2021

Insurance Benefits Guide

PEBA℠

SC Retirement Systems
and State Health Plan

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Disclaimer

Benefits administrators and others chosen by your employer to assist you with your participation in the employee benefit programs administered by the South Carolina Public Employee Benefit Authority (PEBA) are not agents or employees of PEBA and are not authorized to bind PEBA or make representations on behalf of PEBA.

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

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

State Health Plan's grandfathered status

The South Carolina Public Employee Benefit Authority believes the State Health Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act).

As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act 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 Affordable Care Act, for example, the elimination of certain 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 the plan administrator at 803.737.6800 or 888.260.9430.

Notice of non-discrimination

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

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  - Written information in other formats (large print, audio, accessible electronic formats, other formats).
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- Qualified interpreters; and
- Information written in other languages.

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

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
800.368.1019, 800.537.7697 (TDD)

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

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General information

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

The What's new for 2021? section highlights major changes in insurance benefits offered for 2021.

What's new for 2021?

Changes listed below are effective January 1, 2021.

- The 2021 monthly premiums were not finalized at the time this guide was produced. The premiums will be available at peba.sc.gov/monthly-premiums by October 1, 2020.
- Premium factors for Supplemental Long Term Disability decreased effective September 1, 2020. Learn more at peba.sc.gov/monthly-premiums.
- The Standard Plan for Medicare-eligible members will be referred to as the Carve-out Plan to align with how benefits are paid. Learn more about the carve-out method in the *Insurance Coverage for the Medicare-eligible Member* handbook.

Eligibility for insurance benefits

Active employees

Eligible employees generally are those who:

- Work full-time and receive compensation from for the state, a public higher education institution, a public school district or another entity allowed by law to participate, like a county government or municipality; and
- Are hired into an insurance-eligible position.

Eligible employees also include full-time clerical and administrative employees of the South Carolina General Assembly, judges in the state courts, and General Assembly members. Permanent part-time teachers working between 15 and 30 hours a week qualify for health, dental and vision insurance, and MoneyPlus but are not eligible for other PEBA benefits, such as life and disability insurance.

Elected members of participating county and city councils whose members are eligible to participate in one of the retirement systems PEBA administers are considered full-time employees. Generally, members of other governing boards are not eligible for coverage. If you work for more than one participating group, contact your benefits administrator for further information. Other eligibility rules are outlined in the *Plan of Benefits*.

Types of employees

Employees fall into these categories:

- New full-time employees whom the employer expects to work at least 30 hours a week. They are eligible for coverage within 31 days of their hire date.
- Permanent, part-time teachers who work between 15 and 30 hours per week.
- New variable-hour, part-time or seasonal employees whom the employer does not expect to average 30 hours a week during the first 12 months they are employed. Because their employer cannot determine their eligibility, they may not enroll in benefits immediately. Their employer must measure their hours to determine whether these employees work an average of 30 hours a week during the 12 months beginning the first of the month after the employee is hired. If an employee works an average of 30 hours

a week during this period, the employee is eligible for coverage during the 12-month period that follows.

- Ongoing employees who have completed their initial measurement period (October 4, 2019, to October 3, 2020). If an ongoing employee worked an average of 30 hours a week during this 12-month period, the employee is eligible for coverage during 2021 even if the employee's hours decrease during 2021. If an ongoing employee worked an average of less than 30 hours a week during this period, the employee is not eligible for coverage during 2021 unless the employee gains coverage through some other provision of the plan.

Benefits in which eligible employees may enroll

Health insurance

- State Health Plan (includes prescription drug and behavioral health coverage).
  - Standard Plan; or
  - Savings Plan (Health Savings Account-eligible).
- TRICARE Supplement Plan for eligible members of the military community; or
- Medicare Supplement Plan for retirees, survivors and COBRA subscribers who are eligible for Medicare.

Dental insurance

- Dental Plus; or
- Basic Dental.

Vision insurance

- State Vision Plan.

Life insurance

- Basic Life with Accidental Death and Dismemberment (automatically enrolled if enrolled in health insurance);
- Optional Life with Accidental Death and Dismemberment;
- Dependent Life-Spouse with Accidental Death and Dismemberment; and
- Dependent Life-Child.

Long term disability insurance

- Basic Long Term Disability (automatically enrolled if enrolled in health insurance); and
- Supplemental Long Term Disability.

MoneyPlus

- Pretax Group Insurance Premium feature (allows eligible subscribers to pay their premiums for health, including the tobacco-user premium, dental, vision and up to $50,000 in Optional Life coverage with pretax dollars);
- Medical Spending Account;
- Dependent Care Spending Account;
- Health Savings Account (for those enrolled in the Savings Plan); and
- Limited-use Medical Spending Account (for those enrolled in the Savings Plan and a Health Savings Account, or those who have access to a Health Savings Account through their spouse).

An eligible retiree

An employee may also be eligible for health, dental and vision coverage in retirement if the employee meets the requirements for such coverage. Eligibility for retiree insurance coverage and funding depends upon a number of factors, including the employee's eligibility for a retirement benefit, the date the employee was hired into an insurance-eligible position, the employee's retirement service credit earned while working for an employer that participates in the State Health

Plan and the nature of the employee's last five years of active employment with an employer that participates in the State Health Plan.

Please see Page 156 for more information about retiree insurance eligibility requirements.

An eligible spouse

An eligible spouse is one recognized by South Carolina law. A spouse eligible for coverage as an employee of any participating group, including an optional employer, cannot be covered as a spouse under any plan. A spouse who is a permanent, part-time teacher may be covered either as an employee or as a spouse, but not as both. In addition, a spouse who is eligible for retiree coverage and receives full funding of the employer premium from the South Carolina Retiree Health Insurance Trust Fund cannot be covered as a spouse under any plan. A spouse who is eligible for retiree coverage but receives no funding or only partial funding of employer premiums from the Retiree Health Insurance Trust Fund may be covered as either a retiree or as a spouse, but not as both.

A former spouse may enroll in coverage under his own policy if an active employee or retiree is required by a court order to provide coverage. See the Divorce section on Page 22.

An eligible child

- Must be younger than age 26; and
- Must be the subscriber's natural child, adopted child (including child placed for legal adoption), stepchild, foster child[1], a child of whom the subscriber has legal custody or a child the subscriber is required to cover due to a court order.[2]

If both parents are eligible for coverage, only one parent can cover the children under any one plan. For example, if one parent covers the children under health and dental, the other parent cannot cover the children under either health or dental. One parent can cover the children under health, and the other can cover the children under dental.

A child age 19 to age 25

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

A parent may cover a child who is eligible for state benefits because the child works for an employer that participates in PEBA insurance benefits. The child may be covered under his parents' health, dental and vision coverage, and may be subject to additional coverage exclusions under the State Health Plan. If covered by his parent, the child is not eligible for Basic Life, Optional Life, Dependent Life-Child, long term disability insurance or MoneyPlus.

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

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

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

ineligible for Dependent Life–Child coverage.

An incapacitated child

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

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

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

You and your child's physician will need to complete an *Incapacitated Child Certification* form. Please include a copy of your most recent federal tax return, which shows the child is principally dependent on you for support and maintenance. If you do not claim your child on your taxes, a worksheet for determining support (IRS *Publication 501*) should be completed in lieu of your tax returns. Also attach a completed *Authorized Representative Form* signed by the incapacitated child, and a copy of guardianship papers or a power of attorney that verifies your authority to act for your incapacitated child. Any of these documents gives PEBA permission to discuss or disclose the child's protected health information with the child's authorized representative.

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

Coverage under Dependent Life-Child insurance

According to state law, only a dependent child age 19 to 24 who is a full-time student may be covered under Dependent Life-Child insurance. A child of any age who has been certified by PEBA as an incapacitated child may continue to be covered under Dependent Life-Child. For more information about eligibility for Dependent Life-Child coverage, see Page 112.

A survivor

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

Initial enrollment

Employees

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

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

Your benefits administrator will initiate the enrollment process. You will need to provide a valid email address to your employer, then make your elections online through MyBenefits by following the instructions in the email you receive from PEBA. Your benefits administrator can also assist you in completing a paper *Notice of Election* form. Please allow additional processing time for paper forms.

Your coverage starts on the first calendar day of the month in which you become eligible for coverage[3] if you are engaged in active employment[4] that day.

- If your date of hire is 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 your date of hire is the first of the month (i.e., March 1), your coverage starts on the first of that month.
- If you become eligible on a day other than the first calendar day or first working day of the month, your coverage starts on the first day of the next month.
- Coverage of your enrolled spouse or children begins on the same day your coverage begins.

If you do not enroll within 31 days of the date you become eligible for active benefits or experience a special eligibility situation, you cannot enroll yourself, your eligible spouse or children until the next annual open enrollment period, which is held in October. Coverage elected during an annual open enrollment period will begin the following January 1.

Retirees

If you are a retiree of a participating group in South Carolina, you can enroll in insurance coverage within 31 days of the date you retire or during open enrollment. You can also enroll your eligible spouse and/or children. A participating group is a state agency, public 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.

If you do not enroll within 31 days of your retirement date, you cannot enroll yourself, your eligible spouse or children until the next annual open enrollment period, which is held in October. Coverage elected during an annual open enrollment period will begin the following January 1.

You can learn more about insurance coverage in retirement in the **Retiree group insurance** chapter on Page 154.

3 Life insurance coverage is subject to the Dependent Non-confinement Provision (Page 114) as well as the Actively at Work requirement (Page 108). For more information about initial enrollment in Optional Life Insurance, see Page 109.
4 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.

Information you need at enrollment

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

	Required information
For you	Social Security number; personal email address; annual salary; date of hire (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 or Part B	Copy of Medicare card; reason for eligibility; effective date of Medicare coverage
For each beneficiary of your Basic or Optional Life coverage	Social Security number; date of birth
For a beneficiary that is an estate or a trust	Name; address; date trust was signed

Documents you need at enrollment

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

	Required information
To cover a spouse	A copy of marriage license
To cover a natural child	A copy of long-form birth certificate showing subscriber as parent
To cover a stepchild	A copy of long-form birth certificate showing name of natural parent; proof that natural parent and the subscriber are married
To cover an adopted child or a child placed for adoption	A copy of long-form birth certificate showing subscriber as parent or a copy of legal adoption document from court stating adoption is complete; or a letter of placement from an attorney, an adoption agency, or the South Carolina Department of Social Services stating adoption is in progress
To cover a foster child	A court order or another legal document placing child with subscriber, who is a licensed foster parent

Continued on next page

	Required information
To cover other children	For all other children for whom subscriber has legal custody, a court order or other legal document granting custody of child to subscriber (document must verify subscriber has guardianship responsibility for child, not just financial responsibility)
To cover an incapacitated child	*Incapacitated Child Certification* form (see the Incapacitated child section on Page 16 for complete information on the process); plus proof of the relationship
To enroll in the TRICARE Supplement Plan	A copy of subscriber's TRICARE ID card

Completing your initial enrollment through your benefits administrator

Your benefits administrator will initiate the enrollment process. You will need to provide a valid email address to your employer, then make your elections online through MyBenefits by following the instructions in the email you receive from PEBA.

You can provide required documentation by uploading it to MyBenefits or giving copies of any documents to your benefits administrator, who will send them to PEBA.

PEBA encourages benefits administrators to enroll employees online for security and efficiency in the enrollment process. If you or your benefits administrator choose to submit a *Notice of Election* form:

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

After your initial enrollment

Insurance cards

If you enroll in the State Health Plan Standard Plan, Savings Plan or Medicare Supplemental Plan, BlueCross BlueShield of South Carolina (BlueCross) will send you health insurance cards for you and your covered family members. You also will receive two pharmacy benefits cards from Express Scripts. Dental Plus subscribers also receive an insurance card from BlueCross, which serves as the dental plan vendor. State Vision Plan subscribers receive two cards from EyeMed Vision Care.

You can access digital copies of your insurance identification cards from the BlueCross, Express Scripts and EyeMed apps.

Please check to make sure that your coverage is active before you go to a doctor or fill a prescription.

Benefits Identification Number

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

The State Health Plan adds a three-letter prefix to your BIN and places this number on your identification card. The BIN, along with the three-

letter prefix, is also used on Dental Plus cards. The BIN without the three-letter prefix is used on prescription benefit cards. If you are not covered by a plan that uses the BIN, PEBA will send you your number.

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

When medical emergencies occur before you receive your card

If you need emergency medical care before you receive your insurance cards, you can still provide proof of your coverage by obtaining your BIN.

To do this, visit mybenefits.sc.gov and select Get my BIN. You should then give your BIN to your medical care provider. If you have problems or questions when trying to get verification of your benefits, you or the emergency medical care provider should contact BlueCross for assistance.

Enrolling as a transferring employee

PEBA considers you a transfer if you change employment from one participating group to another within 15 calendar days.

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

If you are an academic employee, you are considered a transfer if you complete a school term and move to another participating academic employer at the beginning of the next school term, even if you do not work over the summer. Your insurance coverage with the employer you are leaving will remain in effect until you begin work with your new employer, typically September 1, as long as you pay your premiums. On that date, your new employer will pick up your coverage. You will need to contact your former employer, however, to continue coverage during the summer. 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.

Annual open enrollment

During the October open enrollment period, eligible employees, retirees, survivors and COBRA subscribers may change their coverage[5] without having to have a special eligibility situation.

Changing plans or coverage during an open enrollment period

Changes made during an open enrollment period become effective the following January 1.

- You may add or drop State Health Plan coverage for yourself, your eligible spouse and eligible children during open enrollment. You can also change between the Standard Plan and Savings Plan during open enrollment.
- Retirees and survivors, their eligible spouses and eligible children who are covered by a health plan may change to the Medicare Supplemental Plan within 31 days of Medicare eligibility or during an open enrollment period.
- Eligible members of the military community may add or drop TRICARE Supplement Plan coverage for themselves and for their eligible dependents during open enrollment.

5 You can add or drop Dental Plus and Basic Dental coverage only during an open enrollment period in October of odd-numbered years, or within 31 days of a special eligibility situation.

- You may add or drop Dental Plus and Basic Dental coverage for yourself, your eligible spouse and eligible children during open enrollment in odd-numbered years.
- You may add or drop State Vision Plan coverage for yourself, your eligible spouse and eligible children during open enrollment.
- You may enroll in the Pretax Group Insurance Premium feature; enroll in or re-enroll in a MoneyPlus flexible spending account; or enroll in a Health Savings Account.
- Other changes you may make in your coverage, such as changes to life insurance and long term disability, are explained prior to each open enrollment.

If you are an active employee of a state agency, public higher education institution or public school district, contact your benefits administrator for details. Retirees, survivors or COBRA subscribers should contact PEBA. If you are an active employee, retiree, survivor or COBRA subscriber of an optional employer, contact the benefits administrator at the optional employer with which you have a coverage relationship.

MyBenefits

PEBA's online insurance benefits enrollment system

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

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

- Complete your initial enrollment.
- Update your contact information.
- Print a list of the insurance plans under which you are covered.
- Get your eight-digit Benefits Identification Number (BIN).
- Update your beneficiaries.
- Initiate or approve changes made as a result of certain special eligibility situations.

You cannot access any information about the status of any claims or about your benefits through MyBenefits. Please refer to the appropriate chapter in this guide.

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

Special eligibility situations

A special eligibility situation is an event that allows you, as an eligible employee, retiree, survivor or COBRA subscriber, to enroll in or drop coverage for yourself or eligible family members outside of an open enrollment period.[6]

As an active employee, you can make changes using **MyBenefits** if you have a special eligibility situation, such as adding a newborn, marriage, divorce or adoption. MyBenefits will display the documentation required for each change. The required documents can be uploaded through MyBenefits.

To make a change through your benefits administrator, you will need to:

- Complete and return to your benefits administrator a *Notice of Election* form within 31 days[7] of the event; and
- Upload documentation to **MyBenefits** or give documentation to your benefits administrator.

6 A salary increase or decrease, or transfer does not create a special eligibility situation.
7 Changes related to Medicaid or the Children's Health Insurance Program (CHIP) must be made within 60 days.

If you are an active employee and are eligible to change your health, dental, State Vision Plan or Optional Life insurance coverage due to a special eligibility situation, you also may enroll in or drop the Pretax Group Insurance Premium Feature, which is explained on Page 139.

Marriage

If you want to add a spouse to your coverage because you marry, log in to **MyBenefits** and select the appropriate change reason. The effective date of coverage is the date of marriage.

To make the change through your benefits administrator, complete a *Notice of Election* form and submit it to your benefits administrator, along with a copy of your marriage license, within 31 days of the date of your marriage. The forms are available on PEBA's website at **peba.sc.gov/forms**, or by contacting PEBA or your benefits administrator.

If you and your eligible dependents are not covered, you may add health, dental and vision coverage for yourself, your existing eligible dependents, your new spouse and new stepchildren within 31 days of the date of your marriage. If you add your new spouse or your new stepchildren to your health coverage, you may also change health plans. You may add your new spouse or new stepchildren to dental 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. Marriage also allows a covered subscriber to enroll in or increase Optional Life coverage up to $50,000 without medical evidence. For information about eligibility for Dependent Life - Spouse coverage, including amounts in which a newly eligible spouse may enroll without medical evidence, see the Dependent Life Insurance section, which begins on Page 107 in the **Life insurance** chapter of this guide.

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

Divorce

If you divorce, your former spouse and former stepchildren are no longer eligible for coverage on your policy. Eligible former spouses have the option to elect former spouse coverage if you are required by court order to provide your former spouse coverage, or 36 months of COBRA continuation coverage. If an eligible former spouse elects to enroll in former spouse coverage, he waives his 36-month COBRA continuation rights. Your former spouse must have his own policy under the Plan. Coverage for a former spouse can include health, dental and vision coverage. The cost of former spouse coverage is the full premium amount.

Because former spouse coverage is linked to the sponsor (employee or retiree), if the sponsor loses coverage, the former spouse also loses coverage and would be eligible for 36 months of former spouse COBRA continuation coverage in alignment with the qualifying events of the sponsor.

To cover a former spouse, complete a *Former Spouse Notice of Election* form within 31 days from the date the divorce is finalized and give it to your benefits administrator along with a copy of the divorce decree ordering you to cover your former spouse. Retirees of state agencies, public higher education institutions and public school districts;

survivors; and COBRA subscribers should submit the *Former Spouse Notice of Election* to PEBA. Retirees of optional employers should submit the *Former Spouse Notice of Election* to their benefits administrator at the employer with which they have a coverage relationship.

To remove your former spouse and former stepchildren from your coverage, log in to MyBenefits and select the appropriate change reason.

To make the change through your benefits administrator, complete a *Notice of Election* form and submit a complete copy of your divorce decree within 31 days of the date stamped on the divorce decree. Coverage for your former spouse and former stepchildren will end the last day of the month after the date stamped on the divorce decree. If you drop your former spouse or former stepchildren from coverage after 31 days of the date stamped on the court order or divorce decree by the court, the change in coverage is effective the first of the month after your signature on a completed *Notice of Election* form dropping your former dependents.

You cannot continue to cover your former spouse or former stepchildren under Dependent Life insurance under any circumstances. Dependent Life coverage ends the date of the divorce.

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

In addition, you may be able to make changes in a Medical Spending Account or a Dependent Care Spending Account.

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.

Adding children

Eligible children may be added through MyBenefits by selecting the appropriate change reason. To make the change through your benefits administrator, complete a *Notice of Election* form. The change must be submitted to PEBA within 31 days of:

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

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

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

An employee also may enroll in Dependent Life-Child.

Children must be enrolled individually 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. See Page 59.

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

To add a child under 18 who is adopted or placed for adoption, submit one of the following:

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

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

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

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

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

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

Dropping a spouse or children

If a covered spouse or child becomes ineligible, you must drop them from your health, dental, vision and Dependent Life coverage. This may occur because of divorce. To drop a spouse or child from your coverage, log in to **MyBenefits** and select the appropriate change reason within 31 days of the date he becomes ineligible and upload documentation.

When a child loses eligibility for health, dental or vision coverage because he turned 26, the child will

be dropped automatically the first of the month after they turn 26. If the child is your last covered child to leave coverage, your level of coverage will be changed.

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

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

Gaining other coverage

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

If you, your spouse or children gain coverage outside of insurance benefits through PEBA, and you wish to drop your PEBA insurance coverage for yourself or any dependents, 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 documentation that includes the effective date of coverage, names of all individuals covered and the types of coverage gained (e.g., letter on letterhead, email from benefits office, copy of insurance card, etc.). 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.

If you, your spouse or children become incarcerated, the incarcerated person gains other coverage and can drop PEBA insurance coverage within 31 days. You must complete a *Notice of Election* form and return it to your benefits office with proof of the other coverage.

Gain of Medicare coverage

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

A retiree who gains Medicare Part A coverage may enroll in the Medicare Supplement Plan by submitting a *Notice of Election* form within 31 days of the gain of coverage.

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

For more information, see the *Insurance Coverage for the Medicare-eligible Member* handbook, available at **peba.sc.gov/publications** under Health.

Loss of other coverage

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

coverage (or if the employer stops contributing to the coverage).

- If you are the employee or retiree and you lose other group health coverage, and you are not already covered by health insurance through PEBA, you may enroll yourself and your eligible dependents in health, dental and vision coverage. If you are already covered by health, you cannot make changes.
- If your hours were reduced and you lost coverage, and you are otherwise eligible to be covered as a spouse or a child on your spouse's or parent's plan, you may enroll in health, dental and vision coverage.
- If you are the employee or retiree and have a spouse or child who loses other group health coverage, you may enroll the eligible spouse and children in health, dental and vision coverage. If you are not already covered, you must enroll yourself with the individual who lost coverage. Other dependents who did not lose health insurance coverage may not be enrolled. If you are already covered as an employee or retiree, you may change health plans (for example, Savings Plan to Standard Plan) when you add the spouse or children who lost health insurance coverage. Contributions toward your deductible will start over.
- If you, your spouse or children lose dental coverage, vision coverage or both but do not lose health coverage, then you, your spouse or children who lost the dental or vision coverage may enroll in the type of coverage that was lost. If you are not already covered, you must enroll yourself with the individual who lost coverage.
- If you refused coverage because you were covered under your parent's plan and you lose that coverage, you may enroll yourself and your eligible family members in health, dental and vision coverage. For information about Optional Life, Dependent Life-Spouse, Dependent Life-Child or Supplemental Long Term Disability insurance, contact your benefits administrator.
- Loss of TRICARE coverage is a special eligibility situation that permits an eligible employee or retiree and their eligible dependents to enroll in health, dental and vision coverage.
- If you, your spouse or children are released from incarceration, the released person has experienced a loss of coverage and is eligible to elect coverage within 31 days.

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 documentation that includes the names of those covered and the date coverage was lost (e.g., letter on letterhead, email from benefits office, copy of insurance card, etc.). You must also submit 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 from the date of notification to drop coverage through PEBA. An employee may cancel health, dental 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 *Notice of Election* form.

Eligibility for premium assistance through Medicaid or CHIP

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

Loss of Medicaid or CHIP coverage

If you refused coverage in PEBA-sponsored health, dental and vision insurance for yourself or for your eligible spouse or children because of coverage under Medicaid or CHIP and then lost eligibility for that coverage, you may be able to enroll in a PEBA plan. You must request enrollment within 60 days of the date of notification of loss of coverage. Provide your benefits administrator with a copy of the notification.

Leaves of absence

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

Premiums while on unpaid leave

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

If you are on unpaid leave and you can no longer afford premiums for the health plan in which you are enrolled through PEBA, you may drop all of your coverage with PEBA. 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 Page 28.

A period of unpaid leave may also affect your eligibility for retiree health insurance coverage if you are not considered actively employed or if you stop earning retirement credit at any point during the leave. Retirement service credit purchased for an approved leave of absence is not considered earned service in a PEBA-administered retirement plan, except in certain circumstances. If you have questions about how a period of unpaid leave may affect your eligibility for retiree health insurance coverage, contact PEBA. For more information about eligibility for retiree group insurance, see Page 154.

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 or term life policy by contacting MetLife within 31 days of when your coverage ended.

Supplemental Long Term Disability insurance while on paid or unpaid leave

Your Supplemental Long Term Disability (SLTD) insurance will end 31 days from your last day

worked. There is no option to continue SLTD; however, you can convert your SLTD coverage. Learn more on Page 128 or contact your benefits administrator.

Family and Medical Leave Act (FMLA) leave

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

Military leave

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

Workers' compensation

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

When coverage ends

Your coverage will end:

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

Coverage for your spouse and children will end:

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

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

Continuation of coverage (COBRA)

Eligibility

COBRA, the Consolidated Omnibus Budget Reconciliation Act, requires that continuation of group health, vision, dental or Medical Spending

Account coverage[8] be offered to you and your covered spouse and children if you are no longer eligible for coverage due to a qualifying event. Qualifying events include:

- The covered employee's working hours are reduced from full-time to part-time (outside of a stability period);
- The covered employee voluntarily quits work, retires, is laid off or is fired (unless the firing is due to gross misconduct as determined by the employer);
- A covered spouse loses eligibility due to a change in marital status; or
- A child no longer qualifies for coverage.

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

PEBA serves as the benefits administrator for COBRA subscribers of state agencies, higher education institutions and public school districts. COBRA subscribers from participating optional employers keep the same benefits administrator.

When continued coverage will not be offered

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

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

How to continue coverage under COBRA

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

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

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

Example COBRA scenario

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

8 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.

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

The qualified beneficiary, his personal representative or his guardian is responsible for notifying PEBA when he is no longer eligible for continued coverage. Continued coverage will be canceled automatically by PEBA in the above situations numbered 1, 2 and 3. The qualified beneficiary is responsible for submitting a *Notice to Terminate COBRA Continuation Coverage*, along with supporting documents, in situations 4 and 5.

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

When benefits provided under COBRA run out

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

Extending continued coverage

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

Other coverage options

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

Death of a subscriber or covered spouse or child

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

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

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

Survivors

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

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

Upon the death of a retiree of a state agency, public higher education institution or public school district who was receiving full or partial funding of the employer portion of the premium for retiree coverage, his qualified survivors will have the employee portion of the premium and the funded portion of the employer premium waived for one year. This is not necessarily the case with a retiree of a participating optional employer, because participating optional employers may choose to waive the premiums of survivors of retirees but are not required to do so. A survivor of a retiree of a participating optional employer should check with the retiree's benefits administrator to determine whether the waiver applies.

After the premium has been waived for a year, a survivor must pay the subscriber and employer share of the premium to continue coverage. If the surviving spouse is covered as an employee or retiree at the time of death, the surviving spouse is not eligible for the premium waiver.

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

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

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

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

In cases where the deceased employee worked for a state agency, public higher education institution or public school district, a covered surviving

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

Ongoing eligibility and open enrollment for survivors

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

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

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

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

Appeals of eligibility determinations

What if I disagree with a decision about eligibility?

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

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

- Employees can initiate a request for review through their benefits office. Benefits administrators may submit a review online.
- Retirees, survivors and COBRA subscribers of state agencies, public higher education institutions or public school districts can submit requests directly to PEBA, which serves as their benefits administrator.
- Retirees, survivors or COBRA subscribers of participating optional employers can submit requests through the benefits office of their former employer, which serves as their benefits administrator.

If you disagree with the decision, you may appeal by sending an ***Appeal Request Form*** (found at **peba.sc.gov/forms** under Other forms) to PEBA within 90 days of notice of the decision. Please include a copy of the decision letter with your appeal. Send the request to:

IAD@peba.sc.gov

or

S.C. PEBA
Attn: Insurance Appeals Division
202 Arbor Lake Drive
Columbia, SC 29223

If your appeal relates to a pregnancy, newborn child or the preauthorization of a life-saving treatment or drug, email your ***Appeal Request Form*** to PEBA to **urgentappeals@peba.sc.gov** or fax it to 803.740.1376.

A healthcare provider, employer or benefits administrator may not appeal to PEBA on your behalf. Only you, the member, your authorized representative or a licensed attorney admitted to practice in South Carolina may initiate an appeal through PEBA. A provider, employer or benefits administrator may not be an authorized representative.

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

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

Health insurance

Your State Health Plan choices

The State Health Plan offers the Standard Plan, the Savings Plan 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 (Page 75).

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

Standard Plan

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. When you buy a prescription drug with the Standard Plan, you pay only the required copayment rather than paying the full allowed amount. An allowed amount is defined as the most a health plan allows for a covered service or product, whether it is provided in-network or out-of-network. When providers join the network, they agree to provide prescriptions when members provide only a copayment.

