10 years, of earned service credit with an employer that participates in the state insurance program. The last five years must have been served consecutively in a full-time, permanent position.

You may enroll within 31 days of your retirement or of a special eligibility situation, or during open enrollment.

- You left employment when you were eligible to retire and you retire at age 55 with at least 25 years of SCRS service credit, including 10 years of earned service credit with an employer participating in the state insurance program. This is referred to as the “55/25 rule.” The last five years must be served consecutively in a full-time, permanent position. If you enroll in health insurance, you must pay the full insurance premium until you reach age 60 or the date you

would have had 28 years of service credit, whichever occurs first. At the end of this period, you will begin to pay funded retiree rates if your last five years of service were with a state agency, a higher education institution or a public school district.

This rule applies only to SCRS members.

You may enroll within 31 days of your retirement or of a special eligibility situation, or during open enrollment.

If you do not enroll in health insurance when you retire under the 55/25 rule, you may enroll within 31 days of the date you turn age 60 or would have had 28 years of service credit, whichever occurs first. However, it is your responsibility to keep up with when you become eligible for funded rates and to notify your benefits administrator. If you worked for a local subdivision, your benefits administrator is your former employer. Otherwise, your benefits administrator is PEBA Insurance Benefits.

- You left employment before you were eligible to retire but when you left, you had at least 25 years of SCRS service credit, including 20 years of earned service credit, with an employer that participates in the state insurance program. The last five years must have been served consecutively in a full-time, permanent position.

If you kept your contributions in your SCRS account, you may enroll within 31 days of your 55th birthday, which is when you become eligible for a deferred retirement annuity*, or a special eligibility situation or during open enrollment. If you enroll at age 55, you must pay the full insurance premium until you reach age 60 or the date you would have had 28 years of service credit, whichever occurs first. At the end of the period, you will begin to pay funded retiree rates, if your last five years of service were with a state agency, a higher education institution or a public school district.

*If you left employment before age 55 and kept your contributions in your SCRS account, you may apply for a service retirement benefit when you turn age 55. You may also apply for a refund. However, if you do take your contributions from your account, your years of service credit will not count toward retiree insurance eligibility.

If you do not enroll in health insurance within 31 days of your 55th birthday, you may enroll within 31 days of the date you turn age 60 or would have had 28 years of service credit, whichever occurs first. You will be eligible for funded rates. However, it is your responsibility to keep up with when you become eligible for funded rates and to notify your benefits administrator. If you worked for a local subdivision, your BA is in the personnel office at your former employer. Otherwise, it is PEBA Insurance Benefits.

This rule applies only to SCRS members.

- You are a former municipal or county council member who served on council for at least 12 years and were covered under the state's insurance program when you left the council. It is up to the county or municipal council to decide whether to allow former members to have this coverage. However, you are required to pay the full, non-funded premium.

Employees hired on or after May 2, 2008

Retiree insurance eligibility guidelines established by S.C. Code Ann. Section 1-11-730 (B) apply to new employees hired on or after May 2, 2008. At retirement, you must meet established insurance eligibility rules. Funding

for your health insurance will be determined by calculating the number of years of earned service with an employer participating in the state insurance program.

For insurance eligibility purposes, earned service credit is time earned and established with one of the plans administered by PEBA Retirement Benefits [South Carolina Retirement System (SCRS), Police Officers Retirement System (PORS), General Assembly Retirement System (GARS), or Judges and Solicitors Retirement System (JSRS)]. Insurance eligibility also can be earned by time worked while participating in the State Optional Retirement Program (State ORP) or time worked with a local subdivision that participates in PEBA Insurance Benefits but not with PEBA Retirement Benefits.

This includes time that you worked for an employer that participates in the state insurance program, even if you did not participate in coverage offered through the program. Periods of non-qualified service, federal service, military service and out-of-state service purchased in the retirement systems, as well as sick leave and service with employers that do not participate in the state insurance program, do not count toward earned service with PEBA Insurance Benefits. State ORP participants cannot purchase time to meet eligibility. Service as a TERI participant in a full-time, permanent position with a participating employer may be applied toward earned service credit to determine retiree insurance eligibility.

These funding provisions apply to retirees of state agencies, public school districts and higher education institutions.

Funded retirees (Employer pays its part of the premium)

To be eligible for funded retiree insurance, you must be eligible to retire and have at least 25 years of earned service credit with an employer that participates in the state insurance program. The last five years of service must be served consecutively in a full-time, permanent position. Your former employer pays 100 percent of the employer's share, and you pay the retiree's share.

Partially funded retirees (You split the employer's part of the premium)

To be eligible for partially funded retiree insurance, you must be eligible to retire and have at least 15 years, but fewer than 25 years, of earned service credit with an employer that participates in the state insurance program. The last five years of service must be served consecutively in a full-time, permanent position. Your former employer pays 50 percent of the employer's share of the premium. You pay the retiree's share plus the remaining 50 percent of the employer's contribution.

Non-funded retirees (You pay the entire premium)

To be eligible for non-funded retiree insurance, you must be eligible to retire and have at least five years, but fewer than 15 years, of earned service credit with an employer that participates in the state insurance program. The last five years of service must be served consecutively in a full-time, permanent position. As a non-funded retiree, you pay the entire cost of the insurance. There is no contribution from your former employer.

Medicare and retirement

This section of the Retirement and Disability

chapter provides basic information about ways in which you could become eligible for Medicare.

To learn more about how health insurance offered through PEBA works with Medicare:

- Read PEBA's *When You Become Eligible for Medicare* handbook
- Call PEBA at 803.737.6800 or 888.260.9430.

To learn more about Medicare:

- Read *Medicare and You 2016*
- Go to the Medicare website at www.medicare.gov
- Call Medicare at 800.633.4227 or 877.486.2048 (TTY).

Medicare before age 65: Disability retirees

If you or your eligible spouse or child becomes eligible for Medicare before age 65 due to disability, you must notify PEBA within 31 days of Medicare eligibility by sending in a copy of your Medicare card.

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

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

Even if you are not enrolled in Medicare, PEBA will still become secondary when you become eligible for Medicare.

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

A chart showing how the Medicare Supplemental Plan and the Standard Plan pay with Medicare is in PEBA's *When You Become Eligible for Medicare* handbook. To enroll in the Medicare Supplemental Plan, you must complete a Retiree Notice of Election form. Send it to PEBA if you worked for a state agency, a college or university or a public school district. If you worked for a local subdivision, send it to your benefits administrator. Coverage will begin the first of the month after PEBA is notified that you are covered by Medicare.

Medicare at 65 if you are retired

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

Medicare's Initial Enrollment Period starts three months before your 65th birthday, includes the month of your birthday and extends three months past the month you turn 65. If you are not receiving Social Security

benefits, you should ask about enrolling in Medicare three months before you turn age 65 so your Medicare coverage can start the month you turn 65.

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

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

If you are an active employee at age 65

If you are actively working and/or covered under a state health insurance plan for active employees, you may delay enrollment in Part B because your insurance as an active employee remains primary. If you are an active employee but your spouse is eligible for Medicare, your spouse should enroll in Part A but may delay enrollment in Part B until you retire and your active coverage ends.

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

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

When you leave active employment after age 65

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

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

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

If your spouse or child is eligible for Medicare

If you are a retiree and your spouse or child

is eligible for Medicare and you are not, they can enroll in the Medicare Supplemental Plan. Family members who are not eligible for Medicare will be covered under the Standard Plan provisions.

Sign up for Parts A and B of Medicare

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

How Turning down Part B Affects Medicare Coverage

Unless you are covered as an active employee at the time, if you turn down Medicare Part B when you are first eligible, you must wait until Medicare's General Enrollment Period. This period is from January 1 to March 31 of each year, and coverage begins on July 1. Your Medicare premium will be 10 percent higher for each year you were not covered by Part B after you were first eligible. Contact Medicare for enrollment details and for premium information that applies specifically to you.