Savings Plan

As a Savings Plan subscriber, you save money through lower premiums and you take greater responsibility for your health care costs through a higher annual deductible. You pay the full allowed amount for covered medical benefits, including behavioral health benefits such as mental health and substance use benefits, as well as prescription drug benefits, until you reach the deductible. With the Savings Plan, the family deducible must be met before any member receives payment for benefits.

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

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

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

Medicare Supplemental Plan

To learn more about how the Standard Plan and the Medicare Supplemental Plan work with Medicare, see the *Insurance Coverage for the Medicare-eligible Member* handbook at **peba.sc.gov/publications** under Health.

Comparing the plans

The chart on Page 36 illustrates how your deductible, copayments and coinsurance work together, as well as other features of the Standard Plan and Savings Plan. This overview is for comparison only. The *Plan of Benefits*, which includes a complete description of the Plan, governs the Standard, Savings and Medicare Supplemental plans offered by the state. It is available at **peba.sc.gov/publications**.

Please note that the $14 Standard Plan physician office visit copayment is not charged for services received at a BlueCross BlueShield of South Carolina (BlueCross)-affiliated patient-centered medical home (PCMH). Also, Savings Plan and Standard Plan members pay 10 percent coinsurance rather than 20 percent coinsurance at PCMH providers once their deductibles have

been met. See Page 67 for more information about PCMHs.

Comparison of health plans[1]

	Standard Plan[2]	Savings Plan
Annual deductible	You pay up to **$490** per individual or **$980** per family.	You pay up to **$3,600** per individual or **$7,200** per family.[3]
Coinsurance[4] *Maximum excludes copayments and deductible.*	In network, you pay **20%** up to **$2,800** per individual or **$5,600** per family. Out of network, you pay **40%** up to **$5,600** per individual or **$11,200** per family.	In network, you pay **20%** up to **$2,400** per individual or **$4,800** per family. Out of network, you pay 40% up to **$4,800** per individual or **$9,600** per family.
Physician's office visits[5]	You pay a **$14** copayment plus the remaining allowed amount until you meet your deductible. Then, you pay the copayment plus your coinsurance.	You pay the **full allowed amount** until you meet your deductible. Then, you pay your coinsurance.
Blue CareOnDemand℠ *Details on Page 39.*	You pay a **$14** copayment plus the remaining allowed amount until you meet your deductible. Then, you pay the copayment plus your coinsurance.	You pay the **full allowed amount** until you meet your deductible. Then, you pay your coinsurance.
Outpatient facility/ emergency care[6,7]	You pay a **$105** copayment (outpatient services) or **$175** copayment (emergency care) plus the remaining allowed amount until you meet your deductible. Then, you pay the copayment plus your coinsurance.	You pay the **full allowed amount** until you meet your deductible. Then, you pay your coinsurance.
Inpatient hospitalization	You pay the **full allowed amount** until you meet your deductible. Then, you pay your coinsurance.	You pay the **full allowed amount** until you meet your deductible. Then, you pay your coinsurance.
Chiropractic	$2,000 limit per covered person	$500 limit per covered person
Prescription drugs[8,9] *30-day supply/90-day supply at network pharmacy*	Tier 1 (generic): **$9/$22** Tier 2 (preferred brand): **$42/$105** Tier 3 (non-preferred brand): **$70/$175** You pay up to **$3,000** in prescription drug copayments. Then, you pay nothing.	You pay the **full allowed amount** until you meet your annual deductible. Then, you pay your coinsurance. Drug costs are applied to your coinsurance maximum. When you reach the maximum, you pay nothing.
Tax-favored accounts	Medical Spending Account	Health Savings Account Limited-use Medical Spending Account

Footnotes on following page.

	Medicare Supplemental Plan (in network)
Availability	Same as Medicare and available to retirees and covered dependents/survivors who are eligible for Medicare.
Annual deductible	Plan pays Medicare Part A and Part B deductibles.
Coinsurance	Plan pays Part B coinsurance with no maximum.
Physician's office visits	Plan pays Part B coinsurance of 20%.
Inpatient hospitalization/nursing facility care	**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] *(30-day supply/90-day supply at network pharmacy)*	Tier 1 (generic): **$9/$22** Tier 2 (preferred brand): **$42/$105** Tier 3 (non-preferred brand): **$70/$175** You pay up to **$3,000** in prescription drug copayments. Then, you pay nothing.

1 State Health Plan subscribers who use tobacco or cover dependents who use tobacco will pay a $40 per month premium for subscriber-only coverage and $60 for other levels of coverage. The tobacco-use premium does not apply to TRICARE Supplement subscribers.
2 See the *Insurance Coverage for the Medicare-eligible Member* handbook, located at peba.sc.gov/publications, for information on how this plan coordinates with Medicare.
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 An out-of-network provider may bill you for more than the State Health Plan's allowed amount.
5 The $14 copayment is waived for routine mammograms and well child care visits. Standard Plan members who receive care at a BlueCross-affiliated patient-centered medical home (PCMH) provider will not be charged the $14 copayment for a physician office visit. After Standard Plan and Savings Plan members meet their deductible, they will pay 10 percent coinsurance, rather than 20 percent, for care at a PCMH.
6 The $105 copayment for outpatient facility services is waived for physical therapy, speech therapy, occupational therapy, dialysis services, partial hospitalizations, intensive outpatient services, electroconvulsive therapy and psychiatric medication management.
7 The $175 copayment for emergency care is waived if admitted.
8 Prescription drugs are not covered at out-of-network pharmacies.
9 With Express Scripts' Patient Assurance Program, members in the Standard and Savings plans will pay no more than $25 for a 30-day supply of preferred and participating insulin products in 2021. This program is year-to-year and may not be available in the following year. It does not apply to Medicare members, who will continue to pay regular copays for insulin.

Your online State Health Plan tools

These websites cover information specific to your health and dental benefits. Learn more about online tools for your prescription benefits on Page 79 and State Vision Plan benefits on Page 99.

StateSC.SouthCarolinaBlues.com

The BlueCross website for State Health Plan subscribers offers:

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

My Health Toolkit®

Register and log in so you can:

- See how much of your deductible and coinsurance maximum you have satisfied;
- Check the status of claims, preauthorizations and bills for health and dental providers;
- View your *Explanation of Benefits* online rather than by a mailed paper copy;
- Request a benefits identification card;
- Take a Rally Health Survey;
- Connect with a health coach and access wellness information; and
- Send questions to BlueCross Customer Service.

Rally®

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

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

Companion Benefit Alternatives

On the Member section of Companion Benefit Alternatives' website, www.CompanionBenefitAlternatives.com, you may find under Members:

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

Blue CareOnDemand℠

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

Medicare does not cover video visits, so members enrolled in the Medicare Supplemental Plan are not eligible for this service.

Medical visits

Participating doctors are trained to treat patients through virtual technology, following strict protocols specific to video visits and using best practices for website manner. As part of these protocols, the provider panel treats common urgent care diagnoses including sinusitis, respiratory infection, bronchitis, pink eye and cough as opposed to more severe conditions requiring comprehensive care. If a video visit isn't the right type of service for you, you will be referred to a more appropriate point of service and assisted to ensure you get needed care.

Blue CareOnDemand permits doctors to see patient-supplied background information prior to consultations, and connects with BlueCross' membership system to confirm your eligibility and determine the correct amount of your patient cost share.

This video visit option is covered as a traditional office visit under each Plan. For example, if you have the Standard Plan, a visit before you meet your deductible can total $59, and after you meet your deductible can total $23. If you have the Savings Plan, a visit before you meet your deductible can total $59, and after you meet your deductible can total $11.80.

Lactation consultations

Through Blue CareOnDemand, you can video chat with a lactation consultant at no member cost. Help is available for many of the common issues associated with breastfeeding from the comfort and privacy of your own home. And, it doesn't have to stop after the first visit. You can schedule follow-up appointments at a time and frequency that's right for you. Appointments are available seven days a week.

Behavioral health visits

Don't let emotional difficulties affect your well-being. Video chat with a licensed counselor, therapist, psychologist or psychiatrist from the comfort of your home. And, help doesn't have to stop after your first consultation. Continue follow-up visits as long as you need to. Appointments are available at the time and frequency that are right for you. You pay a $14 copayment,[10] plus the remaining allowed amount until you meet your deductible. Visit **www.BlueCareOnDemandSC.com**, or download the free app today to schedule your first appointment.

MUSC Health Virtual Care

MUSC Health Virtual Care is an easy way to be treated for common conditions such as allergies, pinkeye, sinus infections, skin rashes, sore throat, urinary tract infections and flu. It is available 24/7, but it is not meant to replace your primary care provider. This service is available at no cost to members for all State Health Plan members, including Medicare primary members. There is also

10 Savings Plan members do not pay copayments for any visits, but will pay the full allowed amount until meeting their deductible.

no cost to the Plan when you use this service.

Members ages 18 and older can create an account. Visits for dependent children younger than age 18 must be completed by a parent. You do not need to be a South Carolina resident; however, you must be in the state at the time of the visit.

Learn more about MUSC Health Virtual Care at peba.sc.gov/telehealth.

How the State Health Plan pays for covered benefits

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

- BlueCross serves as the medical claims processor, handling health claims, behavioral health and dental claims. Medi-Call, a division of BlueCross, provides medical preauthorization and case management services. For more information about Medi-Call, see Page 49.
- Companion Benefit Alternatives, a wholly owned subsidiary of BlueCross, is the behavioral health manager, handling mental health and substance use treatment preauthorization, case management, and provider networks. For more information, see Page 51.

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

Allowed amount

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

Paying health care expenses with the Standard Plan

Annual deductible

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

- $490 for individual coverage; and
- $980 for family coverage.

Families enrolled in the Standard Plan have the same deductible, no matter how many family members are covered. The family deductible may be met by any combination of two or more family members' covered medical expenses as long as they total $980. For example, if four people each have $245 in covered expenses, the family deductible has been met, even if no one person has met the $490 individual deductible. If only one person has met the $490 individual deductible, the Plan will begin paying a percentage of the cost of that person's benefits but not a percentage of the cost of the rest of the family's benefits until the family deductible has been met. No family member's claims may contribute more than $490 toward the family deductible.

If the subscriber and the subscriber's spouse, who is also covered on his own plan as an employee or retiree, select the same health plan, they share the family deductible. Both spouses will need to

be listed on the same *Notice of Election* form in this case.

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

Copayments

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

Standard Plan subscribers pay these copayments:

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

The copayment for each visit to a professional provider's office is $14. This copayment is waived for routine Pap tests, routine mammograms and well child care visits. The $14 Standard Plan copayment for services received in a provider's office is not charged for services at a BlueCross-affiliated patient-centered medical home. See Page 67.

The example on Page 41 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 $105. This copayment is waived for physical therapy, speech therapy, occupational therapy, dialysis services, partial hospitalization, intensive outpatient services, electroconvulsive therapy and psychiatric medication management. The copayment for each emergency room visit is $175. This copayment is waived if you are admitted to the hospital.

A prescription drug copayment is a fixed total amount a Standard Plan subscriber pays each time a prescription is filled at an in-network pharmacy. The prescription drug copayment maximum for each family member covered is $3,000. Prescription drug copayments do not apply to the annual deductible or the coinsurance maximum. For more information, see Page 80.

Annual deductible has not been met	
Allowed amount	$56.00
Copayment	- $14.00
Remaining allowed amount (applies to annual deductible)	$42.00
Copayment	$14.00
Amount applied to deductible	+ $42.00
Your total payment	**$56.00**
Annual deductible has been met	
Allowed amount	$56.00
Copayment	- $14.00
Remaining allowed amount	$42.00
	× 20%[11]
Coinsurance	$8.40
Copayment	$14.00
Coinsurance	+ $8.40
Your total payment	**$22.40**

11 In this example, the Standard Plan paid 80 percent, or $33.60, of the $42 allowed amount remaining after the copayment.

Coinsurance

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

If you use out-of-network providers, the plan pays 60 percent of the plan's allowed amount for your covered medical and behavioral health benefits. You pay 40 percent of the allowed amount as coinsurance, which applies to your out-of-network coinsurance maximum. An out-of-network provider may bill you in excess of the allowed amount. Any charge above the plan's allowed amount for a covered medical or behavioral health benefit is your responsibility. See Page 48 to learn more about balance billing and the out-of-network differential.

Standard Plan members pay 10 percent coinsurance, rather than 20 percent coinsurance, for services received at a BlueCross-affiliated patient-centered medical home.

A different coinsurance rate applies for infertility treatments and prescription drugs associated with infertility. See Page 65.

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. For the Standard Plan, it is $2,800 for individual coverage and $5,600 for family coverage for in-network services, and $5,600 for individual coverage and $11,200 for family coverage for out-of-network services.

Please note that the coinsurance for in-network services does not apply to the out-of-network coinsurance maximum. The coinsurance for out-of-network services does not apply to the in-network coinsurance maximum. For example, if you have individual coverage, the network coinsurance maximum is $2,800, and you have paid $2,000 for in-network coinsurance and $800 for out-of-network coinsurance, you have not met your in-network coinsurance maximum.

Standard Plan subscribers continue to pay copayments even after they meet their annual deductible and coinsurance maximum. Copayments for services in a provider's office, a video visit, an outpatient facility and an emergency room do not apply to the annual deductible or to the coinsurance maximum. Prescription drug copayments apply to the $3,000 prescription drug copayment maximum but do not apply to the annual deductible or the coinsurance maximum.

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

Paying health care expenses with the Savings Plan

Annual deductible

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

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

There is no individual deductible if more than one family member is covered. If the subscriber and

spouse, who is also covered as an employee or retiree, select the same health plan, they will share the family deductible. The deductible is not met for any covered individual until the total allowed amount paid for covered benefits exceeds $7,200. For example, even if one family member has paid $3,601 for covered medical benefits, the Plan will not begin paying a percentage of the cost of his covered benefits until his family has paid $7,200 for covered benefits. However, if the subscriber has paid $2,199 for covered benefits, the spouse has paid $3,001 for covered benefits, and a child has paid $2,000 for covered benefits, the plan will begin paying a percentage of the cost of the covered benefits for all family members.

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

Copayments

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

Coinsurance

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

Savings Plan members pay 10 percent coinsurance, rather than 20 percent coinsurance, of the allowed amount for services received at a BlueCross-affiliated patient-centered medical home.

If you use out-of-network providers, the plan pays 60 percent of the Plan's allowed amount for your covered medical and behavioral health benefits. You pay 40 percent of the allowed amount as coinsurance. An out-of-network provider may bill you in excess of the allowed amount. Any charge above the Plan's allowed amount for a covered medical or behavioral health benefit is your responsibility. See Page 48 to learn more about balance billing and the out-of-network differential. Prescription drug benefits are paid only if you use an in-network pharmacy.

A different coinsurance rate applies for infertility treatments and prescription drugs associated with infertility. See Page 65.

Coinsurance maximum

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

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

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

Paying health care expenses if you're eligible for Medicare

To learn more about how the Carve-out Plan (formerly referred to as the Standard Plan) and the Medicare Supplemental Plan work with Medicare, see the *Insurance Coverage for the Medicare-eligible Member* handbook, at peba.sc.gov/publications under Health.

Coordination of benefits

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

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

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

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

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

As part of coordination of benefits with the Standard Plan and the Savings Plan, BlueCross may send you a coordination of benefits questionnaire every year. Complete this form and return it to BlueCross as soon as you are able, because claims will not be processed or paid until BlueCross receives your information. You can also update this information by visiting StateSC.SouthCarolinaBlues.com and going to Resources, then Forms and Documents, then Other Coverage, or by calling BlueCross at 803.736.1576 or 800.868.2520.

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

- For a medical or behavioral health claim, you or your provider files the Explanation of Benefits from your primary plan with BlueCross.
- The State Health Plan will pay the lesser of:
  - What it would pay if it were the primary payer; or
  - The balance after the primary plan's network discounts and payments are deducted from the total charge.

- The State Health Plan's prohibition on balance billing does not apply. Because of this, consider using a provider in your primary plan's network.
- You also will be responsible for the State Health Plan copayments, deductible and coinsurance (if the coinsurance maximum has not been met).

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

End stage renal disease

At the end of the 30-month end stage renal disease coordination period, Medicare will become your primary insurance regardless of your employment status. If you are covered as a retiree, you should contact PEBA within 31 days to change from the Carve-out Plan to the Medicare Supplemental Plan. Refer to the *Insurance Coverage for the Medicare-eligible Member* handbook for more information.

Using State Health Plan provider networks

Because the State Health Plan operates as a preferred provider organization, it has networks of physicians and hospitals, ambulatory surgical centers and mammography testing centers. You will notice that the letters "PPO" are printed on your State Health Plan identification card. The Plan also makes networks available to subscribers for durable medical equipment, labs, radiology and X-ray, physical therapy, occupational therapy, speech therapy, skilled nursing facilities, long-term acute care facilities, hospices and dialysis centers. When joining the network, these providers agree to accept the plan's allowed amount for covered benefits as payment in full. In-network providers will charge you for your deductible, copayments and coinsurance when the services are provided. They also will file your claims.

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

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

Finding a medical or behavioral health network provider

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

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

You can also call BlueCross at 803.736.1576 or 800.868.2520 to request a list of State Health Plan providers in your area.

Companion Benefit Alternatives serves as the behavioral health benefits manager, including

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

Lists of providers from the network directory are also available from BlueCross. If you have questions about network providers, call BlueCross. If you use an out-of-network provider, you will pay more for your care.

Finding a network provider out of state or overseas

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

Inside the United States

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

1. Locate nearby doctors and hospitals by visiting StateSC.SouthCarolinaBlues.com or by calling BlueCard Access at 800.810.2583.
2. Call Medi-Call within 48 hours of receiving emergency care. The toll-free number is on your State Health Plan identification card.
3. The provider should file claims with the BlueCross affiliate in the state where the services were provided.

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

For information about out-of-network benefits, see Page 47.

Outside the United States

Through BlueCross BlueShield Global Core, your State Health Plan identification card gives you access to doctors and hospitals in more than 200 countries and territories worldwide and to a broad range of medical services.

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

Here's how to take advantage of the BlueCross BlueShield Global Core program:

1. If you have questions before your trip, call the phone number on the back of your State Health Plan identification card to check your benefits and for preauthorization, if necessary. Your health care benefits may be different outside of the United States.
2. The BlueCross BlueShield Global Core Service Center can help you find providers in the area where you are traveling. It can also provide other helpful information about health care overseas. Go to bcbsglobalcore.com. You must accept the terms and conditions and login with the first three letters of your BIN. Then you may Select a Provider Type. You also can choose a specialty, city, nation

and distance from the city. You can also call toll-free at 800.810.2583 or collect at 804.673.1177, as toll-free numbers do not always work overseas.

3. If you are admitted to the hospital, call the BlueCross BlueShield Global Core Service Center toll-free at 800.810.2583 or collect at 804.673.1177 as soon as possible.
4. The BlueCross BlueShield Global Core Service Center will work with your plan to arrange direct billing with the hospital for your inpatient stay. When direct billing is arranged, you are responsible for the out-of-pocket expenses (non-covered services, deductibles, copayments and coinsurance) you normally pay. The hospital will submit your claim on your behalf.
5. Please note that if direct billing is not arranged between the hospital and your plan, you must pay the bill up front and file a claim. For outpatient care and doctor visits, pay the provider when you receive care and file a claim.
6. To file a claim for services you paid for when you received care or paid to providers that are not part of the BlueCross BlueShield Global Core network, complete a BlueCross BlueShield Global Core International Claim Form and send it to the BlueCross BlueShield Global Core Service Center with this information: the charge for each service; the date of each service and the name and address of each provider; a complete, detailed bill, including line-item descriptions; and descriptions and dates for all procedures and surgeries. This information does not have to be in English. Be sure to get all of this information before you leave the provider's office.
7. The claim form is on the BlueCross website, StateSC.SouthCarolinaBlues.com under Resources, then Forms and Documents. Then, select the 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. BlueCross BlueShield Global Core will arrange billing to BlueCross.

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

Prescription drug provider network

For more information about your prescription drug provider network, see Page 81.

Vision care provider network

For more information about the State Vision Plan network, see Page 103.

Out-of-network benefits

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

Before the State Health Plan will pay 100 percent of the plan's allowed amount for out-of-network benefits, Standard Plan subscribers will need to meet their annual deductible and then meet the $5,600 individual coinsurance maximum or $11,200 family coinsurance maximum. Savings Plan subscribers will need to meet their annual deductible and then meet the $4,800 individual coinsurance maximum or $9,600 family coinsurance maximum. Subscribers to both plans also may need to fill out claim forms.

Please note that no benefits can be paid for

advanced radiology services (CT, MRI, MRA or PET scans) that are not preauthorized by National Imaging Associates.

There is no coverage available for prescription drugs filled at an out-of-network pharmacy in the United States. Limited drug coverage is offered to members enrolled in the State Health Plan Prescription Drug Program who become ill while traveling overseas. For more information, see Page 81.

Balance billing

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

Out-of-network differential

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

In both examples on this and the following page, 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.

Standard Plan

In-network provider	
Billed charge	$5,000
Allowed amount[12]	$4,000
Annual deductible	- $490
Allowed amount after deductible	$3,510
	× 20%[13]
Coinsurance (applies to maximum)	$702
Copayment[14]	$14
Annual deductible	+ $490
Coinsurance	+ $702
Your total payment	**$1,206**
Out-of-network provider	
Billed charge	$5,000
Allowed amount	- $4,000
Balance bill[15]	$1,000
Allowed amount	$4,000
Annual deductible	- $490
Allowed amount after deductible	$3,510
	× 40%[16]
Coinsurance (applies to maximum)	$1,404
Copayment[14]	$14
Annual deductible	+ $490
Coinsurance	+ $1,404
Balance bill	+ $1,000
Your total payment	**$2,908**

12 Network providers are not allowed to charge more than the allowed amount.
13 The Standard Plan paid 80 percent of the $3,510 allowed amount after the deductible, totaling $2,808.
14 This assumes that the service is an office visit.
15 Out-of-network providers can charge you any amount they choose above the allowed amount and bill you the balance above the allowed amount.
16 The Standard Plan paid 60 percent of the $3,510 allowed amount after the deductible, totaling $2,106.

Savings Plan

In-network provider	
Billed charge	$5,000
Allowed amount[12]	$4,000
Annual deductible	- $3,600
Allowed amount after deductible	$400
	× 20%[17]
Coinsurance (applies to maximum)	$80
Annual deductible	$3,600
Coinsurance	+ $80
Your total payment	**$3,680**
Out-of-network provider	
Billed charge	$5,000
Allowed amount	- $4,000
Balance bill[15]	$1,000
Allowed amount	$4,000
Annual deductible	- $3,600
Allowed amount after deductible	$400
	× 40%[18]
Coinsurance (applies to maximum)	$160
Annual deductible	+ $3,600
Coinsurance	+ $160
Balance bill	+ $1,000
Your total payment	**$4,760**

17 The Savings Plan paid 80 percent of the $400 allowed amount after the deductible, totaling $320.
18 The Savings Plan paid 60 percent of the $400 allowed amount after the deductible, totaling $240.

Getting preauthorization for your medical care

Health care preauthorization

With the State Health Plan, some covered services require preauthorization by a phone call to Medi-Call before you receive them. Your health care provider may make the call for you, but it is your responsibility to ensure the call is made. To preauthorize your medical treatment, call Medi-Call at 800.925.9724.

Please note that in addition to regular health coverage, some behavioral health care services as well as radiology (imaging service) and prescription drug benefits also require preauthorization. See Page 51 for behavioral health, Page 52 for radiology and Page 84 for prescription drugs.

Lab work preauthorization

Certain lab services require prior authorization and require that your provider request Avalon Healthcare Solutions (Avalon)[19] review these services prior to performing the services. Requests may be submitted for prior authorization to Avalon by fax at 888.791.2181 or by phone at 844.227.5769), 8 a.m. to 8 p.m., Eastern Time. Once Avalon receives the request, it will be reviewed by Avalon's clinical staff and they will notify your provider of the determination. An authorization for lab work does not guarantee payment.

Penalties for not calling

If you do not preauthorize treatment when required, you will pay a $490 penalty for each hospital, rehabilitation, skilled nursing facility or behavioral health admission. The penalty amount does not apply to your deductible or coinsurance maximum.

How to preauthorize your treatment

Medi-Call numbers are:

- 803.699.3337 or 800.925.9724.
- 803.264.0183 (fax).

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

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

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

- Any type of inpatient care in a hospital, including admission to a hospital to have a baby[20];
- A preauthorized outpatient service that results in a hospital admission – you must call again for the hospital admission;
- Outpatient surgery for a septoplasty (surgery on the septum of the nose);
- Outpatient or inpatient surgery for a hysterectomy;
- Sclerotherapy (vein surgery) performed in an inpatient, outpatient or office setting;
- A new course of chemotherapy or radiation therapy (one-time notification per course);
- A radiology (imaging) procedure (See Page 52 for more information);
- Pregnancy – you are encouraged to notify Medi-Call within the first three months of your pregnancy (see Page 49 for more information);
- An emergency admission during pregnancy[21];
- Birth of a child (if you plan to file a claim for any birth-related expenses)[21];
- Baby has complications at birth;
- Are going to be, or have been, admitted to a long-term acute care facility, skilled nursing facility or need home health care, hospice care or an alternative treatment plan;
- Need durable medical equipment;
- Undergoing in vitro fertilization, GIFT, ZIFT or any other infertility procedure – this includes you and your covered spouse;
- Need to be evaluated for a transplant – includes you or your covered spouse or family member; and
- Need inpatient rehabilitative services and related outpatient physical, speech or occupational therapy.

Admission to a hospital in an emergency, including emergent care related to the birth of a child, must

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

21 Contacting Medi-Call for the delivery of your baby does not add the baby to your health insurance. You must add your child by logging in to MyBenefits, requesting the change and uploading the required documentation, a long-form birth certificate, within 31 days of birth for benefits to be payable.

be reported within 48 hours or the next working day after a weekend or holiday admission.

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

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

Behavioral health service preauthorization

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

Services that need preauthorization[22]

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

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

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

Although your provider may contact Companion Benefit Alternatives for you, it is your responsibility to see that the call is made and the preauthorization has been granted. A determination by Companion Benefit Alternatives does not guarantee payment. Other conditions, including eligibility requirements, other limitations and exclusions, payment of deductibles and other provisions of the plan must be satisfied before BlueCross makes payment.

22 For behavioral health services, you must call Companion Benefit Alternatives at 800.868.1032.

Penalties for not calling for needed behavioral health service preauthorizations

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

Penalties for not calling for needed facility service preauthorizations

If your provider does not call Companion Benefit Alternatives when required, you will pay a $490 penalty for each hospital admission. The penalty amount does not apply to your deductible or coinsurance maximum.

Advanced radiology preauthorization: National Imaging Associates

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

Doctors can get more information at StateSC.SouthCarolinaBlues.com or by calling 800.444.4311. To request preauthorization online, providers may visit www.RadMD.com or call 866.500.7664, Monday through Friday, from 8 a.m. to 8 p.m.

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

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

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

Penalties for not calling

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

Managing your health

Adult well visits

Adult well visits are covered as a contractual service by the Standard Plan, and are subject to copayments, deductibles and coinsurance. Well visits can be a key part of preventive care. They can reassure members they are as healthy as they feel, or prompt them to ask questions about their health. Evidence-based services, with an A or B recommendation by the United States Preventive Services Task Force (USPSTF), are included as part of an adult well visit under the State Health Plan

(Standard and Savings Plans).

The benefit is available to all non-Medicare primary adults age 19 and older who are covered by the State Health Plan. Adult members can take advantage of this benefit at a network provider specializing in general practice, family practice, pediatrics, internal medicine, gerontology, and obstetrics and gynecology.

Standard Plan members

The Plan covers only one visit in covered years based on the following schedule:

- Ages 19-39, one visit every three years;
- Ages 40-49, one visit every two years; and
- Ages 50 and up, one visit per year.

Eligible female members may use their well visit at their gynecologist or their primary care physician, but not both, in a covered year. If a female visits both doctors for a well visit in the same covered year, only the first routine office visit received will be allowed.

In a non-covered year, members will pay the full allowed amount for the visit, and the full allowed amount will not apply to a member's deductible and coinsurance maximum. The Plan will pay 100 percent of the cost of the lab work and office visit associated with a Pap test for eligible female members in a non-covered year. See the PEBA Perks section on Page 54 for more details.

Savings Plan members

The Plan will cover one visit per year at no member cost. Eligible female members may use their well visit at their gynecologist or their primary care physician, but not both, in a covered year. If a female visits both doctors for a well visit in the same covered year, only the first office visit for which a claim is received will be allowed.

How to get the most out of your benefits

The State Health Plan offers many value-based benefits at no member cost to its primary members through PEBA Perks. Plus, you can set aside money pretax in your MoneyPlus account to pay for your adult well visit. Learn how to coordinate your MoneyPlus and PEBA Perks benefits with your adult well visit below.

1. Set aside money in your MoneyPlus account. Estimate how much you will spend on your adult well visit. Add this amount to your MoneyPlus account.
2. Get your preventive screening. You can receive a biometric screening at no cost, which will minimize cost to you at your adult well visit. Learn more about what's included in a screening on Page 57.
3. Have your adult well visit after your preventive screening. USPSTF A and B recommendations are included as part of an adult well visit. After talking with your doctor during a visit, the doctor can decide which services you need and build a personal care plan for you.
4. Share your preventive screening results with your doctor. You will receive a confidential report with your screening results, and we recommend you share it with your doctor to eliminate the need for retesting at a well visit. Sharing your results will minimize the cost of your adult well visit.
5. Follow your doctor's recommendations and stay engaged with your health. We encourage you to take advantage of the other PEBA Perks available to you. If you're eligible, sign up for No-Pay Copay to receive some generic drugs at no cost to you. Learn more on Page 56.

Services not included as part of an adult well visit

Services not included as part of the adult well visit are those without an A or B recommendation by the USPSTF. Find these recommendations at www.uspreventiveservicestaskforce.org. Other services, including a complete blood count (CBC), EKG, PSA test and basic metabolic panel are covered only if ordered by your physician to treat a specific condition and are subject to the copayment, deductible and coinsurance, as well as normal Plan provisions. Follow-up visits and services as a result of your well visit are also subject to normal Plan provisions.

Learn more about services included in the adult well visit at peba.sc.gov/well-visits.

PEBA Perks

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

Adult vaccinations

Adult vaccinations at intervals recommended by the Centers for Disease Control (CDC) are covered at no cost to Savings Plan, Standard Plan and Medicare Supplemental Plan members at participating providers. Coverage includes the cost of the vaccine and administration fee if the member receives the shot in a network doctor's office. Any associated office visit charges will follow regular Plan coverage rules. Contact your network physician or go to www.cdc.gov/vaccines/schedules and select Adults (19 years and older) to learn which vaccinations are covered.

Breast pump

This benefit provides members with certain electric or manual breast pumps at no cost. Members can learn how to get a breast pump by enrolling in PEBA's maternity management program, Coming Attractions. Learn more about Coming Attractions on Page 59.

Cervical cancer screening

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

- This benefit also covers the cost of the part of the office visit associated with the Pap test.
- Costs for the parts of the office visit not associated with the Pap test are not covered. Charges associated with other exams, lab tests and procedures are the member's responsibility (e.g., pelvic exam, breast exam or physical).
- Eligible Standard Plan female members may use their well visit at their gynecologist or their primary care physician, but not both. If a woman visits both doctors in the same year, only the first routine office visit received will be covered.
- Eligible Savings Plan female members can receive a well visit each year at no member cost. They may receive a routine annual exam or an exam performed in conjunction with the Pap test, but not both. If a woman receives both in the same year, only the first claim received will be covered.

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

Based on the recommendation of the United States Preventive Services Task Force, the Plan will

pay a benefit for human papillomavirus testing once every five years for women ages 30–65, or as otherwise recommended by the U.S. Preventive Services Task Force.

Colorectal cancer screenings

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

The State Health Plan also covers some early detection take-at-home tests to eligible members at no cost for routine and diagnostic colonoscopies. Coverage includes the consultation, generic prep kit, procedure and associated anesthesia. Please note that if you choose a non-generic prep kit, additional charges will apply. Any associated facility charges or lab work as a result of the screening may be subject to patient liability. Visit a qualified network provider to find out which screening option is best for you. You should also contact your provider about the cost of any related services.

Diabetes education

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

Flu vaccine

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

Mammography

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

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

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

Charges for routine mammograms performed by South Carolina providers are not covered unless the provider participates in the BlueCross mammography network, even if the provider participates in the State Health Plan's network. Routine mammograms performed outside of South Carolina are not covered unless the provider participates in a BlueCross network in the state

in which the provider is located. Out-of-network providers are free to charge you any price for their services, so you may pay more.

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

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

No-Pay Copay

The No-Pay Copay program gives eligible[23] State Health Plan members with high blood pressure, high cholesterol, congestive heart failure, cardiovascular disease, coronary artery disease or diabetes a copayment waiver for generic drugs that treat these conditions.[24] The program encourages members to be more engaged in their health — and saves them money. Participants qualify for the program on a quarterly basis. By completing certain activities in one quarter, they are able to receive certain generic drugs at no cost the next quarter.

Members are identified for one of the qualifying conditions automatically by BlueCross. BlueCross notifies members of eligibility and directs them to register for Rally.

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

Once a member who participates in No-Pay Copay enrolls in Medicare as his primary insurance, his copayment waiver is no longer in effect. This is the case regardless of whether the member is enrolled in Employer Group Waiver Plan coverage.

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

Preventive screenings

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

After the screening, you will receive a confidential

23 Employees, retirees, COBRA subscribers, survivors and their covered spouses, and former spouses are eligible to qualify if the State Health Plan is their primary insurance. If a subscriber is enrolled in the Medicare Supplemental Plan but covers a spouse who is not eligible for Medicare, the spouse is eligible for the program. Dependent children are not eligible, regardless of age. If a member qualifies for No-Pay Copay and then becomes Medicare eligible, then the waiver will end at the end of the quarter. These waiver end dates do not apply to members who enroll in Express Scripts Medicare, the State Health Plan's Medicare Part D program. Enrollment in Express Scripts Medicare means that the waiver ends immediately.
24 Diabetes testing supplies (test strips, control solution, lancet, syringes, pen needles, etc.) purchased at an in-network pharmacy are also covered at no charge. A glucometer will be provided by the manufacturer separately.

report with your results and recommendations for improving your health. Taking this report to your doctor may eliminate the need for tests. In addition to taking part in a screening at your workplace, there are other options for taking advantage of this benefit. You are also encouraged to share your results with BlueCross so that they automatically upload into the Rally health survey. Learn more about Rally on Page 38.

Attend a regional preventive screening

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

Visit a participating screening provider

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

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

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

Tobacco cessation

The research-based Quit For Life® program is brought to you by the American Cancer Society and Optum. An expert Quit Coach® will support you over the phone, online and via text as you follow a Quitting Plan customized to your needs.

Quit For Life is offered at no charge to State Health Plan subscribers, their covered spouses and covered dependent children age 13 or older. For eligible 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 a doctor prescribe a tobacco cessation drug, such as bupropion or Chantix, which is available through the State Health Plan's prescription drug coverage. Prescription drugs for tobacco cessation, including Chantix and bupropion, are provided to Savings Plan and Standard Plan members at no cost to the member when obtained from an in-network provider.

To enroll, call 800.652.7230 or 866.QUIT.4.LIFE (866.784.8454). You can also visit www.quitnow.net/SCStateHealthPlan. After your eligibility is verified, you will be transferred to a Quit Coach for your first call.

Well child care benefits

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

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

- Younger than 1 year old (up to six visits);
- 1 year old (up to three visits);
- 2 years old (up to two visits);
- 3 years old until he turns 19 years old (one visit a year).

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

When these services are received from a State Health Plan 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.

Naturally Slim

Naturally Slim is a clinical behavioral weight management program focusing on weight loss and diabetes prevention. State Health Plan members, including spouses and dependent children age 18 and older, are eligible to apply. Medicare-primary members are also eligible to apply. Some medical conditions or body mass indexes (BMIs) may prevent you from participating in the program.

Naturally Slim will teach you it's not what you eat, but when and how you eat that will help you lose weight. Plus, you will reduce your risk for chronic diseases like diabetes and heart disease while increasing your chances of living a longer, healthier life. The program offers an easy-to-use website, welcome kit and video coaching from clinical experts. It is a 10-week, online program that uses weekly video lessons and interactive tools to teach the behavioral skills necessary to lose weight and keep it off long-term. Each week, you will watch lessons at your convenience on your computer, or smartphone and tablet through the iPhone or Android apps.

Following the first 10 weeks, you'll receive seven biweekly sessions and six months of continued support, as needed. This program meets you where you are with simplicity, convenience and an engaging member experience that leads to sustainable health improvement. Learn more at www.naturallyslim.com/PEBA.

Health coaching

The available health coaching programs are designed to help Standard Plan and Savings Plan subscribers and their covered adult family members who have certain behavioral or chronic medical conditions manage their symptoms, and delay or even prevent many of the complications of these diseases.

BlueCross identifies participants by reviewing medical, pharmacy and laboratory claims. If you are identified as someone who could benefit from one of the available health coaching programs, either through your claims or your responses to the Rally Health Survey, you are automatically enrolled, but the programs are voluntary and you can opt out at any time. You may also self-enroll in one or more of the available health coaching programs. If you have high blood pressure, high cholesterol, congestive heart failure, cardiovascular disease, coronary artery disease or diabetes, BlueCross may send you a notification indicating that you also are eligible for the No-Pay Copay program.

As a participant in the health coaching program(s), you will receive educational materials and a welcome letter that will provide the name of and contact information for your BlueCross health coach. Your health coach will be a healthcare professional who will help you learn more about your condition and how to manage it. Your health coach will also help you work with your physician to develop a plan to take charge of your illness, contacting you by phone or through Rally. You can

contact your health coach as often as you like with questions or to ask for advice. To connect with a coach, call 855.838.5897 and select Option 2.

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

Behavioral health

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

- Addiction recovery;
- Attention deficit hyperactivity disorder (ADHD);
- Bipolar disorder; and
- Depression.

Chronic conditions

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

- Asthma;
- Chronic obstructive pulmonary disease (COPD);
- Congestive heart failure;
- Coronary artery disease;
- Diabetes;
- High cholesterol;
- Hypertension (high blood pressure); and
- Migraines.

Healthy lifestyles

If you are ready to get on track with your health but aren't sure where to start, a health coach can help. Your coach can help you achieve a healthier lifestyle with a personalized action plan for meeting your goals.

- Back health;
- Metabolic health;
- Stress management; and
- Weight management for adults and children.

To connect with a coach, call 855.838.5897 and select Option 3.

Maternity

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

To enroll:

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

800.925.9724 to talk to a maternity nurse to complete a maternity health screening.

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

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

Please note that if you do not preauthorize a hospital admission related to your pregnancy or to have your baby, you will pay a $490 penalty for each admission, as you would for any admission, whether the admission was maternity-related or not.

For more information about maternity benefits, including coverage of some breast pumps, see Pregnancy and pediatric care on Page 67.

Medical case management programs

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

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

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

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

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

A Medi-Call nurse stays in touch with the patient, caregivers and providers to assess and re-evaluate the treatment plan and the patient's

progress. All communication between BlueCross and the patient, family members or providers complies with Health Insurance Portability and Accountability Act (HIPAA) privacy requirements. If a patient refuses medical case management, Medi-Call will continue to preauthorize appropriate treatment.

For more information, call 800.925.9724 and ask for a case management supervisor.

Complex care management program

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

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

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

Renal disease case management program

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

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

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

Natural Blue℠ and member discounts

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

Like Natural Blue, Member Discounts offers savings on other products and services that BlueCross makes available but are not State Health Plan benefits. For more information on Natural Blue or Member Discounts, go to StateSC.SouthCarolinaBlues.com, select Resources, then select Member Discounts, or call BlueCross Customer Service at 800.868.2520.

Additional State Health Plan benefits

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

Earlier in this chapter, value-based benefits, including preventive benefits such as immunizations and benefits specific to women and children, are covered in their own section. Behavioral health benefits are also featured in their own section. Prescription drug benefits, dental benefits and vision benefits are covered in later chapters. Some services and treatment require preauthorization from Medi-Call, National Imaging Associates, Companion Benefit Alternatives or Express Scripts. For details read the Medi-Call section beginning on Page 49, the behavioral health section on Page 51 and the National Imaging Associates section on Page 52.

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

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

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

Advanced practice registered nurse

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

Alternative treatment plan

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

Ambulance service

Ambulance service, including air ambulance service, is covered to the nearest hospital to obtain medically necessary emergency care. Ambulance

service may also be 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, if preauthorized. 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, or transport from a higher level of care to a lower level of care. All claims for ambulance service are subject to medical review.

Ambulance services are reimbursed at 80 percent of the allowed amount; however, non- participating providers can balance bill you up to the total of their charge for the service. Please note, all ambulance services, including air ambulance service, may not be in-network. If you have any questions about whether an ambulance service is in-network, contact BlueCross. For information on balance billing, see Page 48.

Autism spectrum disorder benefits

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

Behavioral health benefits

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

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

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

Behavioral health case management

Case management is designed to support members with catastrophic or chronic illnesses. Participants are assigned a case manager, who will help educate you on the options and services available to meet your behavioral health needs and assist in coordinating services.

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

For more information, call 800.868.1032, ext. 25835.

Bone, stem cell and solid organ transplants

State Health Plan transplant contracting arrangements include the Blue Cross Blue Shield Association's 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 49). You must call Medi-Call, even before you or a covered family member is

evaluated for a transplant.

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

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

Chiropractic care

You are covered for specific office-based services from a chiropractor, including detection and correction by manual or mechanical means of structural imbalance, distortion or subluxation in the body to remove nerve interference and the effects of such nerve interference, where such interference is the result of, or related to, distortion, misalignment or subluxation of or in the vertebral column. Diagnostic X-rays are covered if medically necessary. Both the Standard Plan and Savings Plan are limited to one manual therapy per visit, which is subject to the plan maximum. For Standard Plan members, chiropractic benefits are limited to $2,000 per person each year. With the Savings Plan, chiropractic benefits are limited to $500 per person each year for each covered person after the annual deductible has been met. Services of a massage therapist are not covered.

Contraceptives

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

Dental care

Generally, dental care is provided under Dental Plus or Basic Dental, not the State Health Plan. See the **Dental insurance** chapter on Page 88 for more information.

Dental treatments or surgery to repair damage from an accident (for up to one year from the date of the accident), caused by cancer treatment or due to a congenital birth defect are an exception to this, and are covered by the State Health Plan. Dental surgery for bony, impacted teeth is also

covered, when supported by X-rays.

Diabetic supplies

Insulin is allowed under the prescription drug program or under the medical plan but not under both. Diabetic supplies, including syringes, lancets and test strips, are covered at participating pharmacies for a $9 generic copayment, per item, for each supply of up to 30 days. See Page 83 for more information regarding coverage of diabetic supplies and the Express Scripts National Preferred Formulary. Generic drugs to treat diabetes and diabetes testing supplies are covered at no charge for Standard Plan and Savings Plan members enrolled in the No-Pay Copay program. Because insulin is not a generic drug, it is not eligible for the waiver. For more information, see Page 56. Claims for diabetic durable medical equipment should be filed through your medical coverage.

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

Doctor visits

Treatments or consultations for an injury or illness are covered when they are medically necessary within the terms of the plan and not associated with a service excluded by the plan. Some outpatient visits for behavioral health care, such as mental health and substance use care, still require preauthorization. For details on behavioral health benefits, see Page 63.

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 nontherapeutic use;
- Oxygen and equipment for oxygen use outside a hospital setting; and
- Any prosthetic appliance or orthopedic brace, crutch or lift attached to the brace, whether initial or replacement.

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

Home health care

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

Hospice care

The Plan will pay for up to 80 visits per person 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 bereavement counseling, and services must be preauthorized by MediCall.

Infertility

To be eligible for benefits to treat infertility, the subscriber or covered spouse must have a diagnosis of infertility. Coverage is limited to a lifetime maximum payment of $15,000. Please

note that the limit applies to any covered medical benefits and covered prescription drug benefits incurred by the subscriber or the covered spouse, whether covered as a spouse or as an employee. The limit for the individual applies even if the member was married to someone else at the time.

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

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

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 $3,000 per person prescription drug copayment maximum for the Standard Plan. It does apply to the Savings Plan deductible. The 70 percent plan payment for prescription drugs for infertility treatments applies to the $15,000 maximum lifetime payment for infertility treatments. Call Express Scripts' Customer Service at 855.612.3128 for more information about prescription drugs.

Benefits are payable at 70 percent of the allowed amount. Your share of the expenses does not count toward your coinsurance maximum.

All procedures related to infertility must be preauthorized by Medi-Call. For more information, call Medi-Call at 803.699.3337 or 800.925.9724.

Please note that when you become pregnant, you are encouraged to enroll in the Coming Attractions maternity management program. See Page 59 for more information.

Inpatient hospital services

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

Outpatient facility services

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

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

If you are covered by the Standard Plan, you will be charged a $105 outpatient facility services copayment. You will be charged a $175 copayment for emergency room services. These copayments do not apply to your annual deductible or your coinsurance maximum. The copayment for emergency room services is waived if you are

admitted to the hospital.

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

Please note that when lab tests are ordered, you may wish to talk with your provider about having the service performed at an independent, in-network lab. Use of an independent lab may be more cost effective, as it would allow you to avoid paying the $105 copayment for outpatient facility services or the $14 copayment for a physician office visit.

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

Patient-centered medical homes

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

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

To encourage members to seek care at a PCMH, the State Health Plan does not charge Standard Plan members the $14 copayment for a physician office visit. After Savings Plan and Standard Plan subscribers meet their deductible, they will pay 10 percent coinsurance, rather than 20 percent, for services at a BlueCross-affiliated PCMH.

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

Pregnancy and pediatric care

Maternity benefits are provided to subscribers and their covered spouses. Covered children do not have maternity benefits. Maternity benefits include necessary prenatal and postpartum care, including childbirth, miscarriage and complications related to pregnancy. When you become pregnant, you are encouraged to enroll in the Coming Attractions maternity management program. See Page 59 for information.

Breast pumps

Specific models of breast pumps are covered and available at no cost to female subscribers and covered female spouses of subscribers. To use this coverage, you will need to obtain the pump through a BlueCross-contracted provider. While a physician prescription is not required, having a prescription is preferred and will help the order to be processed faster. For more information, go to StateSC.SouthCarolinaBlues.com, then Medical, then PEBA Perks, then Breast Pump.

Length of hospital stay

By federal law, group health plans generally cannot restrict benefits for the length of any hospital

stay in connection with childbirth for the mother or the newborn to fewer than 48 hours after a vaginal delivery or fewer than 96 hours after a caesarean section. The plan may pay for a shorter stay, however, if the attending physician, after consultation with the mother, discharges the mother or newborn earlier.

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

Midwife services

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

Prescription drugs

See the **Prescription benefits** chapter on Page 79 for more information.

Reconstructive surgery after a medically necessary mastectomy

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

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

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

Rehabilitation care

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

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

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

Organizations or the Commission on Accreditation of Rehabilitation Facilities.

Rehabilitation benefits are not payable for:

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

Rehabilitation – acute

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

Rehabilitation – long-term

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

Second opinions

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

Skilled nursing facility

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

Speech therapy

The Plan covers short-term speech therapy to restore speech or swallowing function that has been lost as a result of disease, trauma, injury or a congenital defect, such as cleft lip or cleft palate. Speech therapy must be prescribed by a physician and provided by a licensed speech therapist. Speech therapy, whether it is offered as an inpatient service or in the member's home, requires preauthorization by Medi-Call. Outpatient speech therapy does not require preauthorization. For more information, contact BlueCross Customer Service at 803.736.1576 or 800.868.2520.

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

The State Health Plan covers habilitation speech therapy services for covered dependents ages 6 and under. Speech therapy is not covered when associated with any of the following:

- Verbal apraxia or stuttering ages 7 and above;
- Language delay ages 7 and above;
- Communication delay ages 7 and above;
- Developmental delay ages 7 and above;
- Attention disorders;
- Behavioral disorders;
- Cognitive (mental) retraining;
- Community re-entry programs; or

- Long-term rehabilitation after the acute phase of treatment for the injury or illness.

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

Surgery

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

Other covered benefits

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

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

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

Exclusions – services not covered

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

- Services or supplies that are not medically necessary within the terms of the plan.
- Routine procedures not related to the treatment of injury or illness, except for those specifically listed in the preventive benefits section.
- Routine physical exams, checkups (except adult well visits, well child care and preventive benefits according to guidelines), services, surgery (including cosmetic surgery) or supplies that are not medically necessary.
- Routine prostate exams, screenings or related services are not covered under the plan. A diagnostic prostate exam, screening and laboratory work will be covered when medically necessary but not as part of the Savings Plan annual physical exam. The diagnostic exam will be subject to the State Health Plan's usual deductibles and coinsurance.
- Routine prostate-specific antigen tests.
- Eyeglasses[25].
- Contact lenses[25], unless medically necessary after cataract surgery and for the treatment of keratoconus, a corneal disease affecting vision.
- Routine eye examinations[25].
- Refractive surgery[25], such as radial keratotomy, laser-assisted in situ keratomileusis (LASIK) vision correction and other procedures to alter the refractive properties of the cornea.
- Hearing aids and examinations for fitting them.
- Dental services[26], except for removing impacted teeth, treatment within one year of a condition resulting from an accident, treatment made necessary by the loss of teeth due to cancer treatment and treatment necessary as a result of a congenital birth defect.
- TMJ splints, braces, guards, etc. Medically-necessary surgery for TMJ is covered if preauthorized by Medi-Call. TMJ, temporomandibular joint syndrome, is often

25 Although vision benefits are generally not covered by the State Health Plan, coverage and discounts are available through the State Vision Plan. See the Vision care chapter on Page 98.
26 Dental benefits are available through Dental Plus and Basic Dental. See the Dental insurance chapter on Page 88.

characterized by headache, facial pain and jaw tenderness caused by irregularities in the way joints, ligaments and muscles in the jaws work together.

- Custodial care, including sitters and companions or homemakers/caretakers.
- Admissions or portions thereof for custodial care or long-term care, including:
- Respite care;
  - Long-term acute or chronic psychiatric care;
  - Care to assist a member in the performance of activities of daily living (i.e., custodial care, including, but not limited to: walking, movement, bathing, dressing, feeding, toileting, continence, eating, food preparation and taking medication); and
  - Psychiatric or substance use long-term care, including: therapeutic schools, wilderness/boot camps, therapeutic boarding homes, halfway houses and therapeutic group homes.
- Any item that may be purchased over the counter, including but not limited to medicines and contraceptive devices.
- Surgery to reverse a vasectomy or tubal ligation if elective and not medically necessary to treat a pre-existing condition.
- Diagnosis or treatment of infertility for a subscriber or a spouse if either member has had a tubal ligation or vasectomy.
- Assisted reproductive technologies (fertility treatment), except as described on Page 66.
- Weight loss treatments and all weight loss surgery, including, but not limited to: gastric bypass, gastric banding or stapling; intestinal bypass and any related procedures; the reversal of such procedures; and conditions and complications as a result of such procedures or treatment.
- Equipment that has a nontherapeutic use (such as humidifiers, air conditioners, whirlpools, wigs, artificial hair replacement, vacuum cleaners, home and vehicle modifications, fitness supplies, speech augmentation or communication devices, including computers, etc.), regardless of whether the equipment is related to a medical condition or prescribed by a physician.
- Air quality or mold tests.
- Supplies used for participation in athletics (that are not necessary for activities of daily living), including, but not limited to, splints or braces.
- Physician charges for medicine, drugs, appliances, supplies, blood and blood derivatives, unless they are covered medical benefits under the Plan.
- Medical care by a doctor on the same day or during the same hospital stay in which you have surgery, unless a medical specialist is needed for a condition the surgeon could not treat.
- Physician's charges for clinical pathology, defined as services for reading any machine-generated reports or mechanical laboratory tests. Interpretation of these tests is included in the allowance for the lab service.
- Fees for medical records and claims filing.
- Food supplements, including, but not limited to, infant formula, enteral nutrition, Boost/Ensure or related supplements.
- Services performed by members of the insured's immediate family.
- Acupuncture.

- Chronic pain management programs.
- Transcutaneous (through the skin) electrical nerve stimulation (TENS), whose primary purpose is the treatment of pain.
- Biofeedback.
- Complications arising from the receipt of non-covered services.
- Psychological tests to determine job, occupational or school placement, or for educational purposes; milieu therapy; or to determine learning disability.
- Any service or supply for which a covered person is entitled to payment or benefits pursuant to federal or state law (except Medicaid), such as benefits payable under workers' compensation laws.
- Charges for treatment of illness or injury or complications caused by acts of war or military service.
- Cosmetic goods, procedures, surgery or complications resulting from such procedures or services.
- Smoking cessation or deterrence products or services, except for those covered by the Prescription Drug Program or as authorized by the tobacco cessation program for eligible participants in its tobacco cessation program.
- Sclerotherapy (treatment of varicose veins), including injections of sclerosing solutions for varicose veins of the leg, unless a prior-approved ligation (tying off of a blood vessel) or stripping procedure has been performed within three years and documentation submitted to Medi-Call with a preauthorization request establishes that some varicosities (twisted veins) remained after the procedure.
- Services performed by service or therapy animals or their handlers.
- Abortions, except for an otherwise legal abortion performed in accordance with federal Medicaid guidelines.
- A covered child's infertility treatment, pregnancy or complications from pregnancy or childbirth.
- Storage of blood or blood plasma.
- Experimental or investigational surgery or medical procedures, supplies, devices or drugs. Any surgical or medical procedures determined by the medical staff of the third-party-claims processor, with appropriate consultation, to be experimental or investigational or not accepted medical practice. Experimental or investigational procedures are those medical or surgical procedures, supplies, devices or drugs, which, at the time provided or sought to be provided:
  - Are not recognized as conforming to accepted medical practice in the relevant medical specialty or field of medicine; or
  - The procedures, drugs or devices have not received final approval to market from appropriate government bodies; or
  - Are those about which the peer-reviewed medical literature does not permit conclusions concerning their effect on health outcomes; or
  - Are not demonstrated to be as beneficial as established alternatives; or
  - Have not been demonstrated, to a statistically significant level, to improve the net health outcomes; or
  - Are those in which the improvement claimed is not demonstrated to be obtainable outside the investigational or experimental setting.

Additional limits in the Standard Plan

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

Additional limits and exclusions in the Savings Plan

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

How to file a State Health Plan claim

Services in South Carolina

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

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

To file a claim:

- Complete the claim form.
- Attach your itemized bills, which must show the amount charged; the patient's name; the date(s) and place of service(s); the diagnosis, if applicable; procedure codes; and the provider's name, federal Tax Identification Number or National Provider Identifier, if available.

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

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

Mail claims to:

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

For more information, call BlueCross at 800.868.2520 or 803.736.1576.

Services outside of South Carolina

Generally, if you obtain services outside South Carolina or the U.S. from a BlueCard network doctor or hospital, you should not need to pay up-front for care, except for the usual out-of-pocket expenses, such as deductibles, copayments, coinsurance and non-covered services. The provider should submit the claim on your behalf.

Network providers will file claims to the BlueCross affiliate in the state in which the service was provided. Outside the U.S., you should complete a BlueCross BlueShield Global Core Claim Form and send it to the BlueCross BlueShield Global Core Service Center. This claim form is available at peba.sc.gov/forms and StateSC.SouthCarolinaBlues.com. If services are received from an out-of-network provider, you may be asked to pay up front for the full cost of the services received and may also be required to file the claim to BlueCross yourself.

For more information, call BlueCross BlueShield Global Core at 800.810.2583 or 804.673.1177.

Appeals

Claims and preauthorization appeals to third-party claims processors

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

In the case of BlueCross, Medi-Call or CBA you may appeal an initial claim or preauthorization denial within six months of the decision. If you would like for someone else to appeal on your behalf, you may make this request to BlueCross, Medi-Call or CBA in writing. Please note, medical providers cannot appeal on your behalf. Contact information is provided below if you have questions about how to file an appeal.

BlueCross Blue Shield of South Carolina

- StateSC.SouthCarolinaBlues.com.
- 803.736.1576 or 800.868.2520.