Enrolling in insurance coverage as a retiree

Your insurance is NOT automatically continued when you retire. In addition to completing your retirement paperwork through PEBA retirement benefits, to continue your coverage, you must enroll in retiree insurance with PEBA insurance benefits. To do so, you must complete the Retiree Notice of Election form and the Employment Verification Record. It is recommended that you submit these forms 30 days before your retirement date. This will allow time to process your enrollment so that your insurance coverage as a retiree starts the day your coverage as an active employee ends. You must submit a *Retiree Notice of Election* form and an Employment Verification Record within 31 days of the date you retire or a special eligibility situation. You also may be eligible to enroll during open enrollment.

MyBenefits, PEBA's online insurance benefits enrollment system, is available to retirees. To learn more, see Page 16.

You can print these forms from the PEBA website, www.eip.sc.gov, get copies from your employer or ask PEBA for a retiree insurance enrollment packet by calling 803.737.6800 or 888.260.9430.

If you would like to meet with a PEBA representative come to PEBA's office at 202 Arbor Lake Drive, Columbia. The office is open Monday through Friday, 8:30 a.m. to 5 p.m. Appointments are not scheduled, but walk-ins are welcome.

Within 31 days of retirement

If you are an eligible retiree, you must enroll within 31 days of:

- Your retirement date or
- The end of your TERI period or
- The date on the letter approving your disability retirement from one of PEBA Retirements' defined benefit plans [South Carolina Retirement System (SCRS), Police Officers Retirement System (PORS), General Assembly Retirement System (GARS), or Judges and Solicitors Retirement System (JSRS)] or
- The date on the letter approving

your BLTD/SLTD retirement if you are retiring under State ORP or from an employer that is not covered under PEBA Retirement Benefits.

You may enroll yourself and any eligible family members. However, you are not required to cover the same eligible family members as a retiree that you covered as an active employee.

You may be required to submit the appropriate documents to show that the family members you wish to cover are eligible for coverage. For more information, see Page 13.

After PEBA Insurance Benefits processes your retiree insurance enrollment, you will receive a letter from PEBA Insurance Benefits confirming the coverage selected and the premiums due each month. You have 31 days from the date your retiree insurance becomes effective to make any corrections or changes to your coverage. Otherwise, you must wait to make changes until the next open enrollment period, which occurs yearly in October, or a special eligibility situation. If you do not enroll within 31 days of eligibility, your next opportunity to add or drop dental coverage will be during open enrollment in October of an odd-numbered year.

Note: While some benefits administrators may help you complete your Retiree Notice of Election and Employment Verification Record, it is your responsibility to make sure the forms are received by PEBA within 31 days of your retirement date.

MoneyPlus accounts

To learn how retirement affects your Medical Spending Account and your Dependent Care Spending Account, see Pages 152-153.

Within 31 days of a special eligibility situation

A special eligibility situation is created by certain events. It allows eligible employees and retirees to enroll in an insurance plan, or to make enrollment changes, if the changes are requested within 31 days of the event. For more information, see Pages 16-23.

During open enrollment

If you and/or your spouse and children do not enroll within 31 days of retirement, disability approval or a special eligibility situation, you may enroll during open enrollment, which is offered yearly in October. Dental coverage may be added or dropped only during open enrollment in an odd-numbered year. Your coverage will take effect the following January 1.

Retiree premiums and premium payment

State agency, higher education and school district retirees

PEBA deducts your health, TRICARE Supplement Plan, dental and vision premiums from your monthly pension check.

When you retire, your insurance premiums may be due before your retirement paperwork has been finalized. If this happens, you will receive a monthly bill for the premiums until you receive your first retirement check. If you do not pay the bill, the total premiums due will be deducted from your first retirement check.

Your pension is paid at the end of the month, and your insurance premiums are paid at the beginning of the month. For example: your insurance premiums for April are deducted from your March retirement check. Depending

on when your retirement paperwork is processed, more than one month's premium may be deducted from your first retirement check. If, at any time, the total premiums due are greater than the amount of your pension check, PEBA will bill you for the full amount.

Local subdivision retirees

You pay your health, dental and vision premiums to your former employer. Your employer sends them to PEBA. Contact your benefits office for information about your insurance premiums in retirement.

Failure to pay premiums

Health, dental and vision premiums are due by the tenth of each month. If you do not pay the entire bill, including the tobacco-use surcharge, if it applies, all your coverage will be canceled, including coverage for which you may not pay a premium, such as the State Dental Plan.

Your health plan choices as a retiree

If you are not eligible for Medicare

If you, your covered spouse and your covered children are not eligible for Medicare, you may be covered under one of these plans:

- State Health Plan Standard Plan
- TRICARE Supplement Plan, for eligible members of the military community.

Your health benefits, which are described in the Health Insurance chapter, will be the same as if you were an active employee. However, your premiums may change depending on whether you are a funded or a non-funded retiree. See Pages 184-185 for premiums.

If you are age 65 or older and not eligible for Medicare

If, when you retire, you are age 65 or older and not eligible for Medicare, contact the Social Security Administration (SSA). The SSA will send you a letter of denial of Medicare coverage. Give a copy of the letter to your benefits administrator. You may enroll in health insurance as a retiree within 31 days of loss of active coverage or within 31 days of a special eligibility situation or during open enrollment. You also may enroll your eligible family members.

If you are eligible for Medicare

If you, your covered spouse or your covered children are eligible for Medicare, you may be covered under one of these plans:

- State Health Plan Standard Plan
- State Health Plan Medicare Supplemental Plan

You and your Medicare-eligible dependents will automatically be enrolled in Express Scripts Medicare®, the State Health Plan's Medicare Part D program. However, you may opt out. For more information about the program, see PEBA's *When You Become Eligible for Medicare* handbook.

If you are considering the Savings Plan

If you are a retiree who is not eligible for Medicare, you may enroll in the Savings Plan. However, contributions to a Health Savings Account (HSA) from your retirement check are not deducted pretax. You may deduct your contributions to an HSA on your income tax return.

Dental benefits

If you retire from a participating employer, you can continue your State Dental Plan and Dental Plus coverage if you meet the eligibility requirements (see Pages 161-164). Coverage is not automatic. To maintain continuous coverage, you must file a Retiree Notice of Election form and an Employment Verification Record with PEBA within 31 days of your retirement date, the date your TERI plan ends or the date of disability approval.

If you do not enroll within 31 days of your date of retirement, you may enroll during the next open enrollment period in an odd-numbered year (October 2017). Coverage will be effective the following January 1. You also may enroll within 31 days of a special eligibility situation. For information on the State Dental Plan and Dental Plus, see Pages 85-94.

Vision care

State Vision Plan

If you retire from a participating employer, you can continue your State Vision Plan coverage if you meet the eligibility requirements (see Pages 161-164). Coverage is not automatic. To maintain continuous coverage, you must file a *Retiree Notice of Election* form and an Employment Verification Record with PEBA within 31 days of your retirement date, the date your TERI plan ends or the date of disability approval.

If you do not enroll within 31 days of your date of retirement, you may enroll during the next open enrollment period, which occurs yearly in October. Coverage will be effective the following January 1. For information on vision care benefits, see Pages 96-102.

Vision Care Discount Program

This discount program is available at no cost to retirees, as well as to full-time and part-time employees, covered family members, survivors and COBRA subscribers. See Pages 101-102 for more information.

Other insurance programs PEBA offers

Life insurance

If you are eligible for retiree group insurance when you retire, you may choose to continue or convert your life insurance through Securian. To do so, you must complete the Retiree Life Continuation Election form and/or the Conversion of Group Life Insurance Enrollment form, as well as the PEBA Coverage Verification Notice of Group Life Insurance, which is available from your benefits administrator. The continuation and conversion application period is time-sensitive. Securian must receive the appropriate form(s) within 31 days of the date coverage ends or you will forfeit your right to continue or convert your life insurance. If you need help completing these forms, contact your benefits administrator or PEBA.