Medi-Call

- 803.699.3337 or 800.925.9724.

Companion Benefit Alternatives

- www.CompanionBenefitAlternatives.com.
- 803.736.1576 or 800.868.2520.

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

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

National Imaging Associates

- www.RadMD.com.
- 866.500.7664.

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

Appeals to PEBA: preauthorizations and services that have been provided

If you are still dissatisfied after the decision has been reexamined, you may request a second-level appeal by sending an ***Appeal Request Form*** to PEBA within 90 days of your notice of the denial. Please include a copy of the previous two denials with your appeal to PEBA. Send the request to:

IAD@peba.sc.gov

or

S.C. PEBA
Attn: Insurance Appeals Division
202 Arbor Lake Drive
Columbia, SC 29223

If your appeal relates to a pregnancy, newborn child or the preauthorization of a life-saving treatment or drug, you may email your ***Appeal Request Form*** to urgentappeals@peba.sc.gov.

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

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

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

GEA TRICARE Supplement Plan

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

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

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

Eligibility

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

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

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

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

As a subscriber, you may cover your eligible

dependent children; however, dependent eligibility for the TRICARE Supplement Plan is based on TRICARE eligibility rules and is different from PEBA's dependent eligibility rules.

Eligible dependent children

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

How to enroll

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

To enroll

1. Membership in the Government Employees Association is required for enrollment in the TRICARE Supplement Plan. Information about the Government Employees Association is provided in the TRICARE Supplement Plan welcome packet. Dues are included in the plan's monthly premium. For more information, contact the Government Employees Association at 800.446.7600 or **www.geausa.org**.
2. Complete a *Notice of Election* and check "TRICARE Supplement Plan" in the health plan section. Return the Notice of Election to your benefits administrator, along with a copy of your military ID or TRICARE ID card. Also, if you are an active employee, your benefits administrator can enroll you online. As a subscriber, you can enroll through **MyBenefits.sc.gov** during open enrollment. See Page 20 for more information. If you are a retired employee of a state agency, public higher education institution or public school district, submit a *Retiree Notice of Election* to PEBA. If you are a participating optional employer retiree, submit a *Retiree Notice of Election* to your former employer's benefits office. See Page 162 for more information. Coverage is not automatic.
3. If you are an eligible subscriber, complete the TRICARE Other Health Insurance form if you were previously enrolled in the State Health Plan. The TRICARE Other Health Insurance form for each region is on the TRICARE website, **www.tricare.mil**. Fax the completed forms to TRICARE at the number on the form. Remember, the TRICARE Supplement Plan is not considered other health insurance.

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

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

information.

Plan features

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

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

Filing claims

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

Medicare eligibility and the TRICARE Supplement Plan

If, as an active employee, survivor or retiree, you become eligible for Medicare Part A, you must purchase Medicare Part B to remain eligible for TRICARE. Your TRICARE health benefit changes to TRICARE for Life 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 at 800.638.2610, Option 1 for details.

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

Loss of TRICARE eligibility

The TRICARE Supplement Plan pays after TRICARE pays. Therefore, if an employee, spouse or dependent child loses TRICARE eligibility, TRICARE Supplement Plan coverage ends. Dependents who lose TRICARE eligibility are not eligible for continued TRICARE Supplement Plan coverage through COBRA or on portability. Loss of TRICARE eligibility is a special eligibility situation that permits an eligible employee or retiree and 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 at no cost to active employees who enroll in the State Health Plan.

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

Loss of a dependent child's TRICARE eligibility
A dependent child loses TRICARE eligibility at age 21 if they are not enrolled in school on a full-time basis. A dependent also loses eligibility at midnight on their 23rd birthday, regardless of whether they are a full-time student, or on the date they graduate from college, whichever comes first.

An adult dependent child enrolled in TRICARE Young Adult loses eligibility at midnight the night of their 26th birthday or the date they fail to pay full premiums to their TRICARE regional contractor.

More information

For more information about the Government

Employees Association TRICARE Supplement Plan, contact Selman & Company at **www.selmantricareresource.com/sc** or 800.638.2610, Option 1.

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

Prescription benefits

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

Using generic drugs saves money for you and your plan. You also can save money and receive the same U.S. Food and Drug Administration (FDA) approved drugs when you refill prescriptions through the plan's Retail Maintenance Network or mail-order prescription service. Benefits are paid only for prescriptions filled at network pharmacies or through Express Scripts mail-order pharmacy in the United States. Limited coverage is offered outside the United States. For more information on how to file a claim, see Page 86

Using your prescription benefits

You will receive two prescription drug benefits cards from Express Scripts. Present your card when you fill a prescription, particularly the first time you use your card, and any time you fill a prescription at a different pharmacy to ensure you pay the appropriate amount.

Member resources

Helpful information about your State Health Plan prescription drug benefits is just a click away at www.Express-Scripts.com and on the Express Scripts mobile app. The app can be downloaded for free from the iTunes, Google Play, Windows Phone and Amazon app stores. You are encouraged to create an account to get the most out of these resources. Be sure to have your prescription drug card available when you register. The website and mobile app offer a variety of information and tools:

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

State Health Plan Prescription Drug Program

Standard Plan

Standard Plan members pay a copayment when filling prescriptions at a network pharmacy. Copayments for up to a 30-day supply are:

- Tier 1 (generic): $9
- Tier 2 (brand – preferred): $42
- Tier 3 (brand – non-preferred): $70

The prescription drug copayment is a fixed total amount a member must pay for a covered drug. If the pharmacy's charge is less than the copay, the member pays the lesser amount. The insurance plan pays the cost beyond the copayment, up to the allowed amount. Prescription drug benefits are payable without an annual deductible, and there are no claims to file.

The prescription drug benefit has a separate annual copayment maximum of $3,000 per person. This means that after you spend $3,000 in prescription drug copayments, the plan will pay 100 percent of the allowed amount for your covered prescription drugs for the rest of the year. Drug expenses do not count toward your medical annual deductible or medical coinsurance maximum.

Savings Plan

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

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

Express Scripts Medicare®

If you are enrolled in the State Health Plan as an active employee and you or your covered dependents become eligible for Medicare, PEBA automatically enrolls the Medicare-eligible member in Express Scripts Medicare®, the State Health Plan's Medicare Part D program. For information about Express Scripts Medicare®, see the *Insurance Coverage for the Medicare-eligible Member* handbook, which is available at peba.sc.gov/publications under Health.

Pharmacy network

How to find participating pharmacies

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

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

Retail pharmacies

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

Smart90 Network and Preferred90 Network

You may buy up to 90-day supplies of prescription drugs at discounted prices at your local network pharmacy that participates in the Smart90 Network (Commercial Plan) or Preferred90 Network (Express Scripts Medicare). You will pay a lower copayment than if you purchased this medication one month at a time. Be sure to ask your physician to write your prescription for a 90-day supply. The discount applies only to prescriptions filled for a 61-to-90 day supply. Copayments for prescriptions filled for a 1-to-60 day supply will follow the normal retail prices. You can search for a Smart90 Network or Preferred90 Network pharmacy by logging in to your Express Scripts account at www.Express-Scripts.com or on the Express Scripts mobile app.

Mail order through Express Scripts Pharmacy

The State Health Plan Prescription Drug Program and Express Scripts Medicare® offer home delivery for 90-day supplies of prescriptions through Express Scripts Pharmacy. When you use this service, you receive the same discount on the same FDA-approved prescription drugs that you would receive in the Smart90 or Preferred90 networks.

Some controlled substances may not be available by mail; call Express Scripts at 855.612.3128 before

submitting your prescription to determine if your prescription is available. Be sure to ask your physician to write your prescription for a 90-day supply.

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

Standard Plan and Medicare Supplemental Plan
The copayments for up to a 90-day supply are:

- Tier 1 (generic): $22
- Tier 2 (brand– preferred): $105
- Tier 3 (brand– non-preferred): $175

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 generally be less if you use the Smart90 Network or Express Scripts mail service pharmacy.

How to order drugs by mail

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

How to fill a prescription by fax

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

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

Prescription copayments and formulary

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

Tier 1: generic

$9 copayment

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

Tier 2: preferred brand

$42 copayment

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

Tier 3: non-preferred brand

$70 copayment

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

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

Non-covered formulary drugs

PEBA adopted Express Scripts' National Preferred Formulary. In the State Health Plan Prescription Drug Program only, there are certain brands of products in highly interchangeable therapeutic categories that are not covered. This does not apply to members enrolled in Express Scripts Medicare. There are preferred products covered and available in each of these categories. If you are prescribed a drug that is non-covered, or non-preferred, we encourage you to talk to your doctor about prescribing preferred drugs. As a State Health Plan member, you still have access to comparable medications that are covered by the Plan.

Express Scripts' Patient Assurance Program

With Express Scripts' Patient Assurance Program, State Health Plan primary members will pay no more than $25 for a 30-day supply of preferred and participating insulin products in 2021. This program is year-to-year and may not be available in the following year. It does not apply to Express Scripts Medicare members, who will continue to pay regular copays for insulin.

Pay-the-difference policy

If you purchase a brand-name drug when an FDA-approved generic equivalent is available, the plan will pay only the allowed amount for the generic equivalent. This pay-the-difference policy applies even if your doctor prescribes the drug as Dispense as Written or Do Not Substitute.

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

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

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

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.

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

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

	Tier 1 (generic)	Tier 2 (brand)
Allowed amount for drug		$125
Generic copayment		N/A
Amount you pay[2]		**$42**

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

	Tier 1 (generic)	Tier 2 (brand)
Allowed amount for drug	$65	$125
Generic copayment	$9	N/A
Amount you pay if you chose the generic drug	$9	
Amount you pay because you chose the brand drug[3]		**$69**

Specialty pharmacy programs

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

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

Members who fill prescriptions for specialty medications must use the Plan's custom credentialed specialty network.[4] The network includes South Carolina independently-owned specialty pharmacy accredited pharmacies and Accredo, Express Scripts' specialty pharmacy. Patients seeking specialty medication should contact Express Scripts at 855.612.3128 for more information.

Coverage reviews

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

Prior authorization

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

2 You pay brand copayment only.
3 You pay generic copayment plus difference between allowed amount for generic and brand drugs.

4 Some specialty medications administered in a provider's office may require prior authorization.

your doctor or your pharmacist may begin the review process by contacting Express Scripts at 855.612.3128.

Drug quantity management

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

Step therapy

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

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

Compound prescriptions

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

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

Coordination of benefits

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

Medicare coverage for self-administered medications during an outpatient hospital observation stay

Outpatient hospital observation services are services received at a hospital while the doctor decides whether to admit a patient as inpatient or discharge him from the hospital. Patients can receive observation services in the emergency department or another area of the hospital. Observation can last for up to a 72-hour period. Medicare covers observation services under Medicare Part B. For safety reasons, many hospitals have policies that do not allow patients to bring prescription medications or other drugs

from home. These medications are considered self-administered drugs and Medicare defines these medications as drugs a patient would take by mouth or administer to himself and include, but are not limited to: oral medications, insulin, eye drops and topical treatments. Self-administered drugs are not covered under Medicare Part B.

A Medicare-eligible member who has had a hospital observation stay may have self-administered medication charges denied under Medicare Part B. Self-administered medications may be covered under the prescription benefit for EGWP (Medicare Part D) members and Medicare primary retirees covered under the State Health Plan Commercial Plan. If self-administered medications are denied by Medicare as not covered under Medicare Part B during a hospital observation stay, members can submit a paper claim for reimbursement under the prescription benefit. The claim will be paid at the pharmacy network rate (allowed amount) and may not cover the full amount billed to the member.

Exclusions

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

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

Prescription drugs associated with infertility treatments have a different coinsurance rate. See Page 65 for more information about infertility treatments.

Examples of other drugs that are not covered are:

- Drugs in FDA Phase I, II or III testing; and
- Prescription drugs used for weight loss.
- Drugs that are not covered under the Savings Plan but are covered under the Standard Plan are:
  - Non-sedating antihistamines; and
  - Drugs for treating erectile dysfunction.

Value-based prescription benefits at no cost to you

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

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

Filing a prescription drug claim

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

To file a claim for prescription drug expenses incurred at a participating pharmacy or outside the United States, complete the Express Scripts

Prescription Drug Claim Form. The form is available online at **peba.sc.gov/forms**. You may also request a copy by calling Express Scripts at 855.612.3128.

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

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

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

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

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

Appeals

If Express Scripts denies prior authorization for your medication, you will be informed promptly. If you have questions about the decision, check the information in this chapter. You or your prescriber may also call Express Scripts for an explanation. If you believe the decision was incorrect, you may ask Express Scripts to re-examine its decision.

The request for a review should be made in writing within six months after notice of the decision to:

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

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

IAD@peba.sc.gov

or

S.C. PEBA
Attn: Insurance Appeals Division
202 Arbor Lake Drive
Columbia, SC 29223

If your appeal relates to a pregnancy, newborn child, or the preauthorization of a life-saving treatment or drug, you may send an ***Appeal Request Form*** to PEBA via email to **urgentappeals@peba.sc.gov**.

Appeals to PEBA

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

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

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

Dental insurance

You have two options for dental coverage: Dental Plus or Basic Dental (formerly known as the State Dental Plan). You choose the plan that works best for you. When you make your election, you'll choose either Dental Plus or Basic Dental, not both. If you choose Dental Plus, we will automatically enroll you in both plans.

Dental Plus pays more and has higher premiums and lower out-of-pocket costs. Basic Dental pays less and has lower premiums and higher out-of-pocket costs. Members may enroll in or drop Dental Plus and Basic Dental:

- During initial enrollment in PEBA's insurance programs.
- During an open enrollment period in an odd-numbered year. The next two opportunities will be October 2021 and October 2023.
- Within 31 days of a special eligibility situation. Special eligibility situations are explained on Page 21.

Online resources

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

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

Classes of treatment

Dental coverage offers four classes of treatment. Details about the benefits in each class are in the chart on Page 91.

- **Class I: Diagnostic and preventive** Exams; cleaning and scaling of teeth; fluoride treatment; space maintainers (child); X-rays.
- **Class II: Basic** Fillings; extractions; oral surgery; endodontics (root canals); periodontal procedures.
- **Class III: Prosthodontics** Onlays; crowns; bridges; dentures; implants; repair of prosthodontic appliances.
- **Class IV: Orthodontics** Limited to covered children ages 18 and younger. Correction of malocclusion consisting of diagnostic services (including models, X-rays) and active treatment (including necessary appliances).

Dental Plus

Dental Plus has higher allowed amounts, which are the maximum amounts allowed by the Plan for a covered service. Network providers cannot charge you for the difference in their cost and the allowed amount. The maximum yearly benefit for a person covered by Dental Plus is $2,000. Not all dental procedures are covered. You will be responsible for any charges related to non-covered services. Please see Page 93 for more information.

See the chart on Page 91 for more information.

Dental Plus network

BlueCross offers dentists in South Carolina agreements to participate in the Dental Plus network and accept the lesser of their usual charge or the negotiated allowed amount. Allowed amounts may vary by network dentist and/or

the physical location of the dentist. You are only responsible for any deductibles and coinsurance, plus any non-covered services rendered by an in-network dentist who has accepted BlueCross' agreement. For a list of network dentists, go to StateSC.SouthCarolinaBlues.com and select Find a Dentist under the Find a Doctor section.

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

Basic Dental

Basic Dental has lower allowed amounts, which are the maximum amounts allowed by the plan for a covered service. There is no network for Basic Dental; therefore, providers can charge you for the difference in their cost and the allowed amount. Basic Dental benefits are paid based on the allowed amounts for each dental procedure listed in the Plan's *Schedule of Dental Procedures and Allowed Amounts*, found at StateSC.SouthCarolinaBlues.com under Coverage Information, then Dental and Dental Fee Schedule. The maximum yearly benefit for a person covered by Basic Dental is $1,000. Not all dental procedures are covered. You will be responsible for any charges related to non-covered services. Please see Page 93 for more information.

See the chart on Page 91 for more information.

Special provisions of Basic Dental

Alternate forms of treatment

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

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

Pretreatment estimates

Although it is not required, PEBA suggests that you obtain a pretreatment estimate of your non-emergency treatment for major dental procedures. To do this, you and your dentist should fill out a *Dental Claim Form* before any work is done. The form can be found at peba.sc.gov/forms. The completed form should list the services to be performed and the charge for each one. Mail the claim form to:

BlueCross BlueShield of South Carolina
State Dental Unit
P.O. Box 100300
Columbia, SC 29202

Emergency treatment does not need a pretreatment estimate.

You and your dentist will receive a pretreatment estimate, showing an estimate of the expenses your dental plan will cover. This form can be used to file for payment as the work is completed. Just fill in the date(s) of service, ask your dentist to sign the form and submit it to BlueCross. Your pretreatment estimate is valid for 90 days from the date of the form. The actual date of service may affect the payment allowed. For example, if

you have reached your maximum yearly payment when you have the service performed or if you no longer have dental coverage, you will not receive the amount that was approved on the pretreatment estimate.

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

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

Comparing Dental Plus and Basic Dental

	Dental Plus	Basic Dental
Diagnostic and preventive *Exams, cleanings, X-rays*	You do not pay a deductible. The Plan will pay 100% of a **higher allowed amount**. In network, a provider **cannot charge you for the difference** in its cost and the allowed amount.	You do not pay a deductible. The Plan will pay 100% of a **lower allowed amount**. A provider **can charge you for the difference** in its cost and the allowed amount.
Basic *Fillings, oral surgery, root canals*	You pay up to a **$25** deductible per person.[1] The Plan will pay 80% of a **higher allowed amount**. In network, a provider **cannot charge you for the difference** in its cost and the allowed amount.	You pay up to a **$25** deductible per person.[1] The Plan will pay 80% of a **lower allowed amount**. A provider **can charge you for the difference** in its cost and the allowed amount.
Prosthodontics *Crowns, bridges, dentures, implants*	You pay up to a **$25** deductible per person.[1] The Plan will pay 50% of a **higher allowed amount**. In network, a provider **cannot charge you for the difference** in its cost and the allowed amount.	You pay up to a **$25** deductible per person.[1] The Plan will pay 50% of a **lower allowed amount**. A provider **can charge you for the difference** in its cost and the allowed amount.
Orthodontics[2] *Limited to covered children ages 18 and younger.*	You do not pay a deductible. There is a $1,000 lifetime benefit for each covered child.	You do not pay a deductible. There is a $1,000 lifetime benefit for each covered child.
Maximum payment	$2,000 per person each year for diagnostic and preventive, basic and prosthodontics services.	$1,000 per person each year for diagnostic and preventive, basic and prosthodontics services.

1 If you have basic or prosthodontics services, you pay only one deductible. Deductible is limited to three per family per year.
2 There is a $1,000 maximum lifetime benefit for each covered child, regardless of plan or plan year.

Plan comparison examples

Scenario 1: Routine checkup

Includes exam, four bitewing X-rays and adult cleaning

	Dental Plus		Basic Dental
	In network	Out of network	
Dentist's initial charge	$191.00	$191.00	$191.00
Allowed amount[3]	$135.00	$171.00	$67.60
Amount allowed by the Plan (100%)	$135.00	$171.00	$67.60
Your coinsurance (0%)	$0.00	$0.00	$0.00
Difference between allowed amount and charge	$56.00 *Dentist writes off this amount*	$20.00	$123.40
You pay	**$0.00**	**$20.00** *Difference in allowed amount and charge*	**$123.40** *Difference in allowed amount and charge*

Scenario 2: Two surface amalgam fillings

	Dental Plus		Basic Dental
	In network	Out of network	
Dentist's initial charge	$190.00	$190.00	$190.00
Allowed amount[3,4]	$145.00	$177.00	$44.80
Amount allowed by the Plan (80%)	$116.00	$141.60	$35.84
Your coinsurance (20%)	$29.00	$35.40	$8.96
Difference between allowed amount and charge	$45.00 *Dentist writes off this amount*	$13.00	$145.20
You pay	**$29.00** *20% coinsurance*	**$48.40** *20% coinsurance plus difference*	**$154.16** *20% coinsurance plus difference*

3 Allowed amounts may vary by network dentist and/or the physical location of the dentist.
4 Example assumes that the $25 annual deductible has been met.

Exclusions – dental services not covered

The *Group Dental Insurance Benefit Plan* document lists all exclusions and is found at peba.sc.gov/publications under Dental. The list below includes many of the exclusions.

General benefits not offered

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

Benefits covered by another plan

- Treatment for which the covered person is entitled under any workers' compensation law.
- Services or supplies that are covered by the armed services of a government.
- Dental services for treatment of injuries as a result of an accident that are received during the first 12 months from the date of the accident. These services are covered under the member's health plan.
- Additional benefits for dental services for natural and artificial teeth, dentures, bridges, etc., made necessary by loss of teeth due to cancer treatment or as a result of a congenital birth defect, are 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.
- Investigational or experimental services or supplies.
- Any service or charge for a service not medically necessary.
- Onlays or crowns, when used for preventive or cosmetic purposes or due to erosion, abrasion or attrition.
- Services and supplies for cosmetic or aesthetic purposes, including charges for personalization or characterization of dentures, except for orthodontic treatment as provided for under this plan.
- Myofunctional therapy (i.e., correction of tongue thrusting).
- Appliances or therapy for the correction or treatment of temporomandibular joint (TMJ)

syndrome.

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

Limited benefits

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

osseous (bone) surgery or periodontal scaling and root planing.

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

Prosthodontic and orthodontic benefits

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

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 Basic Dental lists for each dental procedure in the *Schedule of Dental Procedures and Allowed Amounts*, found at **StateSC.SouthCarolinaBlues.com**. Dental Plus has higher allowed amounts. 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 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 Dental Plus and Basic Dental, if the member is covered by a dental plan. The amount paid under the dental plan 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 $2,000 for a person covered by Dental Plus and $1,000 for a person covered by Basic Dental. The maximum lifetime benefit for orthodontic services is $1,000, regardless if covered under Dental Plus or Basic Dental, and it is limited to covered children age 18 and younger. See the chart on Page 91 for more information.

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

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

How to file a dental claim

The easiest way to file a claim is to assign benefits to your dentist. Assigning benefits means you authorize your dentist to file your claims and to receive payment from the plan for your treatment. To do this, show a staff member in your dentist's office your dental identification card and ask that the claim be filed for you. Be sure to sign the payment authorizations in blocks 36 and 37 of the claim form. BlueCross will then pay your dentist directly. If covered by Dental Plus and visit an in-network provider, you are responsible for your coinsurance. If covered by Basic Dental, you are responsible for the difference between the allowed amount and the actual charge, plus your coinsurance.

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

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

- The dentist's name and address and federal Tax Identification Number or National Provider Identifier (NPI);
- The patient's name;
- The date of each service;
- The name of or procedure code for each service; and
- The charge for each service.

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

BlueCross BlueShield of South Carolina
State Dental Unit

P.O. Box 100300
Columbia, SC 29202

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

What if I need help?

You can call BlueCross at 888.214.6230, visit StateSC.SouthCarolinaBlues.com or write BlueCross at the address above.

Appeals

If BlueCross denies all or part of your claim or proposed treatment, you will be informed promptly. If you have questions about the decision, check the information in this chapter or call for an explanation. If you believe the decision was incorrect, you may ask BlueCross to re-examine its decision. The request for a second review should be made in writing within six months after notice of the decision to:

BlueCross BlueShield of South Carolina
Attn: State Dental Appeals
AX-B15
P.O. Box 100300
Columbia, SC 29202-3300

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

IAD@peba.sc.gov

or

S.C. PEBA
Attn: Insurance Appeals Division
202 Arbor Lake Drive
Columbia, SC 29223

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

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

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

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

Vision care

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

Online vision benefits information

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

- The Find a Provider feature;
- The View Your Benefits feature, including which family members are covered and when everyone will be eligible for particular services next. Note: Due to privacy guidelines, EyeMed shows only family members who are under age 18. Anyone ages 18 or older will need to register for his own account;
- Access to claims status updates;
- A printable ID card and out-of-network claim form;
- The option of going paperless for your Explanations of Benefits;
- Ordering contact lenses through ContactsDirect; and
- The Vision Wellness section, where you can learn more about eye exams, eye diseases and selecting eyewear.

State Vision Plan

The State Vision Plan is available to eligible employees; retirees; survivors; permanent, part-time teachers; COBRA subscribers; former spouses; and their covered family members. Subscribers pay the premium without an employer contribution.

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

A benefit may not be combined with any discount, promotional offering or other group benefit plan. The sales tax on any benefit, such as eyeglasses or contact lenses, is not covered by the State Vision Plan.

Eye exams

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

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

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

Frequency of benefits

The State Vision Plan covers:

- A comprehensive eye exam once a year;
- Standard plastic lenses for eyeglasses, or contact lenses instead of eyeglass lenses, once a year;
- Frames once every year; and

- Members with Type 1 or Type 2 diabetes are eligible for office service visits and diagnostic testing once every six months to monitor for signs of diabetic changes in the eye.

Vision benefits at a glance[1,2]

	In-network member cost	Out-of-network member cost
	You pay ...	You receive ...
Comprehensive exam with dilation, as necessary *Limited to once per year*	A **$10** copay.	Up to $35.
Retinal imaging *Covered for members with Type 1 or Type 2 diabetes only*	A **$0** copay.	Up to $50.
Retinal imaging discount *Optional; not a covered benefit*	Up to **$39**.	Not applicable.

Eyeglasses

	In-network member cost	Out-of-network member cost
	You pay ...	You receive ...
Frames *Available every year; this applies to any frames available at the provider's location*	A **$0** copay and **80%** of balance over **$150** allowance. This benefit cannot be used with any promotion.	Up to $75.
Standard plastic lenses[3] (limited to once per year)		
Single vision	A **$10** copay.	Up to $25.
Bifocal	A **$10** copay.	Up to $40.
Trifocal	A **$10** copay.	Up to $55.
Lenticular	A **$10** copay.	Up to $55.
Standard, premium progressive lenses	See chart on next page.	See chart on next page.

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

Eyeglasses (cont.)

	In-network member cost	Out-of-network member cost
	You pay ...	You receive ...
Lens add-ons		
UV treatment, tint (solid, gradient); standard scratch coating; and standard polycarbonate lens (under age 19 only)	A **$0** copay for each option.	Up to $5 for each option.
Standard polycarbonate lens (adults)	A **$30** copay.	Up to $5.
Standard anti-reflective coating	**$45**.	Not applicable.
Premium anti-reflective coating	See chart below.	Not applicable.
Polarized	**20%** off retail price.	Not applicable.
Transition plastic lenses	A **$60** copay.	Up to $5.
Other add-ons	**20%** off retail price.	Not applicable.
Additional savings		
Additional pairs of eyeglasses	**40%** off complete pairs of prescription eyeglasses after using the funded benefit.	Not applicable.

Progressive lens and anti-reflective coating[4]

	In-network member cost	Out-of-network member cost
	You pay ...	You receive ...
Progressive lenses		
Standard progressive lenses	**$35**.	Up to $55.
Premium progressives (scheduled)	A **$55-$80** copay.	Up to $55.
Other premium progressives (non-scheduled)	A **$35** copay and **80%** of charge minus **$130** allowance.	Up to $55.
Anti-reflective coating		
Standard anti-reflective coating	**$45**.	Not applicable.
Premium anti-reflective coatings (scheduled)	**$57-$68**.	Not applicable.
Other premium anti-reflective coatings (non-scheduled)	**80%** of charge.	Not applicable.
Add-ons		
Other add-ons and services	**20%** off retail price.	Not applicable.

Contact lenses[5]

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

	In-network member cost	Out-of-network member cost
	You pay ...	**You receive ...**
Contact lens fit and follow-up *Available after a comprehensive eye exam has been completed*	Standard[6]: A **$0** copay and the service is paid in full, including two follow-up visits. Premium[7]: **10%** off retail price and receive **$40** allowance after discount.	Up to $40.
Conventional	A **$0** copay and 85% of balance over **$130** allowance.	Up to $104.
Disposable	A **$0** copay and balance over **$130** allowance.	Up to $104.
Medically necessary contact lenses	A **$0** copay.	Up to $200.
Additional savings		
Additional contact lenses	**15%** off conventional contact lenses after using the funded benefit.	Not applicable.

Medically-necessary contact lenses

The benefit provides coverage for medically necessary contact lenses when one of the following conditions exists:

- Anisometropia of 3D in meridian powers;
- High ametropia exceeding -10D or +10D in meridian powers;
- Keratoconus where the member's vision is not correctable to 20/30 in either or both eyes using standard spectacle lenses; or
- Vision improvement for members whose vision can be corrected two lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

The benefit may not be expanded for other eye conditions even if you or your providers deem contact lenses necessary for other eye conditions or visual improvement.

5 The contact lens allowance includes materials only. The allowance for disposable contact lenses is $130, and you do not have to use this allowance all at once. For example, you can use $50 of the allowance when you purchase your first supply of disposable contacts and the remainder of the allowance later.

6 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.

7 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.

Diabetic vision benefits at a glance

Type 1 and Type 2 diabetics' frequency: up to two services per benefit year.

	In-network member cost	Out-of-network member cost
	You pay ...	You receive ...
Office service visit *Medical follow-up exam*	A **$0** copay; covered 100%.	Up to $77 per service.
Retinal imaging	A **$0** copay; covered 100%.	Up to $50 per service.
Extended ophthalmoscopy	A **$0** copay; covered 100%.	Up to $15 per service.
Gonioscopy	A **$0** copay; covered 100%.	Up to $15 per service.
Scanning laser	A **$0** copay; covered 100%.	Up to $33 per service.

Using the EyeMed provider network

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

To find a network provider

- Check network providers in or near your ZIP code on the list that comes with your membership card.
- For the most current directory, go to www.eyemedvisioncare.com/pebaoe. Then, enter your Zip code or address.
- Use the Interactive Voice Response system or speak with a representative at the Customer Care Center at 877.735.9314. To speak with a customer service representative, choose your language (1 is for English) and then say, Provider Locator.
- You may also ask your provider if he accepts EyeMed coverage.

When you make an appointment, let the provider know you are covered by EyeMed. You are not required to bring your State Vision Plan identification card to your appointment, but it may be helpful to do so.

How to order contact lenses online

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

Out-of-network benefits

Your benefits are lower when you use a provider outside the network. To learn what you will be reimbursed if you use an out-of-network provider for covered services and supplies, see the charts on Pages 100-103.

To receive out-of-network services:

- You can file an out-of-network claim electronically. The electronic claim form is located on the EyeMed Vision Care member website, www.eyemed.com. You may also print one at peba.sc.gov/forms.
- 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.

For information about out-of-network services, call the EyeMed Customer Care Center at 877.735.9314. You may need to have your State Vision Plan identification card handy.

Exclusions and limitations

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

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

Contact EyeMed

You can reach EyeMed's Customer Care Center at 877.735.9314 or by logging in on EyeMed's homepage and then selecting Contact us under Help and Resources. Be sure to have the following information ready:

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

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

Appeals

If a claims question cannot be resolved by EyeMed's Customer Care Center, you may write to the Quality Assurance Team at:

EyeMed Vision Care
Attn: Quality Assurance Department
4000 Luxottica Place
Mason, OH 45040

Information may also be faxed to 513.492.3259. This team will work with you to resolve your issue within 30 days. If you are dissatisfied with the team's decision, you may appeal to an EyeMed appeals subcommittee, whose members were not involved in the original decision. All appeals are resolved by EyeMed within 30 days of the date the subcommittee receives them.

Since the Vision Care Plan is fully insured, you may not appeal EyeMed determinations to PEBA.

State Vision Plan examples

Example one

	Average retail price[8]	State Vision Plan benefit	In-network member cost
Eye examination	$109	$10 copay	You pay a **$10** copay.
Frames	$200	A $0 copay and 20% off balance over $150 allowance.	You pay **$40**.
Lenses			
Single vision	$72	$10 copay	You pay a **$10** copay.
Polycarbonate (adults)	$62	$30 copay	You pay a **$30** copay.
Premium anti-reflective (Crizal Alize)	$97	$68 copay	You pay a **$68** copay.
Your total payment	**$540**	Not applicable.	**$158**

Example two

	Average retail price[8]	State Vision Plan benefit	In-network member cost
Eye examination	$109	$10 copay	You pay a **$10** copay.
Frames	$150	A $0 copay and 20% off balance over $150 allowance.	You pay **$0**.
Lenses			
Premium progressive (Tier 2)	$230	$65 copay	You pay a **$65** copay.
Premium anti-reflective (Crizal Alize)	$97	$68 copay	You pay a **$68** copay.
Your total payment	**$586**	Not applicable.	**$143**

Example three

	Average retail price[8]	State Vision Plan benefit	In-network member cost
Eye examination	$109	$10 copay	You pay a **$10** copay.
Contact lens fit and follow up (standard)	$71	A $0 copay	You pay $0.
Disposable contact lenses	$130	$130 allowance	You pay a $0.
Your total payment	**$310**	Not applicable.	**$10**

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

Life insurance

The South Carolina Public Employee Benefit Authority's (PEBA's) life insurance program is underwritten by Metropolitan Life Insurance Company (MetLife). The insurance offered is term life insurance, which means coverage is provided for a specific period of time. The policy has no cash value.

The contract for the life insurance program consists of the policy, which is issued to PEBA, PEBA's application and your enrollment application. The policy is held by PEBA. The insurance contract may be changed at any time as long as MetLife and PEBA agree on the change. No one else has the authority to change the contract. All changes must be in writing, made a part of the policy and signed by an official of MetLife and of PEBA.

Eligibility

Generally, to enroll in the life insurance program, you must be a full-time employee who receives compensation from a department, agency, board, commission or institution of the state; public school district; county government, including county council members; participating optional employer; or another eligible employer that is approved by state law and is participating in the state insurance program. Members of the South Carolina General Assembly, clerical and administrative employees of the General Assembly, and judges in the state courts are also eligible for life insurance coverage.

For insurance purposes, an employee is classified as full-time if they work at least 30 hours per week. If you work at least 20 hours per week, you may also be eligible in cases where your covered employer has defined full-time to mean an employee who works at least 20 hours per week. PEBA must also approve this decision. In addition, eligibility requires that employees are citizens or legal residents of the United States, its territories and its protectorates. Temporary, leased or seasonal employees are ineligible.

Actively at Work requirement

To become insured or to receive an increase in the amount of your life insurance coverage, you must be "Actively at Work." This means you are 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 requirements. If you are receiving sick pay, short-term disability benefits or long-term disability benefits, you also do not meet the requirements.

If you are not Actively at Work on the date coverage would otherwise begin, or on the date an increase in your amount of life insurance would otherwise be effective, you will not be eligible for the coverage or the increase until you return to active work. If the absence is on a non-work day, coverage will not be delayed provided you were Actively at Work on the work day immediately preceding the non-work day. Except as otherwise provided for in the life insurance certificate, you are eligible to continue to be insured only while you remain Actively at Work.

Any selection for life insurance coverage or increase in coverage made while you are not Actively at Work will not be eligible for claims. You will receive a refund of premium for any life insurance coverage you paid for which you were not eligible.

Applications

The *Notice of Election* and *Statement of Health* forms that you complete to be covered by this plan are

considered your application for life insurance coverage. MetLife may use misstatements or omissions in your application to contest the validity of insurance or to deny a claim.

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

Any statements that the insured makes in 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.

What's the minimum amount of life insurance you should have? To help you get an idea of how much to consider, try MetLife's calculator at **www.metlife.com/scpeba**.

Basic Life insurance

Automatic enrollment into the Basic Life insurance benefit, including Accidental Death and Dismemberment coverage, is provided to eligible employees enrolled in the State Health Plan or the TRICARE Supplement Plan. There are no specific forms to complete to participate, and you receive this benefit at no cost. Basic Life insurance coverage provides:

- $3,000 in term life insurance to eligible employees age 69 and younger; and
- $1,500 to eligible employees age 70 or older.

The Accidental Death and Dismemberment coverage amounts are the same as the Basic Life insurance.

Your coverage begins on the first day of the month you are Actively at Work as a full-time employee. If you become eligible on a day other than the first calendar day or first working day of the month, your coverage starts on the first day of the next month. All effective dates of coverage are subject to the Actively at Work requirement (see Page 108).

Optional Life insurance

For many people, purchasing additional life insurance over and above employer-provided coverage, can help lend greater financial security. The Optional Life insurance benefit, with Accidental Death and Dismemberment coverage, is a voluntary benefit in which you pay the entire premium with no contributions from PEBA, the state of South Carolina or your employer.

Initial enrollment - active employees

If you are an eligible employee, you can enroll in Optional Life insurance within 31 days of the date you are hired. You will need to complete the required forms. You can elect coverage, in $10,000 increments, up to three times your basic annual earnings (rounded down to the nearest $10,000), or up to $500,000, whichever is less, without providing medical evidence.

You can apply for a higher benefit level, in increments of $10,000, up to a maximum of $500,000, by completing a *Statement of Health* to provide medical evidence. The Statement of Health form is available from your benefits administrator.

Your coverage begins on the first day of the month you are Actively at Work as a full-time employee. If you become eligible on a day other than the first calendar day or first working day of the month,

your coverage starts on the first day of the next month. If you enroll in an amount of coverage that requires medical evidence, your coverage effective date for the amount requiring medical evidence will be the first of the month after approval.

All effective dates of coverage are subject to the Actively at Work provision (see Page 108).

Late entry

With the Pretax Group Insurance Premium feature

If you participate in the MoneyPlus Pretax Group Insurance Premium feature and do not enroll in Optional Life coverage within 31 days of the date you begin employment, you can enroll only within 31 days of a special eligibility situation (see Page 21) or during the annual open enrollment period each October. In certain special eligibility situations, you may purchase Optional Life coverage, in $10,000 increments, up to a maximum of $50,000 without providing medical evidence. Coverage elected as a result of a special eligibility situation will be effective the first of the month after you complete and file a *Notice of Election* form. Otherwise, you will need to complete a *Notice of Election* form and a *Statement of Health* form during the open enrollment period and return these to your benefits administrator. If approved, your coverage will be effective on the first day of January after the enrollment period or, if approved after January 1, coverage will be effective the first of the month after approval. All effective dates of coverage are subject to the Actively at Work provision (see Page 108).

Without the Pretax Group Insurance Premium feature

If you do not participate in the MoneyPlus Pretax Group Insurance Premium feature and do not enroll in Optional Life coverage within 31 days of the date you begin employment, you can enroll throughout the year as long as you provide medical evidence, and it is approved by MetLife. To enroll, you will need to complete a *Notice of Election* form and a *Statement of Health* form and return these to your benefits administrator. Your coverage will be effective on the first of the month following approval. In certain special eligibility situations, you may purchase Optional Life coverage, in $10,000 increments, up to a maximum of $50,000 without providing medical evidence. Coverage will be effective the first of the month after you complete and file the *Notice of Election* form.

All effective dates of Optional Life coverage are subject to the Actively at Work requirement (see Page 108).

Premiums

Optional Life premiums are determined by your age as of the preceding December 31 and the amount of coverage you select. You can pay premiums for up to $50,000 of coverage before taxes through MoneyPlus (see Page 136). Retired employees are not eligible to pay premiums through MoneyPlus.

What if my age category changes?

Rates are based on your age and will increase when your age category changes. If your age category changes, your premium will increase on January 1 of the next calendar year. Your coverage will be reduced at age 70, 75 and 80. Reduced coverage takes place January 1 of the next calendar year.

Changing your coverage amount

With Pretax Group Insurance Premium feature

If you participate in the MoneyPlus Pretax Group Insurance Premium feature, you can increase, decrease or drop your Optional Life coverage only during the annual open enrollment period

in October or within 31 days of a special eligibility situation (see Page 21).

To increase your coverage during open enrollment, you will need to provide medical evidence and be approved by MetLife. If approved, coverage will be effective on January 1 following the enrollment period. All effective dates of Optional Life coverage are subject to the Actively at Work requirement (see Page 108). If you are increasing your Optional Life coverage due to a special eligibility situation, you can increase, in increments of $10,000 up to $50,000 ($500,000 serves as the maximum coverage amount) without providing medical evidence.

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 Optional Life coverage at any time during the year by providing medical evidence and being approved by MetLife. Your coverage at the new level will be effective on the first day of the month following the date of approval. In certain special eligibility situations, you may purchase Optional Life coverage, in $10,000 increments, up to a maximum of $50,000 without providing medical evidence. Coverage will be effective the first of the month after you complete and file the *Notice of Election* form.

All effective dates of Optional Life coverage are subject to the Actively at Work requirement (see Page 108). You can decrease or cancel your coverage at any time. However, if you want to re-enroll or increase coverage at a later date, you must provide medical evidence and be approved by MetLife.

Dependent Life insurance

Eligible dependents

If you are eligible for life insurance coverage, you may enroll your eligible dependents in Dependent Life insurance even if you have not enrolled in the Optional Life program or state health insurance coverage.

Eligible dependents include:

- Lawful spouse:
  - May not be eligible for coverage as an employee of a participating employer.
- Children:
  - Includes natural children, legally adopted children, children placed for adoption (from the date of placement with the adopting parents until the legal adoption), stepchildren or children for whom you have legal guardianship.
  - From live birth to age 19, or a child who is at least 19 years old but younger than age 25 who attends school on a full-time basis (as defined by the institution) as his principal activity and is primarily dependent on you for financial support.

Insurance eligibility changes made by the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, do not apply to Dependent Life-Child insurance.

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

For more information about covering an incapacitated child, see Page 16.

A person who is eligible as an employee or retiree

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

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

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

To file a claim under Dependent Life-Child for a child age 19 through 24, you will be required to show the child was a full-time student at the time of enrollment and at the time of the claim. You will need a statement on letterhead from the educational institution that verifies the child was a full-time student and provides the child's dates of enrollment. The statement should be given to your benefits administrator, who will send it to MetLife with the *Life Insurance Claim Form*.

To file a claim for an incapacitated child over the age of 25, you must give certification of incapacitation to your benefits administrator, who will send it to MetLife with the *Life Insurance Claim Form*.

Excluded dependents

- Any dependent who is eligible as an employee for life insurance coverage, or who is in full-time military service, will not be considered a dependent.
- A former spouse and former stepchildren cannot be covered under Dependent Life insurance through PEBA, even with a court order.
- A foster child is not eligible for Dependent Life coverage.

Dependent Life-Spouse coverage

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

However, if you are not enrolled in Optional Life coverage, you can enroll your spouse for only $10,000 or $20,000.

Medical evidence is required for all coverage amounts greater than $20,000, coverage amount increases of more than $20,000 and for coverage not elected when your spouse first became eligible or due to a special eligibility situation.

Your spouse's coverage will be reduced at ages 70, 75 and 80 based on his age.

Spouses enrolled in Dependent Life coverage are also covered for Accidental Death and Dismemberment benefits. They are eligible for the Seat Belt Benefit, Air Bag Benefit, Child Care benefit and Child Education Benefit (see Pages 116-117).

Dependent Life-Child coverage

The Dependent Life-Child benefit is $15,000 per child, and coverage is guaranteed. Children are eligible from live birth to ages 19 or 25 if a full-time student. A child can be covered by only one parent under this Plan.

Enrollment

Within 31 days of the date you are hired, you can enroll in Dependent Life-Spouse insurance up to $20,000 without providing medical evidence. Enrollment in Optional Life is required to enroll in Dependent Life-Spouse coverage for more than $20,000. You may not cover an ex-spouse.

Eligible children may be added at initial enrollment and throughout the year without providing medical evidence.

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

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

At any time during the year, you can enroll in or add additional Dependent Life-Spouse coverage by completing a *Statement of Health* form to provide medical evidence. The additional coverage is effective the first of the month after approval of medical evidence.

All effective dates are subject to the Actively at Work requirement (see Page 108) and the dependent non-confinement provision, found later in this section.

Adding a new spouse

If you wish to add a spouse because you marry, you can enroll in Dependent Life-Spouse coverage of $10,000 or $20,000 without providing medical evidence. To do this, complete a *Notice of Election* form within 31 days of the date of your marriage. Coverage becomes effective the first of the month after you complete and file the *Notice of Election* form. You cannot cover your spouse as a dependent if your spouse is or becomes an employee of an employer that participates in the plan.

If you divorce, you must drop your spouse from your Dependent Life coverage. You will need to complete a *Notice of Election* form within 31 days of the date of your divorce. Coverage ends the date of the divorce.

Spouse's loss of employment

If your spouse's employment with a participating employer ends, you can enroll your spouse in Dependent Life coverage for up to $20,000 within 31 days of his termination without providing medical evidence. If your spouse loses life insurance through an employer that does not participate in PEBA insurance, he can enroll throughout the year by completing a *Statement of Health* form to provide medical evidence.

Late entry

If you do not enroll within 31 days of the date you begin employment or are married, you can enroll your spouse throughout the year as long as you provide medical evidence and it is approved by MetLife. To do so, complete a *Notice of Election* form and a *Statement of Health* form. Coverage will be effective on the first day of the month after approval. All effective dates of coverage are subject to the Actively at Work requirement and the dependent non-confinement provision.

Adding children

Eligible children may be added throughout the year without providing medical evidence by completing a *Notice of Election* form and returning it to your benefits administrator. Coverage will be effective the first of the month after you complete and file the form.

Your eligible child is automatically covered for 30 days from the child's live birth. To continue your child's coverage, you will need to list each child on your *Notice of Election* form within 31 days of birth; otherwise the child's coverage will terminate at the end of the 30-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 have a new eligible child.

All effective dates of coverage are subject to the dependent non-confinement provision as described below.

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 your life insurance is effective.

Premiums

Dependent Life-Spouse coverage and Dependent Life-Child coverage are separate benefits for which you pay separate premiums. Premiums are paid entirely by you, with no contribution from your employer, and may be paid through payroll deduction.

Premiums for Dependent Life-Spouse are determined by the spouse's age.

The premium for Dependent Life-Child coverage is $1.26, regardless of the number of children covered.

Beneficiaries

A beneficiary is the person or people who will receive insurance payments if you die. You can change your beneficiaries at any time, unless you have given up this right. If you have no eligible beneficiaries named, death benefits will be paid to:

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

Changing your beneficiaries

You can change your beneficiaries online through MyBenefits.sc.gov, or by notifying your benefits administrator and completing a *Notice of Election* form. The change will be effective on the date the request is signed. Please note that MetLife will allow beneficiary changes by power of attorney only if the documents specifically state an attorney-in-fact has the power to change beneficiary designations.

Assignment

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

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

Accidental Death and Dismemberment

This section does not apply to retirees or dependent children.

Schedule of accidental losses and benefits

In addition to any life insurance benefit, MetLife will pay Accidental Death and Dismemberment benefits equal to the amount of Basic and Optional Life insurance for which the employee is insured and an amount equal to the amount of Dependent Life-Spouse insurance for which the spouse is insured, according to the schedule below, if:

1. You suffer accidental bodily injury while your insurance is in force;
2. A loss results directly from such injury, independent of all other causes, and is unintended, unexpected and unforeseen; and
3. Such a loss occurs within 365 days after the date of the accident causing the injury.

Loss of a hand or foot refers to actual and permanent severance from the body at or above the wrist or ankle joint. Loss of sight, speech or hearing means entire and irrecoverable loss. Loss of both a thumb and index finger of same hand, means actual and permanent severance from the body at or above the metacarpophalangeal joints.

The amount of the benefit shall be a percentage of the amount of Basic, Optional and Dependent Life-Spouse insurance. The percentage is determined by the type of loss, as shown in the table to the right.

Description of loss	Percent of life insurance amount
Life	100%
Both hands, both feet or sight of both eyes	100%
One hand and one foot	100%
Speech and hearing in both ears	100%
Either hand or foot, and sight of one eye	100%
Movement of both upper and lower limbs (quadriplegia)	100%
Movement of both lower limbs (paraplegia)	75%
Movement of both legs and one arm, or both arms and one leg	75%
Movement of the upper and lower limbs of one side of body (hemiplegia)	50%
Either hand or foot	50%
Sight of one eye	50%
Speech or hearing in both ears	50%
Movement of one limb (uniplegia)	25%
Thumb and index finger of same hand	25%

What is not covered?

MetLife will not pay Accidental Death and Dismemberment benefits under this section for any loss caused or contributed to by:

- Intentionally self-inflicted injury.
- Suicide or attempted suicide.
- Committing or attempting to commit a felony.
- Bodily or mental infirmity, illness or disease.
- Alcohol in combination with any drug, medication or sedative.
- The voluntary use of prescription drugs,

nonprescription drugs, illegal drugs, medications, poisons, gases, fumes or other substances taken, absorbed, inhaled, ingested or injected unless it is taken upon the advice of a licensed physician in the verifiable prescribed manner and dosage.

- Motor vehicle collision or accident where you are the operator of the motor vehicle and your blood alcohol level meets or exceeds the level at which intoxication is defined in the state where the collision or accident occurred, regardless of any legal proceedings thereto.
- Infection, other than infection occurring simultaneously with, and as a direct and independent result of, the accidental injury.
- Medical or surgical treatment, diagnostic procedures or any resulting complications, including complications from medical misadventure.
- War or any act of war, whether declared or undeclared.
- Service in the military of any nation, except the U.S. National Guard.

Accidental Death and Dismemberment benefits

Seat Belt and Air Bag Benefit (Basic, Optional and Dependent-Life Spouse Accidental Death and Dismemberment only)

The Seat Belt Benefit is an additional 10 percent of your accidental death benefit. However, the amount MetLife will pay for this benefit will not be less than $1,000 or more than $25,000. For example, if your amount of Optional Life insurance is $20,000 and you die in an accident, an additional $20,000 accidental death benefit will be payable. The Seat Belt Benefit increases this accidental death benefit by 10 percent, or $2,000. The total accidental death benefit will then be $22,000, which means the entire death benefit will be $42,000.

The Air Bag Benefit is an additional 5 percent. However, the amount paid for this benefit will not be less than $1,000 or more than $10,000 of your accidental death benefit. For example, if your amount of life insurance is $20,000 and you die in an accident, an additional $20,000 accidental death benefit will be payable. The Seat Belt Benefit increases the accidental death benefit by $2,000, and the Air Bag Benefit increases the accidental death benefit by $1,000 (5 percent of $20,000), which means the entire death benefit will be $43,000.

To be eligible for these benefits, the following must apply:

1. The seat in which the insured was seated was equipped with a properly installed air bag at the time of the accident.
2. The private passenger car is equipped with seat belts.
3. The seat belt was in proper use by the insured at the time of the accident as certified in the official accident report or by the investigating officer.
4. At the time of the accident, the driver of the private passenger car was a licensed driver and was not intoxicated, impaired or under the influence of alcohol or drugs.

Child Care Benefit (Optional and Dependent-Life Spouse Accidental Death and Dismemberment only)

A Child Care Benefit will be paid to each dependent who is younger than age 7 (at the time of the insured's death) and who is enrolled in a day care program. The benefit for each child per year will be the lesser of:

1. Twelve percent of your amount of Accidental

Death and Dismemberment insurance; or

2. $5,000; 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, MetLife will pay $1,000 to the beneficiary.

Dependent Child Education Benefit (Optional and Dependent-Life Spouse Accidental Death and Dismemberment only)

An Education Benefit is paid for each dependent who qualifies as a student. A qualified dependent must be either a post-high school student who attends a school for higher learning on a full-time basis at the time of the insured's death or in the 12th grade and will become a full-time post-high school student in a school for higher learning within 365 days after the insured's death. The benefit is a maximum of $10,000 per academic year with a maximum overall benefit of 25 percent of the coverage amount. The benefit will be payable at the beginning of each school year for a maximum of four consecutive years, but not beyond the date the child turns age 25.

If this benefit is in effect on the date you die or your spouse dies and you do not have a child who could qualify for it, MetLife will pay $1,000 to your beneficiary.

Felonious Assault Benefit (Optional Accidental Death and Dismemberment, Employee only)

A Felonious Assault Benefit is paid if you are injured in a felonious assault and the injury results in a loss for which benefits are payable under the Accidental Death and Dismemberment benefit. The benefit is the lesser of one time your annual earnings, $25,000 or your amount of Optional Accidental Death and Dismemberment insurance coverage.

A felonious assault is a physical assault by another person resulting in bodily harm to you. The assault must involve the use of force or violence with intent to cause harm and must be a felony under the laws of the jurisdiction in which the act was committed.

Repatriation Benefit (Basic Life, Optional Life and Dependent Life- Spouse Accidental Death and Dismemberment)

A Repatriation Benefit will be paid if you or your spouse with Dependent Life-Spouse coverage die in a way that would be covered under the Accidental Death and Dismemberment benefit and if the death occurs more than 100 miles from your principal residence.

The Repatriation Benefit will be the lesser of:

- The actual expenses incurred for:
  - Preparation of the body for burial or cremation, and
  - Transportation of the body to the place of burial or cremation;

or

- $5,000, the maximum amount for this benefit.

Public Transportation (Common Carrier) Benefit (Basic, Optional Accidental Death and Dismemberment, Employee only)

If you die as a result of a covered accident that occurs while you are a fare-paying passenger on a public transportation vehicle, MetLife will pay an additional benefit equal to your full amount of Accidental Death and Dismemberment insurance.

Public transportation vehicle means any air, land or water vehicle operated under a license for the transportation of fare-paying passengers.

MetLife Advantages℠

Your Optional Life insurance benefits include access to MetLife AdvantagesSM—a comprehensive suite of valuable services for support, planning and protection when you need it most at no cost to you.

Will Preparation

Offers you and your spouse unlimited face-to-face or telephone meetings with an attorney, from the MetLife Legal Plans' network of more than 18,000 participating attorneys, to prepare or update a will, living will and power of attorney.

For more information, call MetLife Legal Plans at 800.821.6400, 8 a.m. to 7 p.m., Monday-Friday. Advise the Client Service Representative that you are with PEBA (group number 200879) and provide the last four digits of your Social Security number.

Estate Resolution Services

Estate representatives and beneficiaries may receive unlimited face-to-face legal assistance with probating your and your spouse's estates. Beneficiaries can also consult an attorney, from the MetLife Legal Plans' network of more than 18,000 participating attorneys, for general questions about the probate process.

For more information, call MetLife Legal Plans at 800.821.6400, 8 a.m. to 7 p.m., Monday-Friday. Advise the Client Service Representative that you are with PEBA (group number 200879) and provide the last four digits of your Social Security number.

WillsCenter.com

Helps you or your spouse prepare a will, living will, power of attorney and HIPAA authorization form on your own, at your own pace, 24 hours a day, seven days a week.

Visit www.willscenter.com and register as a new user. Follow the simple instructions to create your online document. This benefit is also available to you even if you only have Basic Life insurance.

Digital Storage

Helps you create a digital legacy for your beneficiaries, estate administrators and others who play important roles in your major life events. MetLife Infinity offers a unique way to capture and securely store your important documents, including deeds, wills and life stage planning documents, as well as photos and videos. You can also share important life events, milestones and other memorable activities for future use.

Visit metlifeinfinity.com to learn more and to download from the App store or Google Play.

Funeral Planning Assistance

Services designed to simplify the funeral planning process for your loved ones and beneficiaries to assist them with organizing an event that will honor a loved one's life from a self-paced funeral planning guide to services, such as locating funeral homes, florists and local support groups.

Call Dignity Memorial 24 hours a day at 866.853.0954 or visit finalwishesplanning.com. You can also use this phone number to locate funeral homes and other important service providers.

Grief Counseling

Provides you and your dependents up to five in-person private counseling sessions per event with a professional grief counselor to help cope with a loss, no matter the circumstances, whether it's a death, an illness or divorce. Sessions also may be held over the phone.

Call LifeWorks US, Inc. 24 hours a day, 7 days a week at 888.319.7819.

Live Settlement Account

The Total Control Account (TCA)® is a settlement option that provides your loved ones with a safe and convenient way to manage life insurance proceeds. They'll have the convenience of immediate access to any or all of their proceeds through an interest-bearing account with unlimited check-writing privileges. The Total Control Account also allows beneficiaries time to decide what to do with their proceeds.

Call MetLife at 800.638.7283, 8 a.m. to 6 p.m., Monday-Friday.

Transition Solutions

Focuses on guidance and services around insurance and other financial products to help you and your family better prepare for your future in response to benefit-changing events.

Call MetLife to be connected with Barnum Financial Group financial professionals at 877.275.6387, 9 a.m. to 6 p.m., Monday-Friday.

Delivering the Promise®

Helps beneficiaries sort through the details and serious questions about claims and financial needs during a difficult time. MetLife has arranged for Barnum Financial Group financial professionals to be available for assistance in person or by telephone to help with filing life insurance claims, government benefits and help with financial questions.