Please note: Retiree life insurance coverage does not include accidental death and dismemberment benefits.

If you have questions about life insurance coverage, billing, claims, etc., call Securian at

If you retired before January 1, 1999, and you continued your coverage, your coverage will end after 11:59 p.m. on December 31 after the date you turn 70.

866.365.2374.

$3,000 Basic Life Insurance

This term life insurance, offered at no charge to you as an active employee, ends with retirement or when you leave your job for another reason. You may convert your Basic Life insurance to an individual whole life policy, a permanent form of life insurance.

Dependent Life Insurance

Any Dependent Life Insurance coverage you have ends when you leave active employment. Your covered spouse or child's coverage may be converted to an individual whole life policy.

Optional Life Insurance

You can continue or convert your Optional Life Insurance through Securian.

You can continue your term life insurance or you can convert your life insurance coverage to a whole life policy, a permanent form of life insurance, within 31 days of the date coverage ends. Your coverage can be continued in $10,000 increments up to the final amount of coverage in force on the day before your loss of coverage.

Continuation

As a retiree, you may continue your Optional Life coverage at the same rates you paid while you were an employee. The minimum amount that can be continued is $10,000. You cannot increase your coverage, but you can decrease it. Rates are based on your age and will increase when your age category changes. Your coverage will reduce to 65 percent at age 70 and then end after 11:59 p.m. on December 31 after the date you turn age 75 if you continued coverage and retired on or after January 1, 1999. When your coverage either reduces or ends, you can convert the amount of reduced or lost coverage within 31 days, as described in Section 2 below. Continued coverage is term life insurance.

To continue your coverage, you and your benefits administrator (or a PEBA Insurance Benefits representative) must complete the Retiree Life Continuation Election form and the PEBA Coverage Verification Notice of Group Life Insurance form. You must submit both documents to Securian at the address or fax number on the continuation form. They must be received within 31 days of your loss of coverage.

Term life insurance provides coverage for a specific time period. It has no cash value.

Conversion

Within 31 days of loss of coverage, you may convert your Basic Life, Optional Life or Dependent Life coverage to an individual whole life policy.

To convert your Basic Life, Optional Life or Dependent Life to an individual life policy, you must contact Securian directly at 866.365.2374 to obtain a conversion brochure. When you receive the forms, you must complete a Conversion of Group Life Insurance Enrollment form and send it with the PEBA Coverage Verification Notice of Group Life Insurance form and the first premium within 31 days of loss of coverage, or you will forfeit your right to convert your life insurance.

Continuation and conversion

You may also split your coverage between term life insurance (continuation) and individual whole life insurance (conversion).

If you participate in the TERI program, you can continue your benefits as an active employee,

if you are eligible. When the TERI period ends, you must file for retiree benefits within 31 days, as explained above.

If you are not approved for retirement or Long Term Disability, you have 31 days from the date your coverage ends to convert your policy. Please see your benefits administrator for more information.

If you return to work as a full-time, permanent employee with a participating employer, you must choose whether to enroll in Optional Life insurance coverage as an active employee or to continue your retiree coverage. If you refuse to enroll as an active employee, you also refuse the $3,000 Basic Life benefit and Optional and/or Dependent Life coverage. Your active group coverage will become effective only if you discontinue the retiree continuation coverage.

MoneyPlus

MoneyPlus is not available in retirement. However, when you retire, you may be able to continue your Medical Spending Account (MSA) on an after-tax basis through COBRA. See Pages 152-153 for more information. If you wish to continue your account, contact your benefits administrator within 31 days of your last day at work and fill out the appropriate forms.

If you do not wish to continue your MSA, you have 90 days from your last day at work to submit claims for eligible expenses incurred before you left employment.

You cannot continue contributing to your Dependent Care Spending Account after you retire. However, you can request reimbursement for eligible expenses incurred while you were employed until you exhaust your account or the plan year ends.

The Pretax Group Insurance Premium Feature, which allows you to pay health, TRICARE Supplement Plan, dental, vision and some life insurance premiums before taxes, is not available in retirement.

Long Term Disability

Disability insurance protects an employee and his family from loss of income due to an injury or an extended illness that prevents the employee from working. When you leave active employment and retire, your Basic and Supplemental Long Term Disability insurance end. Neither policy may be continued or converted to individual coverage.

When your coverage as a retiree begins

Enrollment in retiree insurance is not automatic. Even if you go directly from active employment to retirement, you still have to enroll as a retiree. Your retiree coverage will begin the day after your active coverage ends. If you are enrolling due to a special eligibility situation, your effective date will be either the date of the event or the first of the month after the event, depending on the event. For more information about special eligibility situations, see Pages 16-23. If you enroll during open enrollment your coverage will be effective the following January 1.

Your benefits administrator helps you enroll in or change your insurance coverage. If you worked for a state agency, higher education institution or school district, PEBA is your benefits administrator

after you retire. If you worked for a local subdivision, your benefits administrator is your former employer after you retire.

Information you will receive

After you enroll, you will receive a letter from PEBA that confirms you have retiree group insurance coverage. Because your coverage as an active employee is ending, federal law requires that you also be sent:

- A Certificate of Creditable Coverage, which gives the dates of your active coverage, the names of the individuals covered and the types of coverage
- A Qualifying Event Notice, which tells you that you may continue your coverage under COBRA.

Typically, these letters require no action on your part.

If you are eligible for Medicare, you will be automatically enrolled in Express Scripts Medicare, the State Health Plan's Medicare Part D program. Express Scripts, the State Health Plan pharmacy benefits manager, will send you a packet of information. It will include a letter telling you that you can opt out of the Medicare drug program and remain enrolled in the State Health Plan drug program for members who are not eligible for Medicare. The pharmacy benefits manager is required to give you 21 days to opt out.

Your insurance identification cards in retirement

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

If you or your covered dependents enroll in Express Scripts Medicare each member will receive one prescription drug card issued in his own name. Covered family members who are not enrolled in the Medicare drug program will receive cards showing they are enrolled in the "State Health Plan Prescription Drug Program." Two cards are issued in the subscriber's name.

If your card is lost, stolen or damaged, you may request a new card from these vendors:

- State Health Plan: BlueCross BlueShield of South Carolina
- State Health Plan prescription drug program: Express Scripts
- TRICARE Supplement Plan: Selman & Company
- Dental Plus: BlueCross BlueShield of South Carolina
- State Vision Plan: EyeMed

Contact information is available at the back of this guide.

Changing coverage

Open enrollment is offered every October. Eligible employees, retirees, survivors and COBRA subscribers may enroll in or drop their own health coverage and add or drop their eligible spouse and/or children without regard to special eligibility situations. Eligible subscribers also may change health plans. This includes changing to or from the Medicare Supplemental Plan, if they are retired and enrolled in Medicare. Eligible members of the military community may change to or from the TRICARE Supplement Plan, if they are not eligible for Medicare. They also can enroll in the State Vision Plan. During open enrollment in odd-numbered years, eligible subscribers

may add or drop the State Dental Plan and Dental Plus.

For more information, see Page 15-16 in the General Information chapter.

Dropping a covered spouse or child

If a covered spouse or child becomes ineligible, you must drop him from your health, dental, vision and life coverage. This may occur because of divorce or separation, a spouse gains coverage as an employee of a state insurance program participating group or a child turns 26. If you drop a spouse or child from your coverage, you must complete a Notice of Election form and provide documentation within 31 days of the date he becomes ineligible.

When your child becomes ineligible for coverage because of age, he will be dropped automatically. If he is your last covered child, your level of coverage will be changed.