To be referred to a Delivering the Promise specialist who will contact you directly, call 877.275.6387, prompt 2.

Claims

To pay benefits, MetLife must be given a written proof of loss. This means a claim must be filed as described below.

Your accelerated benefit

If you or your covered dependent is diagnosed by a physician as having a terminal illness, you may request that MetLife pay up to 80 percent of your life insurance prior to your death. Any remaining benefits will be paid to your beneficiary upon your death. A terminal illness means that you have a life expectancy of 12 months or less.

To file a claim, notify your employer. Then you, your employer and the attending physician will each complete a section of MetLife's *Accelerated Benefit Option* form.

How to file a claim

When you or your dependent dies, your employer should be notified. This should be done as soon as reasonably possible. The benefits administrator will complete and submit MetLife's *Life Insurance Claim* form. MetLife will send the beneficiary a beneficiary statement and a condolence letter, which requests an original certified death certificate.

When MetLife receives acceptable proof of your covered dependent's death, it will pay the life insurance benefit to you. If you are no longer living, it will be paid to your beneficiary.

When a retiree dies, the beneficiary, or the employer on his behalf, should notify MetLife of the death by calling 800.638.6420.

Suicide provision

No Optional Life, Dependent Life-Spouse or Dependent Life-Child benefit will be payable if death results from suicide, whether the covered person is sane or insane, within two years of the effective date. If suicide occurs within two years of a coverage increase, the death benefit payable is limited to the amount of coverage in force prior to the increase.

How Accidental Death and Dismemberment claims are paid

In the case of accidental death, your employer should be notified. The benefits administrator will complete and submit MetLife's *Life Insurance Claim* form. MetLife will pay the accidental death benefit to your beneficiaries.

If you sustained other losses covered under Accidental Death and Dismemberment, you, your employer and your physician must complete the *Accidental Death and Dismemberment Claim* form and submit it to MetLife. The benefit for other losses you sustained will be paid to you, if you are living. Otherwise, it will be paid to your beneficiary.

A dependent's Accidental Death and Dismemberment benefit will be paid to you, if you are living. Otherwise, it will be paid to your beneficiary.

Examinations and autopsies

MetLife 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, MetLife reserves the right to have an autopsy performed in case of death.

When your coverage ends

Termination of coverage

Your insurance will end at midnight on the earliest of:

- The last day of the month you terminate your employment;
- The last day of the month you go on unapproved leave of absence;
- The last day of the month you enter a class of employees not eligible for coverage (for example, a change from full-time to part-time status);
- The date PEBA's policy ends; or
- The last day of the month you do not pay the required premium for that month.

Retiree coverage will end the January 1 after:

- You reach age 70, if you continued coverage and retired before January 1, 1999; or
- You reach age 75, if you continued coverage and retired January 1, 1999, and later.

Claims incurred before the date insurance coverage ends will not be affected by coverage termination.

Termination of Dependent Life insurance coverage

Your dependent's coverage will terminate at midnight on the earliest of:

- The day PEBA's policy ends;
- The day you, the employee, die;
- The last day of the month in which the dependent no longer meets the definition of a dependent; or
- The day any premiums for Dependent Life insurance coverage are due and unpaid for a period of 30 days.

Claims incurred before the date insurance coverage ends will not be affected by coverage termination.

Extension of benefits

An extension of benefits is provided according to the requirements below. MetLife is not required by contract to provide these benefits unless you meet these requirements.

Leave of absence

If you are on an employer-approved leave of absence and you remain eligible for active benefits,

you can continue your Optional Life insurance for up to 12 months from the first of the month after the last day worked, as long as you pay the required premiums. MetLife 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 life insurance 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 life insurance 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 coverage can be continued for up to 12 months from your last day worked as long as you remain eligible for active benefits and:

- You continue to pay the premiums; and
- The Optional Life insurance policy does not end.

When you lose eligibility for active benefits due to disability

- 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. Learn more about your options for life insurance on Page 164.
- If you are not eligible for retiree insurance, you can convert your coverage to an individual whole life policy. You must submit an application for 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 MetLife 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 Page 155.

Continuing or converting your life insurance

Please note that Accidental Death and Dismemberment coverage may not be continued or converted.

Continuation

If you are eligible for retiree insurance, you may be able to continue your insurance coverage and pay premiums directly to MetLife. MetLife will mail you a conversion/continuation packet. Packets are sent via U.S. mail three to five business days after MetLife receives the eligibility file from PEBA. To continue your coverage, complete the form that will be included in your packet from MetLife. Coverage is lost due to approved retirement or approved disability retirement.

If you have questions about your options for continuing your insurance coverage or would like to request continuation forms, contact MetLife at 888.507.3767, 8 a.m. to 11 p.m., Monday through Friday. A complete application must be received

within 31 days of your benefit termination.

If you continue your coverage, you will receive a bill from MetLife for your premiums. You will pay your premiums directly to MetLife. Contact MetLife at 888.507.3767 if you wish to make changes to your coverage.

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 medical evidence. MetLife will mail you a conversion packet. Packets are sent via U.S. mail three to five business days after MetLife receives the eligibility file from PEBA. To convert your coverage, follow the instructions included in your packet from MetLife. The policy will be issued without medical evidence if you apply for and pay the premium within 31 days.

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 MetLife's standard rate for the amount of coverage that you wish to convert and your age.

You must contact MetLife within 31 days of the date your insurance coverage ends.

Group policy is terminated

If your group life insurance ends because of termination by the state of the policy or termination as a class, you may be eligible for a conversion policy. For more information, see the MetLife certificate under the Conversion Option section.

Death benefit during conversion period

If you die within 31 days of the date your group insurance was terminated and meet the conversion eligibility requirements, MetLife will pay a death benefit regardless of whether an application for coverage under an individual policy has been submitted. The death benefit will be the amount of insurance you would have been eligible to convert under the terms of the Conversion Right section.

Long term disability

Basic Long Term Disability

The Basic Long Term Disability (BLTD) Plan, administered by Standard Insurance Company (The Standard), is an employer-funded disability plan provided by the state. It helps protect a portion of your income if you become disabled as defined by the Plan. This benefit is provided at no cost to you.

If you have questions or need more information, please contact The Standard at 800.628.9696 or www.standard.com/mybenefits/southcarolina.

BLTD plan benefits overview

Benefit waiting period	90 days
Monthly BLTD benefit percentage	Up to 62.5 percent of your predisability earnings, reduced by deductible income.
Maximum benefit	$800 per month
Maximum benefit period	To age 65 if you become disabled before age 62. If you become disabled at age 62 or older, the maximum benefit period is based on your age at the time of disability. The maximum benefit period for age 69 and older is one year.

Eligibility

You are eligible for BLTD if you are covered under the State Health Plan or the TRICARE Supplement Plan and are an active, full-time employee as defined by the Plan or a full-time academic employee and you are employed by: a department, agency, board, commission or institution of the state; a public school district; a county government (including county council members); or another group participating in the state's insurance program. Members of the General Assembly and judges in the state courts are also eligible for coverage.

To receive benefits, you must be actively employed when your disability occurs.

If you become disabled, you may be eligible for additional benefits through PEBA that are separate from the benefits described here. Call 803.737.6800 for more information.

Benefit waiting period

The benefit waiting period is the length of time you must be disabled before benefits are payable. The BLTD plan has a 90-day benefit waiting period, and benefits are not paid during this period.

Certificate

The BLTD certificate is available at peba.sc.gov/publications under Long term disability. The BLTD plan document is a contract containing the controlling provisions of this insurance plan. Neither the certificate nor any other material, including this publication, can modify the provisions of the plan document.

When are you considered disabled?

You are considered disabled and eligible for benefits if you cannot fulfill the requirements of your occupation due to a covered injury, physical disease, mental disorder or pregnancy. You also will need to satisfy the benefit waiting period and meet the applicable definitions of disability below during the period to which they apply.

Own occupation disability

You are unable to perform, with reasonable continuity, the material duties of your own occupation during the benefit waiting period and the first 24 months of disability.

"Own occupation" means any employment, business, trade, profession, calling or vocation

that involves material duties[1] 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[1] 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

You are considered to be partially disabled if, during the benefit waiting period and the own occupation period, you are working while disabled, but you are unable to earn more than 80 percent of your predisability earnings, adjusted for inflation, while working in your own occupation.

You are considered to be partially disabled if, during the any occupation period you are working while disabled, but you are unable to earn more than 65 percent of your predisability earnings, adjusted for inflation, while working in any occupation.

Pre-existing conditions

"Pre-existing condition" means any injury, illness or symptom (including secondary conditions and complications) that was medically documented as existing, or for which medical treatment, medical service, prescriptions or other medical expense was incurred at any time during the pre-existing condition period shown in the Coverage Features of the *Certificate of Coverage*.

Benefits will not be paid for a disability caused or contributed to by a pre-existing condition unless on the date you become disabled:

- You have been continuously covered under the plan for at least 12 months (this is the exclusion period); or
- Your date of disability falls within 12 months after your BLTD coverage became effective, and you can demonstrate you have not consulted a physician, received medical treatment or services or taken prescribed drugs during the six-month period preceding your coverage effective date (this is the pre-existing condition period).

Claims

Once it appears you will be disabled for 90 days or more, or your employer is modifying your duties due to a health condition, talk to your benefits administrator and download a claim form packet at **peba.sc.gov/forms**. The packet contains:

- *Employee's Statement*;
- *Authorization to Obtain and Release Information*;
- *Authorization to Obtain Psychotherapy Notes*;
- *Attending Physician's Statement*; and
- *Employer's Statement*.

You are responsible for ensuring that these forms are completed and returned to The Standard. You

may fax the forms to 800.437.0961, or you can mail them to the address on the claim form. If you have questions, contact The Standard at 800.628.9696.

Provide the completed claim forms to The Standard within 90 days of the end of your benefit waiting period. If you cannot meet this deadline, you must submit these forms as soon as reasonably possible, but no later than one year after 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.

Predisability earnings

Predisability earnings are the monthly earnings, including merit and longevity increases, from your covered employer as of the January 1 preceding your last full day of active work, or on the date you became a member if you were not a member on January 1. It does not include your bonuses, commissions, overtime or incentive pay. If you are a teacher, it does not include your compensation for summer school, but it does include compensation earned during regular summer sessions by university staff.

Deductible income

Your BLTD benefits will be reduced by your deductible income—income you receive or are eligible to receive from other sources. Deductible income includes:

- Sick pay or other salary continuation (including sick-leave pool);
- Primary Social Security benefits;
- Workers' compensation;
- Other group disability benefits (except Supplemental Long Term Disability benefits described on Page 128);
- Maximum plan retirement benefits; and
- Other income sources.

Please note that vacation pay is excluded from deductible income. BLTD insurance serves as income replacement insurance. The BLTD Plan has no minimum benefit, so if you have enough deductible income, your benefit will be reduced to $0.

Example one	
Predisability earnings	$1,280
	× 62.5%
Maximum benefit	$800
Deductible income	- $0
Your BLTD benefit	**$800**
Example two	
Predisability earnings	$1,280
	× 62.5%
Maximum benefit	$800
Deductible income	- $800
Your BLTD benefit	**$0**

In another example, assume that 62.5 percent of your predisability earnings is $1,200. The Standard will pay the $800 maximum benefit, and your BLTD benefit will be reduced when your deductible income exceeds $400. In other words, your benefit will be reduced when the maximum benefit of $800 added together with your deductible income totals an amount that exceeds 62.5 percent of your predisability earnings. In this example, no benefits would be payable if your deductible income exceeded $1,200.

You must meet deadlines for applying for all

deductible income you are eligible to receive. PEBA has different requirements for disability retirement. Please contact PEBA at 803.737.6800 or 888.260.9430 for more information.

When other benefits are awarded, they may include payments due to you while you were receiving BLTD benefits. If the award includes past benefits, or if you receive other income before notifying The Standard, your BLTD claim may be overpaid. This is because you received benefits from the Plan and income from another source for the same period of time. You will need to repay the Plan for this overpayment.

When BLTD coverage ends

Your BLTD coverage ends automatically on the earliest of:

- The date the plan ends;
- The date you no longer meet the requirements noted in the Eligibility section of this chapter;
- The date your health coverage as an active employee ends; or
- The date your employment ends.

When benefits end

Your benefits will end automatically on the earliest of these dates:

- The date you are no longer disabled under the terms of the BLTD plan;
- The date your maximum benefit period ends (refer to Exclusions and limitations);
- The date benefits become payable under any other group long term disability insurance policy under which you became insured during a period of temporary recovery; or
- The date of your death.

If you are an employee of an optional employer, your employer becomes responsible for your BLTD benefit payments if your employer stops participating in the state insurance program.

Exclusions and limitations

- Disabilities resulting from war or any act of war are not covered.
- Intentional self-inflicted injuries are not covered.
- Benefits are not payable when you are not under the ongoing care of a physician in the appropriate specialty.
- Benefits are not payable for any period when you are not participating, in good faith, in a course of medical treatment, vocational training or education approved by The Standard, unless your disability prevents you from participating.
- Benefits are not payable for any period of disability when you are confined for any reason in a penal or correctional institution.
- Benefits are not payable after you have been disabled under the terms of the BLTD plan for 24 months during your entire lifetime, excluding the benefit waiting period, for a disability caused or contributed to by:
  - A mental disorder, unless you are continuously confined to a hospital solely because of a mental disorder at the end of the 24 months;
  - Your use of alcohol, alcoholism, use of any illicit drug, including hallucinogens or drug addiction;
  - Chronic pain, musculoskeletal or connective tissue conditions;
  - Chronic fatigue or related conditions; or
  - Chemical and environmental sensitivities.
- During the first 24 months of disability, after

the 90-day benefit waiting period, BLTD benefits will not be paid for any period of disability when you are able to work in your own occupation and you are able to earn at least 20 percent of your predisability earnings, adjusted for inflation, but you choose not to work.

- While living outside the United States or Canada, payment of benefits is limited to 12 months for each period of continuous disability.

Appeals

If The Standard denies your claim for basic long term disability benefits, you can appeal the decision to The Standard by sending written notice within six months of receiving the denial letter. Send the appeal to:

Standard Insurance Company
P.O. Box 2800
Portland, OR 97208

If The Standard upholds its decision after a review by its Administrative Review Unit, you may appeal that decision by sending an ***Appeal Request Form*** to PEBA within 90 days of the Administrative Review Unit's denial. Please include a copy of the previous two denials with your appeal to PEBA. Send the request to:

IAD@peba.sc.gov

or

S.C. PEBA
Attn: Insurance Appeals Division
202 Arbor Lake Drive
Columbia, SC 29223

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

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

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

Supplemental Long Term Disability

Supplemental Long Term Disability Insurance (SLTD), fully-insured by Standard Insurance Company (The Standard), is designed to provide additional financial assistance beyond the Basic Long Term Disability plan if you become disabled. Your benefit will be based on a percentage of your predisability earnings. This program is customized for you. The SLTD plan benefits summary on the next page provides more information about your plan, including:

- Your level of coverage;
- How long benefits payments would continue if you remain disabled;
- The maximum benefit amount;
- Your choice of benefit waiting periods; and
- Your premium schedule.

What SLTD insurance provides

- Competitive group rates;
- Survivor benefits for eligible dependents;
- Coverage for injury, physical disease, mental disorder or pregnancy;
- A return-to-work incentive;
- SLTD conversion insurance;
- A cost-of-living adjustment; and
- Lifetime security benefit.

SLTD Plan benefits summary

Benefit waiting period	Plan 1: 90 days Plan 2: 180 days
Maximum SLTD-covered predisability earnings	$12,307 per month
Monthly benefit percentages[2]	Up to 65% 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%. 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 rate[3]	Multiply the premium factor for your age and plan selection by your monthly earnings.

2 These benefits are not taxable provided you pay the premium on an after-tax basis.
3 Premium must be an even amount (amount is rounded up to next even number). See **Monthly premiums** chapter.

Eligibility

You are eligible for SLTD insurance if you are:

- An active, full-time, compensated employee as defined by the Plan;
- A full-time, compensated academic employee; or
- A member of the General Assembly, or a judge in the state courts.

You are not eligible for this coverage if you are an employee of an employer that is covered under any other group long term disability plan that insures any portion of your predisability earnings (other than the BLTD Plan); if you are receiving retirement benefits from PEBA and did not enroll in active employee coverage; if you are a temporary or seasonal employee; if you are a part-time teacher; or if you are a full-time member of the armed forces of any country.

Enrollment

You can enroll in the SLTD program within 31 days of eligibility. You may choose from one of two benefit waiting periods described below. If you fail to enroll within 31 days of your hire date, you must complete a medical history statement. The Standard may require you to undergo a physical examination and blood test. You also may be required to provide any additional information about your insurability that The Standard may reasonably require at your own expense. Throughout the year, you may enroll with medical evidence of good health.

Benefit waiting period

The benefit waiting period is the length of time you must be disabled before benefits are payable. You may choose a 90-day or a 180-day benefit waiting period, and you may change from a 90-day to a 180-day benefit waiting period at any time by completing a *Notice of Election* form and returning it to your benefits administrator.

To change from a 180-day to a 90-day benefit waiting period, you must complete a *Notice of Electio*n form and provide medical evidence of good health, which The Standard will consider in determining whether to approve your application.

Certificate

The SLTD certificate is available on the Long term disability webpage at **peba.sc.gov/publications** under Long term disability. The certificate contains the controlling provisions of this insurance plan. Neither the certificate nor any other material, including this publication, can modify those provisions.

When are you considered disabled?

You are considered disabled and eligible for benefits if you cannot work due to a covered injury, physical disease, mental disorder or pregnancy. You will also need to satisfy your appropriate benefit waiting period and meet the following definitions of disability during the period to which they apply.

Own occupation disability

You are unable to perform, with reasonable continuity, the material duties[4] 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[4] 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

4 "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.

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[5] of any occupation.

"Any occupation" means any occupation or employment you are able to perform, due to education, training or experience, that is available at one or more locations in the national economy and in which you can be expected to earn at least 65 percent of your 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

You are considered to be partially disabled if, during the benefit waiting period and the own occupation period, you are working while disabled, but you are unable to earn more than 80 percent of your predisability earnings, adjusted for inflation, while working in your own occupation.

You are considered to be partially disabled if, during the any occupation period, you are working while disabled but you are unable to earn more than 65 percent of your predisability earnings, adjusted for inflation, while working in any occupation.

Pre-existing conditions

Pre-existing condition means any injury, illness or symptom (including secondary conditions and complications) that was medically documented as existing, or for which medical treatment, medical service, prescriptions or other medical expenses were incurred, at any time during the pre-existing condition period shown in the Coverage Features of the *Certificate of Coverage*.

No benefits will be paid for a disability caused or contributed to by a pre-existing condition unless on the date you become disabled:

- You have been continuously covered under the plan for at least 12 months (this is the exclusion period); or
- Your date of disability falls within 12 months after your SLTD coverage became effective, and you can demonstrate you have not consulted a physician, received medical treatment or services or taken prescribed drugs during the six-month period preceding your coverage effective date (this is the pre-existing condition period).

The pre-existing condition exclusion also applies when you change from the plan with the 180-day benefit waiting period to the plan with the 90-day benefit waiting period. The pre-existing condition period, treatment free period and exclusion period for the new plan will be based on the effective date of your coverage under the 90-day plan. However, if benefits do not become payable under the 90-day plan because of the pre-existing condition exclusion, your claim will be processed under the 180-day plan as if you had not changed plans.

Claims

Once it appears you will be disabled for 90 days or more, talk to your benefits administrator or download a claim form packet at peba.sc.gov/forms. The packet contains:

- *Employee's Statement*;
- *Authorization to Obtain and Release Information*;
- *Authorization to Obtain Psychotherapy Notes*;

5 "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.

- *Attending Physician's Statement*; and
- *Employer's Statement*.

You are responsible for ensuring that these forms are completed and returned to The Standard. You may fax the forms to 800.437.0961, or you can mail them to the address on the claim form. If you have questions, contact The Standard at 800.628.9696.

Provide the completed claim forms to The Standard within 90 days of the end of your benefit waiting period. If you cannot meet this deadline, you must submit these forms as soon as reasonably possible, but no later than one year after 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 prevents you from working the day before the scheduled effective date of your insurance coverage, your coverage will not become effective until the day after you are actively at work for one full day.

Salary change

Your SLTD premium is recalculated based on your age as of the preceding January 1. Any change in your predisability earnings after you become disabled will have no effect on the amount of your SLTD benefit.

Predisability earnings

Predisability earnings are the monthly earnings, including merit and longevity increases, from your covered employer as of the January 1 before your last full day of active work, or on the date you became a member if you were not a member on January 1. It does not include your bonuses, commissions, overtime pay or incentive pay.

If you are a teacher, it does not include your compensation for summer school, but it does include compensation earned during regular summer sessions by university staff.

Deductible income

Your SLTD benefits will be reduced by your deductible income—income you receive or are eligible to receive from other sources. Deductible income includes:

- Sick pay or other salary continuation (including sick-leave pool);
- Primary and dependent Social Security benefits;
- Workers' compensation;
- BLTD benefits;
- Other group disability benefits;
- Maximum plan retirement benefit; and
- Other income sources.

Please note that vacation pay is excluded from deductible income.

For example, your SLTD benefit before being reduced by deductible income is 65 percent of your covered predisability salary. The benefit will then be reduced by the amount of any deductible income you receive or are eligible to receive. The total of the reduced SLTD benefit plus the deductible income will provide at least 65 percent of your covered predisability salary. The guaranteed minimum SLTD benefit is $100, regardless of the amount of deductible income.

You are required to meet deadlines for applying for all deductible income you are eligible to receive. PEBA has different requirements for disability retirement. Please contact PEBA at 803.737.6800 or 888.260.9430 for more information.

When other benefits are awarded, they may include payments due to you while you were

receiving SLTD benefits. If the award includes past benefits, or if you receive other income before notifying The Standard, your SLTD claim may be overpaid. This is because you received benefits from the Plan and income from another source for the same period of time. You will need to repay the Plan for this overpayment.

Lifetime security benefit

SLTD coverage provides lifetime long term disability benefits if, on the last day of the regular maximum benefit period, you are unable to perform two or more activities of daily living or suffer from a severe cognitive impairment that is expected to last 90 days or more, as certified by a physician in the appropriate specialty as determined by The Standard. The lifetime benefit will be equal to the benefit that was being paid on the last day of the regular long term disability period.

Death benefits

If you die while SLTD benefits are payable, The Standard will pay a lump-sum benefit to your eligible survivor. This benefit will be equal to three months of your SLTD benefit, not reduced by deductible income. Eligible survivors include:

- Your surviving spouse;
- Surviving, unmarried children younger than age 25; and
- Any person providing care and support for any eligible children.

This benefit is not available to any eligible survivors if your SLTD benefits and claim have reached the maximum benefit period before your death. Also, this benefit is not available if you have been approved for or you are receiving the lifetime security benefit.

When SLTD coverage ends

Your SLTD coverage ends automatically on the earliest of:

- The last day of the month for which you paid a premium;
- The date the group policy ends; or
- The date you no longer meet the requirements noted in the Eligibility section of this chapter.

When benefits end

Your benefits will end automatically on the earliest of these dates:

- The date you are no longer disabled;
- The date your maximum benefit period ends, unless SLTD benefits are continued by the lifetime security benefit;
- The date benefits become payable under any other group long term disability insurance policy for which you become insured during a period of temporary recovery; or
- The date of your death.

Conversion

When your SLTD insurance ends, you may buy SLTD conversion insurance if you meet all of these criteria:

- Your insurance ends for a reason other than:
  - Termination or amendment of the group policy;
  - Your failure to pay a required premium; or
  - Your retirement.
- You were insured under your employer's long term disability insurance plan for at least one year as of the date your insurance ended.
- You are not disabled on the date your insurance ends.

- You are a citizen or resident of the United States or Canada.
- You complete and return to The Standard a *Request for Long Term Disability Conversion Materials* packet and pay the first premium for SLTD conversion insurance within 31 days after your insurance ends.

If you have questions about converting your SLTD policy, call The Standard at 800.378.4668. You will need to reference the state of South Carolina's group number, 621144.

Exclusions and limitations

- Disabilities resulting from war or any act of war are not covered.
- Intentional self-inflicted injuries are not covered.
- Benefits are not payable when you are not under the ongoing care of a physician in the appropriate specialty.
- Benefits are not payable for any period when you are not participating, in good faith, in a course of medical treatment, vocational training or education approved by The Standard, unless your disability prevents you from participating.
- Benefits are not payable for any period of disability when you are confined for any reason in a penal or correctional institution.
- Benefits are not payable after you have been disabled under the terms of the SLTD plan for 24 months during your entire lifetime, excluding the benefit waiting period, for a disability caused or contributed to by:
    - A mental disorder, unless you are continuously confined to a hospital solely because of a mental disorder at the end of the 24 months;
    - Your use of alcohol, alcoholism, use of any illicit drug, including hallucinogens or drug addiction;
    - Chronic pain, musculoskeletal or connective tissue conditions;
    - Chronic fatigue or related conditions; or
    - Chemical and environmental sensitivities.
- During the first 24 months of disability, after the benefit waiting period, SLTD benefits will not be paid for any period of disability when you are able to work in your own occupation, and you are able to earn at least 20 percent of your predisability salary, adjusted for inflation, but you choose not to work. After this time, no SLTD benefits will be paid for any period of disability when you are able to work in any occupation and able to earn at least 20 percent of your predisability earnings, adjusted for inflation, but choose not to work.
- Generally, benefits are not payable for any period of disability when you are not receiving disability benefits under the BLTD plan. However, this may not apply if:
    - You receive or are eligible to receive other income that is deductible under the BLTD plan, and the amount of that income equals or exceeds the amount of the benefits that would otherwise be payable to you under that plan;
    - Benefits that would otherwise be payable to you under the BLTD plan are being used to repay an overpayment of any claim; or
    - You were not insured under the BLTD plan when you became disabled.
- While living outside the United States or Canada, payment of benefits is limited to 12 months for each period of continuous disability.

Appeals

If The Standard denies your claim for supplemental long term disability benefits, you can appeal the decision by written notice within 180 days of receiving the denial letter. Send the appeal to:

Standard Insurance Company
P.O. Box 2800
Portland, OR 97208

If The Standard upholds its decision, the claim will receive an independent review by The Standard's Administrative Review Unit.

Because supplemental long term disability is fully insured by The Standard, you may not appeal SLTD decisions to PEBA.

MoneyPlus

MoneyPlus allows you to save money on eligible medical and dependent care costs. With MoneyPlus, you elect to contribute an annual amount to an IRS-approved flexible spending account. Your contributions are deducted from your paycheck, before taxes. You can use these funds to pay your eligible medical and dependent care expenses. As you incur eligible expenses during the plan year, you request reimbursement. ASIFlex administers the MoneyPlus program. You can learn more at peba.sc.gov/moneyplus.

How MoneyPlus can save you money

With MoneyPlus, you benefit from having less taxable income in each of your paychecks, which means more spendable income to use toward your eligible medical and dependent care expenses. The monthly savings example on this page shows how paying eligible expenses with a pretax payroll deduction may increase your spendable income. The scenario is for a married person who covers two children enrolled in the Standard Plan and who is also a member of the South Carolina Retirement System, or SCRS.

	Without MoneyPlus	With MoneyPlus	MoneyPlus advantage
Gross monthly pay[1]	$3,750.00	$3,750.00	
State retirement contribution (9%)	- $337.50	- $337.50	
Dependent Care Spending Account fee	- $0.00	- $2.32	
Medical Spending Account fee	- $0.00	- $2.32	
MoneyPlus pretax payroll deductions			
Dependent Care Spending Account	- $0.00	- $400.00	
Medical Spending Account	- $0.00	- $56.00	
Health and dental premiums paid with Pretax Group Insurance Premium feature *Employee/children coverage level*	- $0.00	- $157.58	
Taxable gross income	$3,412.50	$2,794.28	$618.22
Estimated payroll taxes (27%)[2]	**- $921.38**	**- $754.46**	**$166.92**
Expenses			
Dependent care expenses	- $400.00	- $0.00	
Medical expenses	- $56.00	- $0.00	
Health and dental premiums *Employee/children coverage level*	- $157.58	- $0.00	
Take-home pay	**$1,877.54**	**$2,039.82**	**$162.28**
Additional take-home pay per year with MoneyPlus (4.33% increase)			**$1,947.36**

1 Assumes annual salary of $45,000.
2 Includes state and federal taxes; married, filing jointly.

MoneyPlus administrative fees

MoneyPlus accounts have an administrative fee, which is set up to have a minimal impact relative to the tax savings the accounts provide. You will pay an administrative fee for every account in which you enroll. Because MoneyPlus is governed by the Internal Revenue Code, Internal Revenue Service (IRS) requirements and restrictions exist for program participants.

Monthly administrative fees	
Pretax Group Insurance Premium feature	$0.00
Medical Spending Account	$2.32
Health Savings Account	$1.00
Limited-use Medical Spending Account	$2.32
Dependent Care Spending Account	$2.32
Central Bank (HSA)	
Maintenance fee (balances less than $2,500)	$1.25
Paper statements	$3.00

The Pretax Group Insurance Premium feature allows you to pay your premiums with pretax money.

Member resources

ASIFlex website

The website, www.ASIFlex.com/SCMoneyPlus, allows you to:

- Review your account, online statement, claims information and card transactions;
- Submit claims;
- Set up direct deposit;
- Set up email and/or text alert notifications for your account;
- Learn about the specific tax benefits available to you; and
- Access resources, including eligible expenses, program descriptions, debit card information, online claim and administrative forms, and an expense estimator and cost savings tool.

ASIFlex mobile app

The ASIFlex mobile app allows participants to file claims and view their MoneyPlus accounts from their phone or tablet. The claim filing feature allows you to capture documentation using the mobile device's camera and submit that documentation with your claim. The mobile app also allows you to use the microphone feature to enter a claim. This means you can choose to speak, rather than type, some of the claim information. In addition to filing claims, you can view your annual election amount, account balance, contributions, reimbursements and previously submitted claims. The app is free and available online at www.ASIFlex.com/SCMoneyPlus or through Google Play or the App Store.

Responsibilities for using an account

When you enroll in any MoneyPlus spending account, you certify that you will:

- Ask for and keep copies of the documentation you will need for your reimbursement claims, including itemized statements of service and insurance plan explanation of benefits (EOBs);
- Use the account to pay only for IRS-qualified expenses for yourself and your IRS-eligible dependents;
- First use all other sources of reimbursement, including those provided by your insurance plan or plans, before seeking reimbursement from your spending account; and
- Not seek reimbursement through any additional source after seeking it from your account.

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. See *IRS Publication 596* or talk to a tax professional for more information.

IRS rules for spending accounts

- You can enroll each year during open enrollment to make a new election because elections for Medical Spending Accounts (MSAs), Limited-use MSAs and Dependent Care Spending Accounts (DCSAs) do not automatically renew; however, elections for an Health Savings Accounts (HSAs) do renew, and you are not required to re-enroll each year.
- You may be able to change your election if you experience a qualifying change in status event, as stated in the plan.
- You do not have to be enrolled in PEBA's medical, dental or vision plans to participate. For example, you may have insurance through a spouse's employer, and you can still sign up for spending accounts through PEBA (subject to plan and IRS limits).
- You have access to your entire MSA election amount on January 1. Therefore, you can be reimbursed up to this amount, minus previous reimbursements, any time during the year regardless of your balance.
- You cannot pay any insurance premiums through any type of flexible spending account. These accounts are separate from the Pretax Group Insurance Premium feature.
- You cannot pay a dependent care expense from your MSA, or a medical expense from your DCSA.
- The MSA includes a carryover provision. You may carry over up to $550 of unused funds into the new plan year in your in Medical Spending Account. You will forfeit any unused funds over $550.
- The DCSA includes a grace period. This means you can continue to spend 2020 funds through March 15, 2021. Expenses incurred from January 1, 2020, through March 15, 2021, can be considered for reimbursement from your 2020 account.
- You may not be reimbursed through your MoneyPlus accounts for expenses paid by insurance or any other source.
- You cannot deduct reimbursed expenses from your income tax.
- You can only be reimbursed for services received. You cannot be reimbursed for a future service, nor can you make an advance payment for a future service.

Pretax Group Insurance Premium feature

The Pretax Group Insurance Premium feature allows you to pay your State Health Plan premiums with money from your paycheck before taxes are withheld. You may also use your pretax income to pay premiums for Dental Plus, Basic Dental, the State Vision Plan, Optional Life coverage up to $50,000 and the TRICARE Supplement Plan.

Eligibility and enrollment

Everyone who pays health, dental, vision care, Optional Life or TRICARE Supplement Plan premiums is automatically enrolled in the Pretax Group Insurance Premium feature. However, you can decline it when you first enroll.

If you decline the feature, you can enroll in it during open enrollment, which takes place in October, or within 31 days of a special eligibility situation. To do this, see Making changes to your MoneyPlus coverage on Page 151. To learn about

special eligibility situations, see Page 21.

Medical Spending Account

A Medical Spending Account (MSA) allows you to pay eligible medical expenses not covered by insurance, including copayments and coinsurance, with pretax income. MSAs offer the ASIFlex Card, which functions like a debit card. You can use this card to spend funds as an alternative to submitting claims for reimbursement. You can carry over up to $550 of funds placed in your MSA that you did not use during the plan year into the next plan year. You will forfeit funds over $550 left in your account after the reimbursement deadline.

Eligibility

You must be eligible for state group insurance benefits to participate in an MSA. However, you are not required to be covered by an insurance program to participate, nor do you have to enroll in the Pretax Group Insurance Premium feature. Members enrolled in the Standard Plan are encouraged to participate in an MSA.

Enrollment

You can enroll in an MSA within 31 days of your hire date through your employer. If you do not enroll then, you can enroll during the next open enrollment period in October through MyBenefits at MyBenefits.sc.gov.

You also can enroll in, or make changes to this account within 31 days of a special eligibility situation. To do this, see Making changes to your MoneyPlus coverage on Page 151. To learn about special eligibility situations, see Page 21.

You will need to re-enroll each year during open enrollment to continue your account the following year.

Deciding how much to set aside

Estimate the amount you and your family will spend on routine, recurring and predictable medical expenses throughout the year. You are allowed to carry over $550 of funds each year into the next plan year. You have until March 31, 2022, to file claims for reimbursement and submit documentation for eligible expenses incurred during 2021. You will forfeit funds over $550 left in your account after the reimbursement deadline.

The yearly amount you elect to contribute to your account will be divided into equal installments and deducted from each paycheck before taxes.

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.

Contribution limits

The contribution limit for 2021 is $2,750. If you are married, and your spouse is eligible for PEBA-sponsored insurance coverage as an employee, you may each contribute up to $2,750 annually.

People who can be covered by an MSA

An MSA may be used to reimburse eligible expenses for:

- You;
- Your spouse (even if they have a separate MSA);
- Your qualifying child; and
- Your qualifying relative.

An individual is a qualifying child if he is not someone else's qualifying child, although an eligible child of divorced parents is treated as a dependent of both, so either or both parents can establish an MSA. Additionally, a child qualifies if he:

- Does not reach age 27 during the taxable

year (if a qualifying child is physically or mentally incapable of self-care, there is no age limitation);

- Has a specified family-type relationship to you: son/daughter, stepson/stepdaughter, eligible foster child, legally adopted child or child placed for legal adoption; and
- 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.

For more information, contact your employer or tax advisor. You can also contact the IRS at www.irs.gov or 800.829.1040, or view IRS Publications 501 and 502.

Eligible expenses

Expenses eligible for reimbursement include your copayments, deductibles and coinsurance. You can also use your MSA to pay for:

- Adult well exams;
- Vision care, including prescription eyeglasses/sunglasses, contact lenses, cleaning solutions, eye drops for contact lens wearers, over-the-counter reading glasses and vision correction surgery;
- Out-of-pocket dental fees, such as deductibles or coinsurance, including fillings, crowns, bridges, dentures and adhesives, occlusal guards, implants and orthodontics ;
- Hearing exams, hearing aids and batteries;
- Mileage expenses incurred traveling to obtain health care (subject to IRS limit);
- Over-the-counter health care items such as adhesive bandages, birth control, feminine hygiene products, pregnancy and fertility kits, prenatal vitamins, breast pumps, sunscreen or lip balm (15 SPF and broad spectrum), first aid supplies/kits, joint braces and supports, blood pressure monitors, diabetic supplies, thermometers, canes, crutches, pill holders/splitters and thousands of other items;
- Over-the-counter medicines or drugs (pain relief, allergy medicines, cold/cough/flu medicines, stomach/digestive aids, etc.); and
- Any other out-of-pocket medical expenses deductible under current tax laws, including travel to and from medical facilities (subject to IRS limits).

Ineligible expenses

- Insurance premiums;
- Vision warranties and service contracts;
- Expenses for a service not yet provided or for pretreatment estimates;
- Expenses for general good health and well-being;
- Illegal operations;
- Expenses paid by insurance or any other source;
- Health or fitness club membership fees; and
- Cosmetic surgery, treatments or medications not deemed medically necessary to alleviate, mitigate or prevent a medical condition.

Using your MSA funds

You have several ways to access your MSA funds. You can use a special debit card, known as the ASIFlex Card, to pay for expenses directly, or you can have expenses reimbursed to you through direct deposit by submitting a claim online at www.ASIFlex.com/SCMoneyPlus, or via the ASIFlex mobile app, toll-free fax or mail.

ASIFlex Card

The ASIFlex Card, a debit card issued at no cost to MSA participants, can be used to pay eligible, uninsured medical expenses for you and your covered family members. When signing up for an MSA, you will receive two cards so you can give one to your spouse or child.

Activating your card

To activate your ASIFlex Card so you may begin using it, call the toll-free number on the card sticker. You can set up a PIN known only to you.

Using your card

You can sign for credit transactions or enter your PIN for debit transactions.

The card is a limited-use card and can be used at health care providers and merchants who accept VISA®. It can also be used at retail merchants who use the Inventory Information Approval System, known as IIAS, and identify which products are MSA-eligible. To find a current list of available IIAS merchants, go to www.ASIFlex.com/SCMoneyPlus.

Use of the card is not paperless. Each time you swipe the card, ask the provider for an itemized statement of service that includes the provider name, patient name, date of service, description of service and dollar amount. ASIFlex will automatically accept and process as many transactions as possible; however, IRS regulations do require that you provide backup documentation to substantiate certain transactions.

You can request the documentation and keep the paper copy; or, simply snap a picture of the documentation and store in your device gallery. See the Auto-validation of transactions section below for more information.

Documenting ASIFlex Card transactions

According to the IRS, it is not necessary to submit documentation for:

- Known copayments for services provided through the State Health Plan in which you are enrolled;
- Eligible prescriptions purchased through your health plan's mail-order pharmacy;
- Recurring expenses at the same provider for the exact same dollar amount (such as monthly orthodontia payments); or
- IRS-approved over-the-counter health care products.

Auto-validation of transactions

For other health care expenses, documentation is needed. ASIFlex will receive claims data from BlueCross BlueShield of South Carolina and EyeMed. ASIFlex will auto-validate debit card transactions it can match to claims received from other vendors. If ASIFlex cannot validate a claim, you will need to provide documentation for that transaction.

Requests for documentation are emailed and posted online to your account. You have 52 days to respond or your card will be deactivated.

- Initial notice - sent approximately 10 days after ASIFlex receives notice of the card transaction.
- Reminder notice - sent 21 days after initial notice.
- Deactivation notice - sent 21 days after reminder notice. Your card will be deactivated and future claim submissions will be offset by

the outstanding amount.

When documentation is submitted, your card will be automatically reinstated. Any amounts from the plan year that are not documented by March 31, 2022, will not meet IRS guidelines and will be taxed as income.

You should keep all documents substantiating your claims for at least one year and submit them to ASIFlex on request.

Lost cards

If your ASIFlex Card is lost or stolen, call ASIFlex at 833.726.7587 immediately.

Requesting reimbursement of eligible expenses

Before you file claims for reimbursement, you must first file insurance claims for the benefits you have received. Out-of-pocket expenses remaining after that may then be submitted to ASIFlex for reimbursement from your MSA. The minimum check reimbursement is $25, except for the last reimbursement, which brings your account balance to zero. Be sure to sign up for direct deposit, as there is no minimum for electronic transactions.

If you do not use your ASIFlex Card, you can submit a *MoneyPlus Claim Form* online at **www.ASIFlex.com/SCMoneyPlus** or via the ASIFlex mobile app. You may also submit a paper claim form, along with a copy of your expense documentation or the Explanation of Benefits. In addition, you should note the deadlines described in the IRS restrictions section on Page 139.

When gathering documentation, consider these requirements:

- Documentation can be an invoice or bill from your health care provider listing the date of service, the cost of the service, the type of service, the service provider and the person for whom the service was provided. Note: copayment receipts must show a description, such as "office visit copay."
- Documentation can also be an Explanation of Benefits from your insurance plan showing the insurance plan payment and the amount you are responsible to pay.
- For over-the-counter health care products, provide the itemized merchant receipt.
- For over-the-counter drugs or medications, submit with the itemized merchant receipt.
- For prescriptions, provide the pharmacy receipt showing the prescription number and the name of the drug. You can also request a printout from the pharmacy that itemizes your prescriptions; or otherwise obtain this information from the pharmacy website. For mail-order prescriptions, simply provide the itemized mail order receipt.
- In some circumstances, a written statement from your health care provider that the service was medically necessary may be needed. A sample Letter of Medical Necessity can be found on **www.ASIFlex.com/SCMoneyPlus** under the Resources tab.

ASIFlex will process your claim within three business days of receiving it. Your reimbursement may be direct deposited into your bank account within one day of processing your claims. This service has no extra fee and includes notifications of when your funds are processed. To set up direct deposit, log in to your online account and update your personal account settings. You should also sign up for email and/or text alerts.

Comparing the MSA to claiming expenses on *IRS Form 1040*

You can claim itemized medical and dental expenses on your *IRS Form 1040* only if they exceed

10 percent of your adjusted gross income. If you file a joint tax return, your adjusted gross income includes both your income and your spouse's. The tax-free MSA gives you an alternate way to save taxes on your uninsured, out-of-pocket medical expenses. Refer to the chart on Page 137 for an example.

To learn more about the tax credit, see *IRS Publication 502* or use the services of a tax professional.

What happens to your MSA when you leave your job?

When you have an MSA and you leave your job, you may be eligible to continue to contribute to your MSA through the end of the plan year.

COBRA coverage will consist of the amount you have in your MSA at the time of the qualifying event, plus additional contributions up to the annual amount you elected to contribute. You will pay 102 percent of your normal cost, which is your contribution amount plus the $2.32 administrative fee, for COBRA coverage. If you have funds remaining at the end of the plan year, up to $550 will carry over and be available to you until the end of your COBRA period of coverage. ASIFlex will contact you about continuation of coverage.

If you do not continue your MSA as permitted under COBRA, you have until March 31 of the following year or until you exhaust your account, whichever is sooner, to submit eligible MSA expenses incurred before you left employment. Any funds still in your account will not be returned to you.

If you return to employment with an employer who participates in PEBA-administered insurance within 30 days, your original MSA elections will automatically be reinstated. If you return to employment with an employer who participants in PEBA-administered insurance after 30 days, you cannot participate in an MSA for the remainder of the plan year. You can, however, re-enroll during open enrollment for the next plan year.

The Family and Medical Leave Act (FMLA) may affect your rights to continue coverage while on leave. Contact your employer for further information.

What happens to your MSA after you die?

Your MSA ends on the date you die, and the balance is not refunded to your survivors. An IRS-qualified dependent or beneficiary may continue an MSA through the end of the plan year under COBRA. Contact ASIFlex for more information. If the MSA is not continued through COBRA, your beneficiary has 90 days from the date of your death or the end of the run-out period, whichever is sooner, to submit claims for eligible expenses incurred through your date of death.

The death of a spouse or child creates a change in status. You may stop, start or change the amount contributed to your MSA at that time. You have 31 days from the date of their death to make the change. See Page 151 for information about changing your contribution.

Dependent Care Spending Account

A Dependent Care Spending Account, or DCSA, allows you to pay work-related dependent care expenses with pretax income. This account is only for daycare costs for children and adults, and cannot be used to pay for dependent medical care. The funds can be used only for expenses incurred during the 2021 plan year. If you have money left in your account on December 31, you have until March 15, 2022, to spend funds deposited during 2021. You will have until March 31, 2022, to request reimbursement from your 2020 funds for

expenses incurred on or before March 15, 2022. You will forfeit any funds left in your account after the reimbursement deadline.

Eligibility

You must be eligible for state group insurance benefits to participate in a DCSA. However, you are not required to be covered by an insurance program to participate, nor do you have to enroll in the Pretax Group Insurance Premium feature.

Enrollment

You can enroll in a DCSA within 31 days of your hire date through your employer. If you do not enroll then, you can enroll during the next open enrollment period in October through MyBenefits at MyBenefits.sc.gov.

You also can enroll in or make changes to this account within 31 days of a special eligibility situation. To do this, see Making changes to your MoneyPlus coverage on Page 151. To learn about special eligibility situations, see Page 21.

You will need to re-enroll each year during open enrollment to continue your account the following year.

Deciding how much to set aside

Estimate the amount you will spend on dependent care throughout the year. Take into account vacation and holiday time, when you may not have to pay for dependent care. The yearly amount you elect to contribute to your account will be divided into equal installments and deducted from each paycheck before taxes.

The IRS will not allow any money still in your account after you have claimed all of your expenses at the end of the year to be returned to you, or be carried over into the next plan year. If you have money left in your account on December 31, you have until March 15, 2022, to spend funds deposited during 2021. You will have until March 31, 2022, to request reimbursement for expenses incurred on or before March 15, 2022. You will forfeit any funds left in your account after the reimbursement deadline.

Once you sign up for a DCSA and decide how much to contribute, you have to wait for the funds to accumulate in your account before being reimbursed for eligible expenses.

Contribution limits

The contribution limit for a DCSA is based upon your tax filing status. Below are the 2021 limits.

- Married, filing separately: $2,500
- Single, head of household: $5,000
- Married, filing jointly: $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.

In 2021, the DCSA is capped at $1,700 for highly compensated employees. The IRS set the salary for 2021 as $130,000 or greater. The cap is subject to adjustment during the year if PEBA's DCSA does not meet the federal average benefit test. The test is designed to ensure that highly compensated employees do not receive a benefit that is out of proportion with the benefit received by other employees.

For more information, talk with a tax professional or contact the IRS at www.irs.gov or 800.829.1040.

People who can be covered by a DCSA

Your child and dependent care expenses must be for the care of one or more qualifying persons. A qualifying person is:

1. Your qualifying child who is your dependent and was under age 13 when the care was provided;

2. Your spouse who was not physically or mentally able to care for himself and lived with you for more than half the year; or
3. A person who was not physically or mentally able to care for himself, lived with you for more than half the year, and either:
    a. Was your dependent; or
    b. Would have been your dependent except that:
        i. He received gross income of $4,050 or more;
        ii. He filed a joint return; or
        iii. You or your spouse, if filing jointly, could be claimed as a dependent on someone else's tax return.

Eligible expenses

Generally, child, adult and elder care costs that allow you and your spouse to work or actively look for work are eligible for reimbursement. If you are married, your spouse must work, be a full-time student or be mentally or physically incapable of self-care. Examples include:

- Daycare facility fees;
- Local day camp fees;
- Before or after school care;
- Preschool or nursery school; and
- Babysitting 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.
- Educational tuition.
- Overnight camps.
- Overnight care for your dependents, unless it allows you and your spouse to work during that time.
- Nursing home fees.
- Diaper services.
- Books and supplies.
- Activity fees.
- Tuition.

Requesting reimbursement of eligible expenses

When you have a dependent care expense, you request reimbursement from your account online at www.ASIFlex.com/SCMoneyPlus. You will also need to submit documentation for your expense. A paper claim form is also available online at peba.sc.gov/forms.

Your claim and the expense documentation should show the following:

- The dates your dependent received the care, not the date you paid for the service;
- The name and address of the facility; and
- The name, address and signature of the individual who provided the dependent care.

This information is required with each reimbursement request. The claim form may serve as documentation if it includes the provider's signature. Although the form does not request the provider's Tax ID Number or Social Security number, you should be prepared to provide it to the IRS, if asked.

ASIFlex will process your claim within three

business days of receiving it. Your reimbursement may be direct deposited into your bank account within one day of processing your claims. This service has no extra fee and includes notifications of when your funds are processed. To set up direct deposit, log in to your online account and update your personal account settings. You should also sign up for email and/or text alerts at www.ASIFlex.com/SCMoneyPlus.

An approved expense will not be reimbursed until after the last date of service for which you are requesting reimbursement. For example, if you pay your dependent care provider on October 1 for the month of October, you can submit your reimbursement request for the entire month. Payment will not be made, though, until you receive the last day of care for October.

An approved expense will also not be reimbursed until enough funds are in the DCSA to cover it. On your claim, 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.

Reporting your DCSA to the IRS

If you participate in a DCSA, you must attach *IRS Form 2441* to your 1040 income tax return. Otherwise, the IRS may not allow your pretax exclusion. To claim the income exclusion for dependent care expenses on *Form 2441*, you must list each dependent care provider's Social Security number or Employer Identification Number (EIN). If you are unable to obtain one of these numbers, you will need to provide a written statement with your *Form 2441* explaining the situation and stating that you made a serious effort to get the information.

Comparing the DCSA to the child and dependent care credit

If you pay for dependent care so you can work, you may be able to reduce your taxes by claiming those expenses on your federal income tax return through the child and dependent care credit instead of using a DCSA. Depending on your circumstances, participating in a DCSA on a salary-reduction basis may produce a greater tax benefit. For more information, see *IRS Publication 503* or speak with a qualified tax advisor.

What happens to your DCSA if you leave your job?

If you leave your job permanently or take an unpaid leave of absence, you cannot continue contributing to your DCSA. You can, however, continue to incur expenses through March 15 of the following year, and request reimbursement for eligible expenses until March 31 of the following year, or until you exhaust your account, whichever is sooner.

If you return to employment with an employer who participates in PEBA-administered insurance within 30 days, your original DCSA elections will automatically be reinstated. If you return to employment with an employer who participants in PEBA-administered insurance after 30 days, you cannot participate in a DCSA for the remainder of the plan year. You can, however, re-enroll during open enrollment for the next plan year.

What happens to your DCSA after you die?

Your DCSA ends on the date you die and is not refunded to your survivors. DCSA claims for expenses which occurred up through your date of death may be submitted until the account is exhausted or through the end of the plan year.

The death of a spouse or child creates a change in

status. You may stop, start or change the amount contributed to your DCSA at that time. You have 31 days from the date of their death to make the change. See Page 151 for information about changing your contribution.

Health Savings Account

Members enrolled in the State Health Plan Savings Plan are encouraged to participate in a Health Savings Account, or HSA. An HSA is a tax-favored account that offers several advantages for insurance and even retirement. HSAs carry over from one year to the next, and you do not have to spend the funds in the year they are deposited. You can even take your account with you if you leave your job. Because of this, you can use your HSA to save up over time for future medical expenses, and in doing so, you can offset the higher deductible of your insurance plan. Learn more about the State Health Plan's Savings Plan on Page 42.

Also, once you have accumulated a balance of $1,000 in your HSA, you can invest the funds among a variety of investment options. The investment earnings are tax-free as long as the funds are spent for qualified medical expenses or you reach age 65 (see Eligibility section). However, you cannot invest so much that it would bring the balance of your HSA below the threshold of investment eligibility. Learn more about investment options at schsa.centralbank.net.

When you deposit funds to your HSA through payroll deduction, the $1.00 monthly administrative fee is also deducted.

Eligibility

You must be enrolled in the Savings Plan to be eligible for an HSA. You cannot be covered by any other health plan that is not a high deductible health plan, including Medicare. You may, however, still be covered for specific injuries, accidents, disability, dental care, vision care and long-term care. Additionally, you cannot be claimed as a dependent on another person's income tax return.

An MSA, even a spouse's MSA, is considered to be another health plan under HSA regulations, and as such, prevents you from contributing to an HSA. If you have no funds in your MSA on December 31, you may begin contributing to an HSA on January 1.

When an active subscriber who is enrolled in the Savings Plan turns 65, he remains eligible to contribute to an HSA if he delays enrollment in Medicare Part A by delaying receiving Social Security. He can delay enrolling in Social Security until he turns age 70½. Once he enrolls in Social Security, and therefore Medicare Part A, he can no longer make contributions to an HSA. The funds already in the HSA, however, may be withdrawn to pay Medicare premiums, but not Medigap premiums, and may also be used to pay deductibles and coinsurance.

Enrollment

You can enroll in, change or stop your contributions to an HSA at any time. You do not need to do so during open enrollment or a special eligibility situation. You can enroll through your employer. Once you enroll in an HSA, you do not need to re-enroll as long as you remain eligible. Changes to your contributions are limited to once a month.

To contribute money pretax through payroll deduction, you must enroll in the MoneyPlus HSA. Although ASIFlex administers HSAs, Central Bank serves as the custodian for HSAs. To complete your HSA enrollment, you must open a bank account with Central Bank and enter a validation code in MyBenefits. To open your Central Bank HSA account, visit schsa.centralbank.net and select the

Open HSA button. Your payroll contributions will automatically transfer to your bank account within three business days of ASIFlex receiving the funds from your employer. Central Bank will mail you a debit card within 10 business days that you can use to access your funds.

Contribution limits

The contribution limit, set by the IRS, for an HSA is based upon your health plan coverage level. Below are limits for 2021.

- Single coverage: $3,600.
- Family coverage: $7,200.
- Additional catch-up contributions for a subscriber who is age 55 or older: $1,000.

When you enroll in an HSA, you may begin contributing your maximum beginning on the first of the month in which it goes into effect, but only so long as you remain eligible for the following 12 months. You may contribute up to the maximum in a lump sum payment or in equal amounts through payroll deduction with MoneyPlus.

ASIFlex will monitor your HSA contributions and send an alert to your employer if you are exceeding your contribution limit. The best way to avoid problems is to divide your desired annual contribution among the number of paychecks you receive, or expect to receive through the remainder of the year if a mid-plan-year enrollment. For example, if you have single coverage, you can contribute a maximum of $3,600 for 2021. If you receive 24 paychecks each year, you can contribute $150 each pay period.

Subscribers who are transitioning from an MSA to an HSA may face a restriction on when they may begin making HSA contributions. IRS regulations do not allow you to use your MSA in conjunction with an HSA; however, regulations allow you to use a Limited-use MSA in conjunction with an HSA. You can use a Limited-use MSA to pay for those expenses the Savings Plan does not cover, like dental and vision care. If you have any carryover funds, ASIFlex will automatically convert those funds to a Limited-use MSA because of your new plan year HSA election.

When your funds become available

Each contribution to your MoneyPlus HSA will be available after your employer's payroll is received and processed by ASIFlex, transferred to Central Bank and deposited in your account. Funds will be available in your HSA at Central Bank no later than one business day after ASIFlex receives the money from your employer.

Using your funds

After you enroll in an HSA, you will receive a MasterCard® debit card from Central Bank to use for all of your qualified medical expenses. You may reimburse yourself with a direct deposit to a checking or savings account of your choice or through Bill Pay at no additional charge. Checks may be purchased at an additional cost.

If you use your debit card for a transaction and do not have enough money in your account, the transaction will not go through or could overdraw your account.

You can log in to your Central Bank account to check your balance, make online contributions, review monthly statements and annual tax reporting, transfer funds, set up your HSA investment account and more. Central Bank will provide monthly paper statements for a $3 monthly fee.

In addition, there is a $1.25 monthly maintenance fee for account balances less than $2,500.

Eligible expenses and documentation

You may use your HSA funds, tax free, to pay for

unreimbursed eligible medical expenses for you, your spouse and your tax dependents. Medical expenses include the costs of diagnosis, cure, treatment or prevention of physical or mental defects or illnesses, including dental and vision expenses. HSA funds can only be used tax-free to pay for over-the-counter drugs if the drugs were prescribed by a physician.

You should keep receipts for expenses paid from your HSA with your tax returns in case the IRS audits your tax return and requests copies. You may upload scanned copies or pictures of your eligible receipts by logging in to your Central Bank account.

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.