Returning to work in a benefits-eligible job

If you, your spouse or your children are covered under retiree group insurance and you return to work for a participating employer, and are eligible for enrollment in the State Health Plan, you will need to make decisions about your coverage.

As long as you or any of your covered family members are not eligible for Medicare, you can decide whether to return to coverage under active group employee benefits or to continue your retiree group benefits. You cannot be covered under both. If you or any of your covered family members are eligible for Medicare, you cannot remain on retiree group coverage while employed, as explained below.

Beginning January 1, 2016, all employees who are eligible for enrollment in the State Health Plan (the Savings Plan and the Standard Plan), are also eligible for these programs:

- State Dental Plan and Dental Plus
- State Vision Plan
- Basic, Optional and Dependent Life insurance (with the exception of part-time teachers eligible for the State Health Plan according to S.C. Code 59-25-45)
- Basic and Supplemental Long Term Disability insurance (with the exception of part-time teachers eligible for the State Health Plan according to S.C. Code 59-25-45)
- MoneyPlus Pretax Group Insurance Premium Feature
- MoneyPlus Medical Spending Account. Limited-use Medical Spending Account and Dependent Care Account
- Health Savings Account (for employees enrolled in the Savings Plan)

If no one in your family, including yourself, is eligible for Medicare and you prefer to continue your retiree group insurance benefits, you must complete and sign an Active Group Benefits Refusal form

Retirees who continued life insurance

Retirees hired in a benefits-eligible job

If you continued your Optional Life coverage as a retiree, you may keep the policy if you decide to continue your retiree group benefits. However, you must cancel the policy if you choose active benefits. You may then enroll in Optional Life as an active employee. Contact Securian within 31 days of returning to work and cancel your continued coverage before

enrolling in active coverage.

If you are considered a "New Hire," see the Life Insurance chapter, which begins on Page 104.

If you or a member of your family is covered by Medicare

Medicare cannot be the primary insurance for you, or for any of your covered family members, while you are employed in a benefits-eligible job, according to federal law. To comply with this regulation, you are required to suspend your retiree group coverage and enroll as an active employee with Medicare as the secondary payer, or refuse all PEBA-sponsored health coverage for yourself and your eligible family members and have Medicare coverage only.

When you leave work and return to retiree group coverage before age 65, be sure to contact the Social Security Administration within 60 days of turning 65. You should enroll in Medicare Part A and Part B.

If you enroll in active group coverage, you must notify the Social Security Administration (SSA), since Medicare will pay after or secondary to your active group coverage. You may remain enrolled in Medicare Part B and continue paying the premium, and Medicare will be the secondary payer. You may also delay or drop Medicare Part B without a penalty while you have active group coverage. Contact the SSA for additional information.

When you stop working and your active group coverage ends, you may re-enroll in retiree group coverage within 31 days of your active termination date. In addition, you must notify the SSA that you are no longer covered under an active group so that you can re-enroll in Medicare Part B, if you dropped it earlier.

If your new position does not make you eligible for benefits, your retiree group coverage continues, and Medicare remains the primary payer.

When coverage ends

Your coverage will end:

- If you do not pay the required premium when it is due.
- The date it ends for all employees and retirees.
- The day after your death.

Coverage of your family members will end:

- The date your coverage ends.
- The date coverage for spouses or children is no longer offered.
- The last day of the month your spouse or child is no longer eligible for coverage. If your spouse or child's coverage ends, he may be eligible for continuation of coverage under COBRA (see Pages 25-27).

If you are dropping a spouse or child from your coverage, you must complete a Notice of Election form within 31 days of the date the spouse or child is no longer eligible for coverage.

Death of a retiree

If a retiree dies, a surviving family member should contact PEBA to report the death and end the retiree's health coverage. If the deceased was a local subdivision retiree, contact his benefits administrator, who works in the personnel office of his former employer.

Survivors of a retiree

Spouses or children who are covered as dependents under the State Health Plan, a dental plan or the State Vision Plan are classified as "survivors" when a covered employee or retiree dies. Survivors of funded retirees of a state agency, a higher education institution or a school district may be eligible for a one-year waiver of health insurance premiums. Survivors of non-funded retirees may continue their coverage. However, they must pay the full premium.

Participating local subdivisions may, but are not required to, waive the premiums of survivors of retirees, but a survivor may continue coverage, at the full rate, for as long as he is eligible. If you are a retiree of a participating local subdivision, check with your benefits administrator to see whether the waiver applies.

To continue coverage, a Survivor Notice of Election form must be completed within 31 days of the subscriber's date of death. A new Benefits ID number will be created, and new identification cards will be issued by carriers of the programs in which the survivors are enrolled.

After the first year, a survivor who qualifies for the waiver must pay the full premium to continue coverage. At the end of the waiver, health coverage can be canceled or continued for all covered family members. If coverage is continued, no covered family members can be dropped until open enrollment or within 31 days of a special eligibility situation.

If you and your spouse are both covered employees or funded retirees at the time of death, your surviving spouse is not eligible for the premium waiver.

Dental and vision premiums are not waived. However, survivors, including survivors of a subscriber enrolled in the TRICARE Supplement Plan and dental and/or vision coverage, can continue coverage by paying the full premium.

As a surviving spouse, you can continue coverage until you remarry. If you are a child, you can continue coverage until you are no longer eligible. If you are no longer eligible for coverage as a survivor, you may be eligible to continue coverage under COBRA. If your spouse retired from a state agency, a higher education institution or a school district, contact PEBA Insurance Benefits for more information. If your spouse retired from a local subdivision, contact his benefits administrator.

A surviving spouse or child of a military retiree should contact Selman & Company.

As long as a survivor remains covered by health, dental or vision insurance, he can add health and vision coverage at open enrollment or within 31 days of a special eligibility situation. Dental coverage can be added or dropped but only during open enrollment in an odd-numbered year or within 31 days of a special eligibility situation. If a survivor has health, dental and vision, and drops all three, he is no longer eligible as a survivor and cannot re-enroll in coverage, even at open enrollment.

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

Until you become eligible for Medicare, your health insurance pays claims the same way it

did when you were an active employee. For more information, see the Health Insurance chapter and the chart on the following pages.

Footnotes for comparison chart on Page 182:

[1]After the deductible is met, other benefits are paid at the same level as the SHP Standard Plan.

[2]To receive the higher level of benefits, subscribers should use a network provider.

[3]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.

[4]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. See Page 40 for details about a PCMH.

Health plans offered in 2016 for retirees and dependents not eligible for Medicare

This chart is a summary of benefits. More information is available in the *Retirement and Disability* and *Health Insurance* chapters.

Type	High Deductible Health Plan[1]		Preferred Provider Organization[2]	
Plan	SHP Savings Plan		SHP Standard Plan	
	In-network	Out-of-network	In-network	Out-of-network
Availability	Coverage worldwide		Coverage worldwide	
Annual deductible	• Single: $3,600 • Family: $7,200[3]		• Single: $445 • Family: $890	
Coinsurance[4]	• Plan pays 80% • You pay 20%	• Plan pays 60% • You pay 40%	• Plan pays 80% • You pay 20%	• Plan pays 60% • You pay 40%
Coinsurance maximum	• Single $2,400 • Family $4,800 • Excludes deductible	• Single $4,800 • Family $9,600 • Excludes deductible	• Single $2,540 • Family $5,080 • Excludes deductible and copayments	• Single $5,080 • Family $10,160 • Excludes deductible and copayments
Physicians office visits[4]	• No copayment • Plan pays 80% • You pay 20% • Chiropractic payments limited to $500 a year, per person	• No copayment • Plan pays 60% • You pay 40% • Chiropractic payments limited to $500 a year, per person	• $12 copayment • Plan pays 80% • You pay 20% • Chiropractic payments limited to $2,000 a year, per person	• $12 copayment • Plan pays 60% • You pay 40% • Chiropractic payments limited to $2,000 a year, per person
Hospitalization/ emergency care	No copayments		• Outpatient facility services: $95 copayment • Emergency care: $159 copayment • Plan pays 80% • You pay 20%	• Outpatient facility services: $95 copayment • Emergency care: $159 copayment • Plan pays 60% • You pay 40%
Prescription drugs	Participating pharmacies and mail order: You pay 100% of the Plan's allowed amount until the annual deductible is met. Afterward, the Plan will reimburse 80% of the allowed amount. The remaining 20% will be credited to your coinsurance maximum. Pay-the-difference applies: see Page 69		**Participating pharmacies only (up to 31-day supply)** • Tier 1 (generic-lowest cost alternative): $9 • Tier 2 (brand-higher cost alternative): $38 • Tier 3 (brand-highest cost alternative): $63 **Mail order and retail maintenance network pharmacies (up to 90-day supply)** • Tier 1: $22 • Tier 2: $95 • Tier 3: $158 • Copay maximum: $2,500 • Pay-the-difference applies: see Page 69	
Mental health/ substance abuse	Preauthorization required for some services. Call 800.868.1032. Subject to above deductibles and coinsurance.		Preauthorization required for some services. Call 800.868.1032. Subject to above copayments, deductibles and coinsurance.	
Lifetime maximum	None		None	

Footnotes listed on previous page

RETIREMENT AND DISABILITY

Premiums

2016 monthly premiums for active employees[1,2]

	Employee	Employee/spouse	Employee/children	Full family
Savings Plan	$9.70	$77.40	$20.48	$113.00
Standard Plan	$97.68	$253.36	$143.86	$306.56
TRICARE Supplement	$62.50	$121.50	$121.50	$162.50
Dental	$0.00	$7.64	$13.72	$21.34
Dental Plus[3]	$25.96	$52.46	$60.50	$78.60
Vision	$7.00	$14.00	$14.98	$21.98

2016 monthly premiums for funded retirees[1,2]

Retiree eligible for Medicare/spouse eligible for Medicare

	Retiree	Retiree/spouse	Retiree/children	Full family
Savings Plan	N/A	N/A	N/A	N/A
Standard Plan	$79.68	$217.36	$125.86	$270.56
Medicare Supplement[4]	$97.68	$253.36	$143.86	$306.56
TRICARE Supplement	N/A	N/A	N/A	N/A
Dental	$0.00	$7.64	$13.72	$21.34
Dental Plus[3]	$25.96	$52.46	$60.50	$78.60
Vision	$7.00	$14.00	$14.98	$21.98

Retiree eligible for Medicare/spouse not eligible for Medicare

	Retiree/spouse	Full family
Savings Plan	N/A	N/A
Standard Plan	$235.36	$281.54
Medicare Supplement[4]	$253.36	$299.54
TRICARE Supplement	N/A	N/A
Dental	$7.64	$21.34
Dental Plus[3]	$52.46	$78.60
Vision	$14.00	$21.98

Retiree not eligible for Medicare/spouse eligible for Medicare

	Retiree/spouse	Full family
Savings Plan	$77.40	$113.00
Standard Plan	$235.36	$281.54
Medicare Supplement[4]	$253.36	$299.54
TRICARE Supplement	N/A	N/A
Dental	$7.64	$21.34
Dental Plus[3]	$52.46	$78.60
Vision	$14.00	$21.98

Footnotes listed on Page 190

Retiree not eligible for Medicare/spouse not eligible for Medicare

	Retiree	Retiree/spouse	Retiree/children	Full family
Savings Plan	$9.70	$77.40	$20.48	$113.00
Standard Plan	$97.68	$253.36	$143.86	$306.56
Medicare Supplement[4]	N/A	N/A	N/A	N/A
TRICARE Supplement	$62.50	$121.50	$121.50	$162.50
Dental	$0.00	$7.64	$13.72	$21.34
Dental Plus[3]	$25.96	$52.46	$60.50	$78.60
Vision	$7.00	$14.00	$14.98	$21.98

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

	Retiree/children	Full family
Savings Plan	$20.48	$113.00
Standard Plan	$143.86	$306.56
Medicare Supplement[4]	$161.86	$324.56
TRICARE Supplement	N/A	N/A
Dental	$13.72	$21.34
Dental Plus[3]	$60.50	$78.60
Vision	$14.98	$21.98

2016 monthly premiums for non-funded retirees[1,2]

Retiree eligible for Medicare/spouse eligible for Medicare

	Retiree	Retiree/spouse	Retiree/children	Full family
Savings Plan	N/A	N/A	N/A	N/A
Standard Plan	$439.78	$930.62	$678.54	$1,163.60
Medicare Supplement[4]	$457.78	$966.62	$696.54	$1,199.60
TRICARE Supplement	N/A	N/A	N/A	N/A
Dental	$11.72	$19.36	$25.44	$33.06
Dental Plus[3]	$25.96	$52.46	$60.50	$78.60
Vision	$7.00	$14.00	$14.98	$21.98

Footnotes listed on Page 190

Retiree eligible for Medicare/spouse not eligible for Medicare

	Retiree/spouse	Full family
Savings Plan	N/A	N/A
Standard Plan	$948.62	$1,174.58
Medicare Supplement[4]	$966.62	$1,192.58
TRICARE Supplement	N/A	N/A
Dental	$19.36	$33.06
Dental Plus[3]	$52.46	$78.60
Vision	$14.00	$21.98

Retiree not eligible for Medicare/spouse eligible for Medicare

	Retiree/spouse	Full family
Savings Plan	$790.66	$1,006.04
Standard Plan	$948.62	$1,174.58
Medicare Supplement[4]	$966.62	$1,192.58
TRICARE Supplement	N/A	N/A
Dental	$19.36	$33.06
Dental Plus[3]	$52.46	$78.60
Vision	$14.00	$21.98

Retiree not eligible for Medicare/spouse not eligible for Medicare

	Retiree	Retiree/spouse	Retiree/children	Full family
Savings Plan	$369.80	$790.66	$573.16	$1,006.04
Standard Plan	$457.78	$966.62	$696.54	$1,199.60
Medicare Supplement[4]	N/A	N/A	N/A	N/A
TRICARE Supplement	$62.50	$121.50	$121.50	$162.50
Dental	$11.72	$19.36	$25.44	$33.06
Dental Plus[3]	$25.96	$52.46	$60.50	$78.60
Vision	$7.00	$14.00	$14.98	$21.98

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

	Retiree/children	Full family
Savings Plan	$573.16	$1,006.04
Standard Plan	$696.54	$1,199.60
Medicare Supplement[4]	$714.54	$1,217.60
TRICARE Supplement	N/A	N/A
Dental	$25.44	$33.06
Dental Plus[3]	$60.50	$78.60
Vision	$14.98	$21.98

Footnotes listed on Page 190

2016 monthly premiums for non-funded survivors[1,2]

Spouse eligible for Medicare/children eligible for Medicare

	Spouse	Spouse/children	Children only
Savings Plan	N/A	N/A	N/A
Standard Plan	$439.78	$678.54	$238.76
Medicare Supplement[4]	$457.78	$714.54	$256.76[5]
TRICARE Supplement	N/A	N/A	N/A
Dental	$11.72	$25.44	$13.72
Dental Plus[3]	$25.96	$60.50	$34.54
Vision	$7.00	$14.98	$7.98

Spouse eligible for Medicare/children not eligible for Medicare

	Spouse	Spouse/children	Children only
Savings Plan	N/A	N/A	$203.36
Standard Plan	$439.78	$678.54	$238.76
Medicare Supplement[4]	$457.78	$696.54	N/A
TRICARE Supplement	N/A	N/A	N/A
Dental	$11.72	$25.44	$13.72
Dental Plus[3]	$25.96	$60.50	$34.54
Vision	$7.00	$14.98	$7.98

Spouse not eligible for Medicare/children eligible for Medicare

	Spouse	Spouse/children	Children only
Savings Plan	$369.80	$573.16	N/A
Standard Plan	$457.78	$696.54	$238.76
Medicare Supplement[4]	N/A	$714.54[8]	$256.76[5]
TRICARE Supplement	N/A	N/A	N/A
Dental	$11.72	$25.44	$13.72
Dental Plus[3]	$25.96	$60.50	$34.54
Vision	$7.00	$14.98	$7.98

Spouse not eligible for Medicare/children not eligible for Medicare

	Spouse	Spouse/children	Children only
Savings Plan	$369.80	$573.16	$203.36
Standard Plan	$457.78	$696.54	$238.76
Medicare Supplement[4]	N/A	N/A	N/A
TRICARE Supplement	$62.50	$121.50	$61.00
Dental	$11.72	$25.44	$13.72
Dental Plus[3]	$25.96	$60.50	$34.54
Vision	$7.00	$14.98	$7.98

Footnotes listed on Page 190

2016 monthly premiums for COBRA[1,2]

18 and 36 months

	Subscriber	Subscriber/ spouse	Subscriber/ children	Full family	Children only
Savings Plan	$377.20	$806.48	$584.62	$1,026.16	$207.42
Standard Plan	$466.94	$985.96	$710.48	$1,223.60	$243.54
Medicare Supplement[4]	$466.94	$985.96	$710.48	$1,223.60	$243.54
Dental	$11.95	$19.75	$25.95	$33.72	$14.00
Dental Plus[3]	$26.48	$53.52	$61.72	$80.18	$35.24
Vision	$7.14	$14.28	$15.28	$22.42	$8.14

29 months

	Subscriber	Subscriber/ spouse	Subscriber/ children	Full family	Children only
Savings Plan	$554.70	$1,186.00	$859.74	$1,509.06	$305.04
Standard Plan	$686.68	$1,449.94	$1,044.82	$1,799.40	$358.14
Medicare Supplement[4]	$686.68	$1,449.94	$1,044.82	$1,799.40	$358.14
Dental	$11.95	$19.75	$25.95	$33.72	$14.00
Dental Plus[3]	$26.48	$53.52	$61.72	$80.18	$35.24
Vision	$7.14	$14.28	$15.28	$22.42	$8.14

2016 monthly premiums for permanent, part-time teachers[2]

Category I: 15-19 hours

	Employee	Employee/spouse	Employee/children	Full family
Savings Plan	$189.74	$434.02	$296.82	$559.52
Standard Plan	$277.72	$609.98	$420.20	$753.08
TRICARE Supplement	$62.50	$121.50	$121.50	$162.50
Dental	$5.86	$13.50	$19.58	$27.20
Dental Plus[3]	$25.96	$52.46	$60.50	$78.60
Vision	$7.00	$14.00	$14.98	$21.98

Footnotes listed on Page 190

Category II: 20-24 hours

	Employee	Employee/spouse	Employee/children	Full family
Savings Plan	$128.52	$312.78	$202.86	$407.70
Standard Plan	$216.50	$488.74	$326.24	$601.26
TRICARE Supplement	$62.50	$121.50	$121.50	$162.50
Dental	$3.86	$11.50	$17.58	$25.20
Dental Plus[3]	$25.96	$52.46	$60.50	$78.60
Vision	$7.00	$14.00	$14.98	$21.98

Category III: 25-29 hours

	Employee	Employee/spouse	Employee/children	Full family
Savings Plan	$70.92	$198.64	$114.44	$264.82
Standard Plan	$158.90	$374.60	$237.82	$458.38
TRICARE Supplement	$62.50	$121.50	$121.50	$162.50
Dental	$2.00	$9.64	$15.72	$23.34
Dental Plus[3]	$25.96	$52.46	$60.50	$78.60
Vision	$7.00	$14.00	$14.98	$21.98

2016 monthly life insurance premium

Optional Term Life and AD&D, Dependent Life - Spouse and AD&D

Rates shown per $1,000 of coverage

Age	Rate per $1,000/month	Age			Rate per $1,000/month
Under 35	$0.052	**50-54**	$0.170	**70-74**	$2.002
35-39	$0.068	**55-59**	$0.296	**75-79**	$3.256
40-44	$0.076	**60-64**	$0.548	**80 and over**	$5.442
45-49	$0.108	**65-69**	$1.160		

Dependent Life - Child

$1.10 per month for $15,000 of coverage; one premium provides coverage for all eligible children.

Footnotes listed on Page 190

2016 monthly employer contributions[1]

Active employees

	Employee	Employee/spouse	Employee/children	Full family
Health	$360.10	$713.26	$552.68	$893.04
Dental	$11.72	$11.72	$11.72	$11.72
Life	$0.28	$0.28	$0.28	$0.28
Long term disability	$3.22	$3.22	$3.22	$3.22

Permanent, part-time teachers (Category I: 15-19 hours)

	Employee	Employee/spouse	Employee/children	Full family
Health	$180.06	$356.64	$276.34	$446.52
Dental	$5.86	$5.86	$5.86	$5.86

Permanent, part-time teachers (Category II: 20-24 hours)

	Employee	Employee/spouse	Employee/children	Full family
Health	$241.28	$477.88	$370.30	$598.34
Dental	$7.86	$7.86	$7.86	$7.86

Permanent, part-time teachers (Category III: 25-29 hours)

	Employee	Employee/spouse	Employee/children	Full family
Health	$298.88	$592.02	$458.72	$741.22
Dental	$9.72	$9.72	$9.72	$9.72

Footnotes for comparison and premium charts on Pages 184-190:

[1]Premiums for local subdivisions may vary. To verify your rates, contact your benefits office.

[2]State Health Plan subscribers who use tobacco or cover dependents who use tobacco will pay a $40-per-month surcharge for subscriber-only coverage. The surcharge is $60 for other levels of coverage. The tobacco-use surcharge does not apply to TRICARE Supplement subscribers.

[3]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.

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

[5]This premium applies only if one or more children are eligible for Medicare.

Appendix

Claims procedures

How to file a State Health Plan claim

Medical and mental health and substance abuse claims

If you received services from a physician, a hospital or another provider that participates in a State Health Plan network, you do not have to file a claim. Your provider will file for you. You are responsible for the usual out-of-pocket expenses (deductibles, copayments, coinsurance and non-covered services).

However, if you did not use a network provider or if you have a claim for a non-network service, you may have to file the claim yourself. You can get claim forms from your benefits office, PEBA and BlueCross BlueShield of South Carolina (BCBSSC). Claim forms also are on PEBA's insurance benefits website, www.eip.sc.gov. You should complete a separate claim form for each individual who received care.

To file a claim:

- Complete the claim form.
- Attach your itemized bills, which must show: the amount charged; the patient's name; the date(s) and place of service(s); the diagnosis, if applicable; procedure codes; and the provider's name, federal Tax Identification Number or National Provider Identifier (NPI), if available.
- File claims within 90 days of the date you receive services or as soon as reasonably possible.

BCBSSC must receive claims by the end of the calendar year after the year in which expenses are incurred. Otherwise, claims cannot be paid.

Mail claims to:

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

What if I need help?

Call BCBSSC at 803.736.1576 or 800.868.2520.

Claims filed outside South Carolina only

Generally, if you obtain services outside South Carolina or the U.S. from a BlueCard (network) doctor or hospital, you should not need to pay up-front for care, except for the usual out-of-pocket expenses (deductibles, copayments, coinsurance and non-covered services). The provider should submit the claim on your behalf. Network providers will file claims to the BlueCross BlueShield affiliate in the state where the service was provided. Outside the U.S., you should complete a BlueCard Worldwide International Claim Form and send it to the BlueCard Worldwide Service Center. This claim form is available from your benefits administrator. If services are received from an out-of-network provider, you may be asked to pay-up front for the full cost of the services received. You may also be required to file the claim to BlueCross yourself.

The Worldwide Claim Form is also available on the "Forms and Documents" page, which is under "Member Resources" on the state-specific BlueCross BlueShield of South Carolina website, Statesc.southcarolinablues.com.

What if I need help?

Call BlueCard Worldwide collect at 804.673.1177 or toll-free at 800.810.2583.

How to file a dental claim

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

If your dentist will not file your claims, you can file to BCBSSC. The claim form is available on PEBA's Insurance Benefits website, www.eip.sc.gov, or StateSC.SouthCarolinaBlues.com. Complete blocks 4-23 on the claim form, and ask your dentist to complete blocks 1-2, 24-35 and 48-58.

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

- The dentist's name and address and federal Tax Identification Number or National Provider Identifier (NPI)
- The patient's name
- The date of each service
- The name of and/or procedure code for each service
- The charge for each service.

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

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

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

What if I need help?

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

How to file a prescription drug claim

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

States, complete Express Scripts' Direct Claim Form. You may print it from www.Express-Scripts.com. You may also request a copy by calling Express Scripts at 855.612.3128.

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

Express Scripts
Attn: Commercial Claims
P.O. Box 2872
Clinton, IA 52733-2872

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

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

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

Confidentiality policies

PEBA is committed to protecting the privacy of your health information. PEBA strives continually to ensure its compliance with the Health Insurance Portability and Accountability Act (HIPAA), which mandates the security and privacy of health information by setting standards for access and distribution of that information.

PEBA provides a Notice of Privacy Practices directly to all persons covered under the state insurance program. This brochure outlines the situations in which PEBA uses and discloses health information. It also outlines your rights with regard to the information and disclosure. A copy of PEBA's Notice of Privacy Practices begins on this page and is also on the PEBA insurance benefits website, www.eip.sc.gov.

If you would like for someone, such as your spouse, your parents or your children, to have access to your protected health information—or if they would like for you to have access to theirs—you, as a subscriber or a covered dependent, must complete an Authorized Representative Form. The form is on the PEBA insurance benefits website under "Forms."

If you have any questions about HIPAA, please contact:

S.C. Public Employee Benefit Authority
Attn: HIPAA Privacy Officer
202 Arbor Lake Drive
Columbia, SC 29223

803.734.0678
Email: privacyofficer@peba.sc.gov

Fraud Prevention Hotline

Inspector General's Fraud Hotline (State agency fraud only)

855.723.7283 or 855.SCFRAUD
http://oig.sc.gov
Email: oig@oig.sc.gov

You also may file a complaint online via the Inspector General's website, oig.sc.gov, or by mail by at State Inspector General's Office, 111 Executive Center Drive, Enoree Building, Suite 204, Columbia, SC 29210.

If you would like to report a fraud related to a specific program offered through the PEBA, you may also call 855.723.7283.

Notice of privacy practices

Effective April 14, 2003

Revised September 23, 2013

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

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; 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 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 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 and right to request confidential communications.** 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. For example, you may ask that PEBA not use or disclose information about an immunization or particular service that you received. 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. For example, you may request that your claims information not be sent to your home address.

  In addition, you have the right to request that PEBA communicate with you by certain means or at a certain location. PEBA will accommodate reasonable request(s). 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 insurance benefits' website at www.eip.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

To file a complaint with the Office for Civil Rights, US 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.

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.

On the following pages 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.

Additional information about COBRA is on Pages 25-27. 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 Benefits Authority (PEBA) Insurance Benefits 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 Insurance Benefits 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 Insurance Benefits (the Health, Dental, Dental Plus, Vision and

MoneyPlus Medical Spending Account) and not to any other benefits offered by PEBA Insurance Benefits.

PEBA Insurance Benefits 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 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 Insurance Benefits (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 Insurance Benefits as a child (for example, you turn age 26). For more information about when a child ceases to be eligible for coverage under PEBA Insurance Benefits, please refer to your Insurance Benefits Guide.

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 Insurance Benefits 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 at the address on the first page of this document. See "How do you provide a proper and timely notice?" for details.

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 Insurance Benefits. These forms are available at no cost from the benefits office or PEBA Insurance Benefits at 803.737.6800 (toll-free at 888.260.9430) or can be printed from www.eip.sc.gov. 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 Insurance Benefits 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 Insurance Benefits would be lost because of the event. **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 Insurance Benefits 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 Insurance Benefits' form, "Notice to Extend COBRA Continuation Coverage" (you may obtain a copy of this form from the benefits office or PEBA Insurance Benefits at no charge, or you can print the form at www.eip.sc.gov under "Forms"). You must follow the notice procedures outlined in the section entitled "How do you provide a proper and timely notice?" I**f 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 Insurance Benefits.

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 Insurance Benefits' form entitled "Notice to Extend COBRA Continuation Coverage." (You may obtain a copy of this form from PEBA Insurance Benefits at no charge, or you can print the form at www.eip.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 Insurance Benefits, 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 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 Insurance Benefits' 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 Insurance Benefits' 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 Insurance Benefits pursuant to a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) received by PEBA Insurance Benefits 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 many of these options at www.healthcare.gov.

For more information

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

If you have any questions concerning the information in this notice, your rights to coverage, or if you want a copy of the Insurance Benefits Guide, contact your benefits office, contact PEBA Insurance Benefits at 803.737.6800 (toll-free at 888.260.9430), or visit PEBA Insurance Benefits'

website (www.eip.sc.gov).

For more information about your rights under COBRA, contact the Centers for Medicare & Medicaid Services at www.cms.gov/COBRAContinuationofCov/ or 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 Insurance Benefits

The State of South Carolina Public Employee Benefits Authority (PEBA) Insurance Benefits 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 Insurance Benefits by calling 803.737.6800 (toll-free at 888.260.9430) or visiting PEBA Insurance Benefits' website (www.eip.sc.gov). PEBA Insurance Benefits' mailing address is 202 Arbor Lake Drive, Columbia, SC 29223.

Terms to know

Here are definitions of some terms used in the *Insurance Benefits Guide*. For more information, refer to the Pages listed or contact your benefits administrator.

Allowed amount The most a plan allows paying a provider for a covered service, procedure or supply.

Authorized representative An individual with whom a health plan has permission to discuss a covered person's Protected Health Information. An authorized representative can be named by completing an Authorized Representative Form, which is available on PEBA's website, www.eip.sc.gov, under "HIPAA."

Balance bill The difference between what a health plan pays for a service and the provider's actual charge. State Health Plan network providers may not balance bill members. See also Out-of-network differential.

Change in status An event, such as marriage, divorce or birth of a child that makes it possible to change a Medical Spending Account or a Dependent Care Spending Account. For more information, see Pages 151-152.

Coinsurance A percentage of the cost of health care a member pays after his deductible has been met. Under the State Health Plan, the coinsurance rate is different for network services, services at a BlueCross BlueShield of South Carolina-affiliated Patient-Centered Medical Home, out-of-network services and infertility treatment and fertility drugs.

Coinsurance maximum The amount of coinsurance a member is required to pay each year before he is no longer required to pay coinsurance.

Coordination of benefits (COB) A system to determine how claims are handled when a person is covered under more than one insurance plan. For information about how health claims are coordinated, see Pages 38-40. For information about how dental claims are coordinated, see Page 91.

Copayment A fixed amount a subscriber must pay for a drug or service. Savings Plan members do not pay copayments. Standard Plan members pay prescription drug copayments and copayments for office visits, emergency care and outpatient facility services. For more information, see Pages 35-36.

Deductible Generally, the amount a member must pay yearly for covered health care before the plan begins to pay a portion of the cost of his care. The deductible may not apply to all services.

Exclusion A condition for which, or a circumstance under which, an insurance plan will not pay benefits.

Individual whole life insurance A permanent form of life insurance.

Local subdivision A local subdivision is any participating group other than a state agency, a higher education institution or a public school district. Examples include: counties, municipalities, councils on aging, commissions on alcohol and other drug abuse, special purpose districts, community action agencies, disabilities and special needs boards, recreation districts, hospital districts and councils of government. The General

Assembly passed legislation extending voluntary participation in the state insurance program to certain local subdivisions. For a local subdivision to be eligible to participate in the state insurance program, it must fall within one of the categories established by statute (Section 1-11-720 of the S.C. Code of Laws, as amended).

Member A person covered by a health, dental or vision plan.

Network A group of providers, facilities or suppliers under contract to provide care for people covered by a health, dental or vision plan.

Out-of-network differential A State Health Plan member pays 40 percent coinsurance, rather than 20 percent, when he uses a provider that is not in the network. For more information, see Pages 45-46.

Outpatient facility services Services provided in a hospital for patients who do not stay overnight or services provided in a freestanding medical center.

Pay-the-difference policy If a member buys a brand-name drug when a generic drug is available, he will be charged the generic copayment plus the difference between the allowed amounts for the generic drug and the brand-name drug. Only the copayment for the generic drug will apply toward his prescription drug copayment maximum. For more information and charts illustrating the policy, see Pages 68-69.

Please note: The pay-the-difference policy does not apply to Express Scripts Medicare®, the State Health Plan's Medicare Part D program.

Plan of Benefits (POB) A document establishing eligibility requirements and benefits offered to individuals covered by the State Health Plan.

Preauthorization To require preauthorization is to require that a member get permission from the plan before he receives a particular service, supply or piece of equipment. For example, Medi-Call preauthorizes some services for State Health Plan members. The term prior authorization is used by the State Health Plan pharmacy benefits program.

Premium The amount a covered person pays for insurance coverage.

Qualifying event A change in a person's life, such a reduction in working hours, job loss or loss of eligibility for insurance coverage, that makes him eligible to enroll in continued coverage provided under COBRA.

Special eligibility situation An event that allows an eligible employee, retiree, survivor or COBRA subscriber to enroll in or drop coverage for himself and/or for eligible family members outside an open enrollment period. The coverage change must be made within 31 days of the event.

Subrogation A claim is subrogated when someone else is responsible for a member's injury. To the extent provided by South Carolina law, health plans offered through PEBA have the right to recover payment in full for benefits provided to a covered person under the terms of the plan when the injury or illness occurs through the act or omission of another person, firm, corporation or organization. If a covered person receives payment for such medical expenses from another who caused the injury or illness, the covered person agrees to reimburse the plan in full for any medical expenses paid by the

plan.

Subscriber An individual, such as an employee or a retiree, who is covered by an insurance plan. Because the individual is eligible and covered, members of his family also may be eligible to enroll in the plan.

Term life insurance Life insurance coverage that is provided for a specific period of time. It has no cash value. All life insurance offered through PEBA is term life.

Third-party claims processor (claims processor) A company, such as BlueCross BlueShield of South Carolina, that is under contract to PEBA to process claims for members.

Vendor A company under contract to PEBA.

Acronyms and initials

ACA Affordable Care Act

BIN Benefits Identification Number

COBRA Consolidated Omnibus Budget Reconciliation Act

DCSA Dependent Care Spending Account

EOB Explanation of Benefits

FMLA Family and Medical Leave Act

FSA Flexible Spending Account

HIPAA Health Insurance Portability and Accountability Act

HSA Health Savings Account

IBG *Insurance Benefits Guide*

MSA Medical Spending Account

NOE *Notice of Election* form

PCMH Patient-Centered Medical Home

PCP Primary Care Physician

PEBA South Carolina Public Employee Benefit Authority

PPO Preferred Provider Organization

RNOE Retiree Notice of Election form

SHP State Health Plan

SOC Summary of Change

SOE Summary of Enrollment

SSN Social Security number

Contact information

S.C. PEBA

202 Arbor Lake Drive | Columbia, SC 29223
8:30 a.m.-5 p.m., Monday-Friday

- **Customer Contact Center:** 803.737.6800 or 888.260.9430
- **Retiree billing:** 803.734.1696
- peba.sc.gov

2016 insurance vendors

BlueCross BlueShield of South Carolina

State Health Plan Standard Plan, Savings Plan, Medicare Supplemental Plan

P.O. Box 100605 | Columbia, SC 29260-0605

- **Customer Service:** 803.736.1576 or 800.868.2520
- **BlueCard Program:** 800.810.BLUE (2583)
- StateSC.SouthCarolinaBlues.com

Medi-Call (medical preauthorization)

AX-650 | I-20 at Alpine Road
Columbia, SC 29219

- 803.699.3337 or 800.925.9724
- **Fax:** 803.264.0183

Companion Benefit Alternatives (Behavioral Health)

P.O. Box 100185, AX-315 | Columbia, SC 29202

- **Mental Health and Substance Abuse Customer Service:** 803.736.1576 or 800.868.2520
- **Mental Health Precertification/Case Management:** 800.868.1032
- **Mental Health fax:** 803.714.6456
- **Tobacco cessation:** 866.784.8454
- www.CompanionBenefitAlternatives.com

Health/Wellness Management

- 855.838.5897, option 2
- **Fax:** 803.264.4204

National Imaging Associates (advanced radiology preauthorization)

- 866.500.7664
- www.RadMD.com

State Dental Plan, Dental Plus

P.O. Box 100300 | Columbia, SC 29202-3300

- **Customer Service:** 888.214.6230 or 803.264.7323
- **Fax:** 803.264.7739
- StateSC.SouthCarolinaBlues.com

Express Scripts

State Health Plan Prescription Drug Program, Express Scripts Medicare®

Claims:
Attn: Commercial Claims
P.O. Box 2872 | Clinton, IA 52733-2872

Medicare members:
Attn: Medicare Part D
P.O. 14718 | Lexington, KY 40512-4718

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

EyeMed

State Vision Plan (Group No.: 9925991)

Claims:
OON Claims
P.O. Box 8504 | Mason, OH 45040-7111

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

Securian

Basic Life, Optional Life, Dependent Life (Policy No.: 34407)

Group Administration Department
400 Robert Street North | St. Paul, MN 55101

- **Customer Service:** 866.486.5298
- **Evidence of insurability:** 800.872.2214
- **Claims:** 888.658.0193
- **Continuation or conversion:** 866.365.2374
- **Fax:** 651.665.4827

Selman & Company

GEA TRICARE Supplement Plan

6110 Parkland Boulevard | Cleveland, OH 44124

- **Customer Service:** 866.637.9911, Option 1
- **Claims fax:** 800.310.5514
- www.selmantricareresource.com/SC

The Standard Insurance Company

Long Term Disability (Group No.: 621144)

P.O. Box 2800 | Portland, OR 97208-2800

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

WageWorks

MoneyPlus

P.O. Box 14766 | Lexington, KY 40512-4766

- **Customer Care Center:** 800.342.8017
- **Automated information:** 800.865.3262
- **Claims fax:** 888.800.5217
- www.myFBMC.com

Other helpful contacts

Medicare

- 800.633.4227
- **TTY:** 877.486.2048
- www.medicare.gov

Social Security Administration

- 800.772.1213
- **TTY:** 800.325.0778
- www.socialsecurity.gov

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Launching January 1, 2016 ...
a new PEBA website experience!

Beginning January 1, PEBA's insurance website (www.eip.sc.gov) and retirement website (www.retirement.sc.gov) will be combined into one agency site.

Members can find all the information they need about their benefits at www.peba.sc.gov!

202 Arbor Lake Drive
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