Investing HSA funds

Your HSA funds will be held in an interest-bearing checking account with Central Bank. As the account grows, you may be eligible to invest your funds in excess of $1,000. Investments may not be federally insured or guaranteed. You should review investments in detail before making your investment selections. Investment risk is the uncertainty of how a given investment will perform. When you choose to invest your funds, your account balance is affected by investment gains or losses as a result of those choices. You bear all investment risk related to your HSA. The monthly fee is $1.50 and additional fees may be charged based upon the investment options you select. Learn more about investment options at schsa.centralbank.net.

Reporting your HSA to the IRS

After year end, Central Bank will provide information to use in reporting your HSA contributions and withdrawals when you file your taxes. You should save documentation, including receipts, invoices and explanations of benefits from your health insurance claims processor, in case you are asked to show the IRS proof that your HSA funds were used for qualified expenses.

Pretax HSA contributions will appear on your W-2 as employer-paid contributions. This is because the money was deducted from your salary before it was taxed. You should not deduct this money on your return. Only after-tax contributions may be deducted. Consult with a tax professional for more information.

What happens to your HSA after you die?

If your spouse is the beneficiary of your HSA, the account can be transferred to an HSA in your spouse's name. If your beneficiary is someone other than your spouse, the account will cease to be an HSA on your date of death. If the beneficiary is your estate, the fair market value of the account on your date of death will be taxable on your final return. For beneficiaries other than your spouse or estate, the fair market value of the account is taxable to the beneficiary for the tax year in which you died.

For more information, see the *Health Savings Account Custodial Agreement*.

Closing your HSA

If you are no longer eligible to contribute to an HSA or would like to stop contributing, complete a *Notice of Election* form. If money remains in the account, you may continue to use it for qualified, unreimbursed medical expenses. You must contact Central Bank to close your HSA bank account.

Limited-use Medical Spending Account

If you are making contributions to an HSA, you also may be eligible for a Limited-use Medical Spending Account (MSA). This account may be used for expenses not covered by the Savings Plan. Eligible expenses include dental and vision care. Except for the restriction on what kinds of expenses are reimbursable, a Limited-use MSA works the same as a Medical Spending Account. Learn more on Page 140.

Eligible expenses

You may use your HSA, but not your Limited-use MSA, for medical deductibles and coinsurance. You may use your Limited-use MSA for other expenses not covered by the Savings Plan, like dental and vision care.

Ineligible expenses - Limited-use MSA only

- Insurance premiums;
- Vision warranties and service contracts;
- Expenses for a service not yet provided or for pretreatment estimates;
- Expenses for general good health and well-being;
- Illegal operations;
- Expenses paid by insurance or any other source;
- Health or fitness club membership fees;
- Cosmetic surgery, treatments or medications not deemed medically necessary to alleviate, mitigate or prevent a medical condition;
- Medical plan deductibles and coinsurance; and
- Over-the-counter health care products that are not for dental or vision care.

Making changes to your MoneyPlus coverage

You have limited circumstances for starting or stopping your DCSA, MSA and Limited-use MSA, or varying the amounts you contribute. Any changes you make to your DCSA, MSA or Limited-use 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 former spouse's out-of-pocket medical expenses.

Within 31 days of one of the events listed below, contact your employer if you wish to make changes.

Any related claims you submit while ASIFlex is processing your change in status will be held until the processing is complete. Birth, adoption and placement for adoption are effective on the date of the event. All other changes are effective on the first of the month following the request.

Some special eligibility situations that may permit changes to your MoneyPlus account are:

- Marriage or divorce (you cannot make changes because you are in the process of divorce, but you may after it is final);
- Birth, placement for adoption or adoption;
- Placement for custody;
- Dependent loses eligibility;
- Death of spouse or child;
- Gain or loss of employment;
- Begin or end unpaid leave of absence;
- Change from full-time to part-time employment or vice versa; and
- Change in daycare provider.

How changes affect your period of coverage

Your MoneyPlus flexible spending account is set up for the entire calendar year, which is your period of coverage. If you make an approved, mid-plan-year election change and increase your contributions, expenses you had before the mid-year change cannot be reimbursed for more money than was in the account at the time of the change. This does not apply to HSAs.

Appeals

Reimbursement or claim for benefits

If your request for reimbursement or claim for benefits is denied in full or in part, you have the right to appeal the decision. Appeals are approved only if the extenuating circumstances and supporting documentation are within your employer's, your insurance provider's and IRS' regulations governing the Plan.

Send a written request within 31 days of the denial for review to:

ASIFlex Appeals
Attn: S.C. MoneyPlus
P.O. Box 6044
Columbia, MO 65205-6044

Please retain copies of claims and receipts for your records.

Your appeal must include the completed *Appeal Form* found at www.ASIFlex.com/SCMoneyPlus and:

- The name of your employer;
- The date of the services for which your request was denied;
- A copy of the denied request;
- A copy of the denial letter you received;
- Why you think your request should not have been denied; and
- Any additional documents, information or comments you think may have a bearing on your appeal.

You will be notified of the results of this review within 31 business days from receipt of your appeal. In unusual cases, such as when an appeal requires additional documentation, the review may take longer. If your appeal is approved, additional processing time is required to modify your benefit elections.

If you are still dissatisfied after the decision is re-examined, you may ask PEBA to review the matter by sending an ***Appeal Request Form*** to PEBA within 90 days of notice of ASIFlex's denial of your appeal. Send the request to:

IAD@peba.sc.gov

or

S.C. PEBA
Attn: Insurance Appeals Division
202 Arbor Lake Drive
Columbia, SC 29223

A healthcare provider, employer or your benefits administrator may not appeal to PEBA on your behalf. Only you, the member, your authorized representative or a licensed attorney admitted to practice in South Carolina may initiate an appeal through PEBA. A provider, employer or benefits administrator may not be an authorized representative.

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

in the mail.

If the denial is upheld by PEBA, 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.

Enrollment

You have the right to appeal enrollment decisions, as well, by submitting a request for review through your benefits administrator. Benefits administrators may submit a request for review online.

If the request for review is denied, you may then appeal by sending an ***Appeal Request Form*** to PEBA within 90 days of notice of the decision. Please include a copy of the denial with your appeal. Send the request to:

IAD@peba.sc.gov

or

S.C. PEBA
Attn: Insurance Appeals Division
202 Arbor Lake Drive
Columbia, SC 29223

A healthcare provider, employer or your benefits administrator may not appeal to PEBA on your behalf. Only you, the member, your authorized representative or a licensed attorney admitted to practice in South Carolina may initiate an appeal through PEBA. A provider, employer or benefits administrator may not be an authorized representative.

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

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

Contacting ASIFlex

www.ASIFlex.com/SCMoneyPlus

Customer Care Center
8 a.m.-8 p.m., Monday through Friday
10 a.m.-2 p.m., Saturday

833.SCM.PLUS (833.726.7587)

Toll-free claims fax: 877.879.9038

asi@asiflex.com

Retiree group insurance

Are you eligible for retiree group insurance?

Some of the insurance benefits you enjoy as an active employee may be available to you as a retiree through the group insurance programs PEBA sponsors. This chapter covers retiree group insurance eligibility and whether your employer may pay a portion of your retiree insurance premiums.

Eligibility for retiree group insurance is not the same as eligibility for retirement.

An employee has retired and established a date of retirement for the purpose of the State Health Plan if they:

1. Have terminated from all employment with a participating employer;
2. Have terminated from all employment covered by a PEBA-administered retirement plan; and
3. Are eligible to receive a service or disability retirement benefit from a PEBA-administered retirement plan.

Determining retiree insurance eligibility is complicated, and only PEBA can make that determination. It is very important to contact PEBA before making final arrangements for retirement.

Your eligibility for retiree group insurance coverage and funding depends upon a number of factors, including your eligibility for a retirement benefit, the date you were hired into an insurance-eligible position, your retirement service credit earned while working for an employer that participates in the State Health Plan and the nature of your last five years of active employment with an employer that participates in the State Health Plan.

Earned service credit is time earned and established in one of the defined benefit retirement plans PEBA administers; time worked while participating in the State Optional Retirement Program (State ORP); or time worked for an employer that participates in the State Health Plan, but not the retirement plans PEBA administers. Earned service credit does not include any purchased service credit not considered earned service in the retirement plans (e.g., non-qualified service or employer-approved sabbatical leave) or service accrued with an employer that does not participate in the State Health Plan.

If you are a member of one of the defined benefit retirement plans PEBA administers, your eligibility for retiree group insurance will depend on whether you have met the minimum statutory requirements for retirement eligibility established for the plan in which you are a member when you leave employment.

PEBA's defined benefit plans include the South Carolina Retirement System (SCRS), the Police Officers Retirement System (PORS), the General Assembly Retirement System (GARS) and the Judges and Solicitors Retirement System (JSRS).

PEBA also administers a defined contribution plan, the State Optional Retirement Program (State ORP). For State ORP participants and employees whose employer does not participate in a PEBA-administered retirement plan, eligibility is determined as if the participant were a member of the South Carolina Retirement System.

Will your employer pay part of your retiree insurance premiums?

As an active employee, your employer pays part of the cost of your health and dental insurance. When you retire, several factors determine if you pay all or part of your insurance premiums. These factors include your years of earned service credit, the type of employer from which you retire and the date you were hired into an insurance-eligible position.

Employees of state agencies, public higher education institutions and public school districts that participate in the state insurance program may be eligible for a state contribution to their retiree insurance premiums based on when they began employment and on their number of years of earned service credit.

Retiree insurance eligibility rules are the same for retirees of optional employers as they are for state agency, public higher education institution and public school district retirees. However, the funding is different. Participating optional employers may or may not pay a portion of the cost of their retirees' insurance premiums. Each participating optional employer develops its own policy for funding retiree insurance premiums for its eligible retirees. If you are an employee of a participating optional employer, contact your benefits office for information about retiree insurance premiums.

Early retirement: SCRS Class Two members

A Class Two member of SCRS who retires under the 55/25 early retirement provision and who is otherwise eligible for funding toward retiree insurance premiums from the South Carolina Retiree Health Insurance Trust Fund must pay the full premium (employee and employer share) until he reaches age 60 or the date he would have reached 28 years of service credit had he not retired, whichever occurs first.

Certain elected officials

Special retiree insurance rules apply to members of the General Assembly and members of a municipal or county council who began employment eligible for coverage under the State Health Plan before May 2, 2008. Contact PEBA for more detailed information.

Only PEBA can confirm your eligibility

Eligibility for retiree group insurance is not the same as eligibility for retirement. Determining retiree insurance eligibility is complicated, and only PEBA can make that determination. You are encouraged to confirm your eligibility before retiring. After confirmation of eligibility, you must submit the necessary forms to enroll in retiree coverage. Coverage does not automatically continue at retirement.

If you plan to retire in three to six months, submit a completed *Employment Verification Record* to PEBA. If you plan to retire within 90 days, complete and submit to PEBA an *Employment Verification Record*, a *Retiree Notice of Election* form and a *Certification Regarding Tobacco and E-cigarette Use* form. The *Employment Verification Record* and the retiree packet are available at **peba.sc.gov/forms**. You may also get copies from your employer or contact PEBA at 803.737.6800 or 888.260.9430.

In some situations, eligibility determinations are available in Member Access, the member portal for retirement benefits and/or MyBenefits. PEBA will also send you written confirmation of your eligibility. PEBA does not confirm eligibility for retirement dates further out than six months. PEBA cannot confirm eligibility for retiree group insurance or funding of your retiree insurance premiums by telephone.

Retiree insurance eligibility, funding

For members who work for a state agency, public higher education institution or public school district

The charts on Page 158 illustrate eligibility and funding guidelines for retiree group insurance. Please refer to the ***Plan of Benefits*** for more detailed information on these and other eligibility and funding rules. When reviewing the charts,

keep these things in mind:

- For any retiree coverage, your last five years of employment must have been served consecutively in a full time, insurance-eligible permanent position with an employer that participates in the State Health Plan.
- Changing jobs could affect your eligibility for funding. The information on Page 158 applies only if your last employer prior to retirement is a state agency, public higher education institution, public school district or other employer that participates in the state's Retiree Health Insurance Trust Fund. Contact your employer if you are unsure whether it participates in the Retiree Health Insurance Trust Fund.
- To receive state funding toward your premiums, your last five years of employment must have been in service with a state agency, public higher education institution, public school district or other employer that participates in the state's Retiree Health Insurance Trust Fund. Early retirement from the South Carolina Retirement System under the 55/25 provision will delay your eligibility for funding.
- If the charter school for which you work does not participate in a PEBA-administered retirement plan, and you meet the eligibility requirements for retiree group insurance, employer funding, if any, is at the discretion of your charter school.
- Earned service credit is time earned and established in one of the defined benefit retirement plans PEBA administers. Earned service credit does not include any purchased service credit not considered earned service in the retirement plans (e.g., non-qualified service or employer-approved sabbatical leave).
- For State ORP participants and members whose employer does not participate in a PEBA-administered retirement plan, eligibility is determined as if the participant were a member of the South Carolina Retirement System (SCRS), including reaching retirement eligibility. This means one year of employment is equated to one year of earned service credit. Learn more about SCRS retirement eligibility requirements in the ***South Carolina Retirement System Member Handbook***.

Employees hired into an insurance-eligible position before May 2, 2008

Retirement status	Earned service credit with an employer participating in the State Health Plan	Responsibility for paying premiums
Left employment after reaching service or disability retirement eligibility *Learn more about retirement eligibility at peba.sc.gov.*	Five years, but less than 10 years	You pay the full premium (employee and employer share).
	10 or more years	You pay only the employee share of the premium.
Left employment before reaching retirement eligibility	Less than 20 years	You are not eligible for retiree insurance coverage.
	20 or more years	You are eligible for coverage upon reaching retirement eligibility. You pay only the employee share of the premium.

Employees hired into an insurance-eligible position on or after May 2, 2008

Retirement status	Earned service credit with an employer participating in the State Health Plan	Responsibility for paying premiums
Left employment after reaching service or disability retirement eligibility *Learn more about retirement eligibility at peba.sc.gov.*	Five years, but less than 15 years	You pay the full premium (employee and employer share).
	15 years, but less than 25 years	You pay the employee share of the premium and 50% of the employer share of the premium.
	25 or more years	You pay only the employee share of the premium.
Left employment before reaching retirement eligibility	Less than 20 years	You are not eligible for retiree insurance coverage.
	20 years, but less than 25 years	You are eligible for coverage upon reaching retirement eligibility. You pay the employee share of the premium and 50% of the employer share of the premium.
	25 or more years	You are eligible for coverage upon reaching retirement eligibility. You pay only the employee share of the premium.

For members who work for participating optional employers, such as county governments and municipalities

The chart below illustrates eligibility and funding guidelines for retiree group insurance. Please refer to the ***Plan of Benefits*** for more detailed information on these and other eligibility and funding rules. When reviewing the charts, keep these things in mind:

- Your last five years of employment must have been served consecutively in a full-time, insurance-eligible permanent position with an employer that participates in the State Health Plan.
- Changing jobs could affect your eligibility for funding. The information below applies only if your last employer prior to retirement is an optional employer or other employer that does not participate in the state's Retiree Health Insurance Trust Fund. Contact your employer if you are unsure whether it participates in the Retiree Health Insurance Trust Fund.
- Earned service credit is time earned and established in one of the defined benefit retirement plans PEBA administers. Earned service credit does not include any purchased service credit not considered earned service in the retirement plans (e.g., non-qualified service).
- If your employer does not participate in a PEBA-administered retirement plan, your eligibility is determined as if you were a member of the South Carolina Retirement System (SCRS), including reaching retirement eligibility. This means one year of employment is equated to one year of earned service credit. Learn more about SCRS retirement eligibility requirements in the ***South Carolina Retirement System Member Handbook***.

Employees hired into an insurance-eligible position

Retirement status	Earned service credit with an employer participating in the State Health Plan	Responsibility for paying for premiums
Left employment after reaching service or disability retirement eligibility *Learn more about retirement eligibility at peba.sc.gov.*	At least five years	Your portion of the premium, up to the full amount of the employee and employer share, is at your employer's discretion.
Left employment before reaching retirement eligibility	Less than 20 years	You are not eligible for retiree insurance coverage.
	20 or more years	Your portion of the premium, up to the full amount of the employee and employer share, is at your employer's discretion.

Your retiree insurance coverage choices

If you are not eligible for Medicare

If you, your covered spouse and your covered children are not eligible for Medicare, you may be covered under one of these plans:

- State Health Plan Standard Plan; or
- State Health Plan Savings Plan; or
- TRICARE Supplement Plan (for eligible members of the military community).

Your health insurance benefits, which are described in the **Health insurance** chapter (see Pages 36-37), will be the same as if you were an active employee. Your premiums may change depending on whether you are a funded or a non-funded retiree (see Retiree insurance eligibility, funding on Pages 156-159).

If you are considering the Savings Plan
If you are a retiree who is not eligible for Medicare, you may enroll in the Savings Plan, but contributions to a Health Savings Account (HSA) from your annuity payment are not deducted pretax. You may deduct your contributions to an HSA on your income tax return.

If you are age 65 or older and not eligible for Medicare

If, when you retire, you are age 65 or older and not eligible for Medicare, contact the Social Security Administration (SSA). The SSA will send you a letter of denial of Medicare coverage. Give a copy of the letter to your benefits administrator. You may enroll in health insurance as a retiree within 31 days of loss of active coverage, within 31 days of a special eligibility situation, or during an annual open enrollment period. You also may enroll your eligible family members.

If you are eligible for Medicare

If you, your covered spouse or your covered children are eligible for Medicare, you may be covered under one of these plans:

- State Health Plan Medicare Supplemental Plan; or
- State Health Plan Carve-out Plan (formerly referred to as the Standard Plan).

You and your Medicare-eligible dependents will automatically be enrolled in Express Scripts Medicare®, the State Health Plan's Medicare Part D prescription drug program. For more information about the program, including how to opt out of the program, see PEBA's *Insurance Coverage for the Medicare-eligible Member* handbook, at peba.sc.gov/publications.

To learn more about how health insurance offered through PEBA works with Medicare:

- Read PEBA's *Insurance Coverage for the Medicare-eligible Member* handbook; or
- Call PEBA at 803.737.6800 or 888.260.9430.

To learn more about Medicare:

- Read *Medicare and You*;
- Visit www.medicare.gov; or
- Call Medicare at 800.633.4227 or 877.486.2048 (TTY).

Dental benefits

If you retire from a participating employer, you can continue your Dental Plus or Basic Dental coverage if you meet the eligibility requirements listed on Pages 156-159. Information about dental benefits is on Page 88.

Vision care

If you retire from a participating employer, you can continue your State Vision Plan coverage if you meet the eligibility requirements listed on Pages

156-159. Information about vision care benefits is on Page 98.

When to enroll in retiree insurance coverage

Your insurance does not automatically continue when you retire. Before enrolling in retiree insurance, you will need to confirm eligibility for retiree group insurance by completing an *Employment Verification Record*. If eligible, submit the required forms to PEBA (See Page 156) at least 31 days before your retirement date, or the date of your approval for disability benefits. This will provide PEBA with enough time to process your enrollment so your insurance coverage as a retiree starts the day your coverage as an active employee ends.

If you do not submit the required forms to 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. You also may enroll within 31 days of a special eligibility situation. Dental enrollment is available only during open enrollment periods in odd-numbered years (October 2021), or within 31 days of a special eligibility situation.

Service retirement

If you are eligible, you may enroll in retiree insurance within 31 days of your retirement. If you do not enroll within 31 days of your retirement, you may enroll within 31 days of a special eligibility situation (defined on Page 21), or during an annual open enrollment period.

Disability retirement

If you are approved for disability retirement benefits through one of the defined benefit retirement plans PEBA administers (SCRS, PORS, GARS or JSRS), and you meet the eligibility rules for retiree group insurance (see Pages 156-159), you may apply for retiree group insurance within 31 days of the date on the letter from PEBA approving your disability benefits.

If you are approved for disability by the Social Security Administration, but are not otherwise eligible for insurance coverage as a retiree through PEBA, your coverage under PEBA cannot begin earlier than the first day of the month that occurs after your Social Security disability approval.

State ORP participants and employees of optional employers who do not participate in a PEBA-administered retirement plan are considered retired due to disability if they meet the requirements for a disability retirement benefit from SCRS. For retirements after December 31, 2013, approval for SCRS disability retirement benefits requires approval for disability benefits from the Social Security Administration. You may apply for retiree group insurance within 31 days of the date on the letter from the Social Security Administration approving your disability benefits. Your retiree insurance coverage will be effective the first of the month after PEBA receives documentation establishing your eligibility for disability retirement benefits.

Within 31 days of a special eligibility situation

A special eligibility situation is created by certain events, such as marriage, birth of a child or loss of other insurance coverage. A special eligibility situation allows you to enroll in an insurance plan or make enrollment changes. You have 31 days from the date of the event to enroll or make changes. More information about special eligibility situations is on Page 21. You can use PEBA's secure, online insurance benefits enrollment website, MyBenefits.sc.gov, to make changes.

During an open enrollment period

If you, your spouse and children do not enroll within 31 days of your retirement, within 31 days of approval for disability benefits or within 31 days of a special eligibility situation, you may enroll during an open enrollment period, which is held in October. Dental coverage may be added or dropped only during an open enrollment period in an odd-numbered year. Your coverage will take effect the following January 1. You can use PEBA's secure, online insurance benefits enrollment website, **MyBenefits.sc.gov**, to make changes, but not to enroll in coverage.

How to enroll in retiree insurance coverage

If eligible to continue PEBA-administered insurance coverage at retirement, complete a *Retiree Notice of Election* form and a *Certification Regarding Tobacco and E-cigarette Use* form and submit to PEBA. This is in addition to your previously submitted *Employment Verification Record*. The forms are available at **peba.sc.gov/forms**. You may also get copies from your employer or contact PEBA at 803.737.6800 or 888.260.9430. You may ask your benefits administrator for help in completing the forms.

You may enroll yourself and any eligible family members. As a retiree you will make new elections; you do not have to keep the same coverage or cover the same eligible family members you covered as an active employee.

You may be required to submit the appropriate documents to show that the family members you wish to cover are eligible for coverage. More information about documents needed at enrollment is on Page 18.

After PEBA processes your retiree insurance enrollment, you will receive a letter confirming the coverage selected and the premiums due each month. You have 31 days from the date your retiree insurance becomes effective to make any corrections or changes to your coverage. Otherwise, you will have to wait until the next open enrollment period, which occurs every year in October, or until a special eligibility situation to make changes. If you do not enroll in dental coverage within 31 days of eligibility, your next opportunity to add, drop or change dental coverage will be during open enrollment in October of an odd-numbered year.

Retiree premiums and premium payment

State agency, public higher education institution and public school district retirees

If you receive a monthly benefit from a PEBA-administered defined benefit retirement plan, PEBA deducts your health, dental and vision premiums from the monthly benefit payment. If you do not receive a monthly benefit from a PEBA-administered retirement plan, PEBA will send you a monthly bill for your retiree insurance premium.

When you retire, your insurance premiums may be due before your benefits begin. If this happens, PEBA will send you a monthly bill for your insurance premiums until you receive your first annuity payment.

Your annuity is paid on the last business day of each month, and your insurance premiums are paid at the beginning of the month. For example, your insurance premiums for April are deducted from your March annuity payment. Depending on when your retirement paperwork is processed, more than one month's premium may be deducted from your first annuity payment. If at any time the total premiums due add up to an amount greater

than the amount of your annuity payment, PEBA will bill you for the full amount.

Participating optional employer 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.

Charter school retirees

If your charter school participates in a PEBA-administered retirement plan, PEBA deducts your health, dental and vision premiums from the monthly annuity payment you receive from PEBA.

If your charter school does not participate in a PEBA-administered retirement plan, you pay your health, dental and vision premiums to the charter school. The charter school sends them to PEBA. Contact your benefits office for information about your insurance premiums in retirement.

Failure to pay premiums

Health, dental and vision premiums are due by the 10th of each month. If you do not pay the entire bill, including the tobacco-user premium, if it applies, PEBA will cancel all of your coverage, including coverage for which you may not pay a premium, such as Basic Dental.

When your coverage as a retiree begins

If you go directly from covered employment into retirement, your retiree coverage will begin the day after your active coverage ends. If you enroll in retiree insurance coverage upon a deferred retirement, your coverage starts on the first day of the month following your retirement. If you are enrolling due to a special eligibility situation, your effective date will be either the date of the event or the first of the month after the event, depending on the type of event. More information about special eligibility situations is on Page 21. If you enroll during an annual open enrollment period, your coverage will be effective the following January 1.

If you worked for a state agency, public higher education institution or public school district, PEBA is your benefits administrator after you retire. If you worked for a participating optional employer, your benefits administrator is your former employer after you retire.

Information you will receive

After you enroll, PEBA will send you a letter confirming you have retiree group insurance coverage. If your coverage as an active employee is also ending, federal law requires that PEBA send you:

- A *Certificate of Creditable Coverage*, which gives the dates of your active coverage, the names of the individuals covered and the types of coverage; and
- A *Qualifying Event Notice*, which tells you that you may continue your coverage under COBRA.

Typically, these letters require no action on your part.

If you are eligible for Medicare, you will be automatically enrolled in Express Scripts Medicare, the State Health Plan's Medicare Part D prescription drug program. Express Scripts, the State Health Plan's pharmacy benefits manager, will send you an information packet that includes a letter telling you that you can opt out of the Medicare drug program and remain enrolled in the State Health Plan drug program for members who are not eligible for Medicare. The pharmacy benefits manager is required to give you 21 days to

opt out.

Your insurance identification cards in retirement

You may keep and use your same insurance identification cards if you do not change plans when you retire. Your Benefits Identification Number (BIN) 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;
- Basic Dental: PEBA or your former benefits administrator; or
- State Vision Plan: EyeMed.

Contact information is available at the end of this guide.

Other insurance programs PEBA offers

Life insurance

If you go directly from covered employment to retirement and are eligible for retiree group insurance when you retire, you may choose to continue or convert your life insurance through MetLife, the vendor that underwrites PEBA's life insurance program. PEBA sends a weekly file with employee status changes to MetLife. MetLife uses this file to mail a conversion/continuation packet to eligible retirees. Packets are sent via U.S. mail three to five business days after MetLife receives the file. The continuation and conversion application period is time-sensitive. If MetLife does not receive the appropriate form(s) within 31 days of the date your coverage as an active employee ends, you will forfeit your right for retiree group life insurance. If you need help completing these forms, contact your benefits administrator or PEBA. If you have questions about life insurance coverage issues, such as billing or claims, call MetLife at 866.365.2374.

Retiree life insurance coverage does not include Accidental Death and Dismemberment benefits.

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.

Basic Life insurance
This term life insurance, offered at no charge to you as an active employee, ends with retirement or when you leave your job for another reason. You may convert your Basic Life Insurance to an individual whole life policy, which is a permanent form of life insurance.

Optional Life insurance
You can continue or convert your Optional Life insurance through MetLife.

You can continue your term life insurance or convert your life insurance coverage to a whole life policy, a permanent form of life insurance, within 31 days of the date your coverage ends. Your coverage can be continued in $10,000 increments up to the final amount of coverage in force on the day before you left covered employment and lost active employee coverage.

Dependent Life insurance

Any Dependent Life insurance coverage you have ends when you leave active employment. However, you may convert the coverage for your spouse or child to an individual whole life policy within 31 days of the date your coverage ends.

Continuation

As a retiree, you may continue your Optional Life coverage at the same rates you paid while you were an employee. The minimum amount that can be continued is $10,000. You cannot increase your coverage, but you can decrease it. Rates are based on your age and will increase when your age category changes. Your coverage will reduce to 65 percent at age 70 and then end after 11:59 p.m. on December 31 after the date you turn age 75 if you continued coverage and retired on or after January 1, 1999. When your coverage either reduces or ends, you can convert the amount of reduced or lost coverage within 31 days, as described in the Conversion section below. Continued coverage is term life insurance.

To continue your coverage, complete the information you receive from MetLife following your retirement. Submit to MetLife at the address or fax number on the information. MetLife must receive your completed forms within 31 days of your loss of coverage.

Term life insurance provides coverage for a specific time period. It has no cash value.

Conversion

Within 31 days of loss of coverage, you may convert your Basic Life, Optional Life or Dependent Life coverage to an individual whole life policy.

MetLife has contracted with Barnum Financial Group to help with converting coverage. To convert your Basic Life, Optional Life or Dependent Life to an individual whole life policy, contact MetLife at 877.275.6387 to be connected with a financial professional from Barnum Financial Group.

The policy will be issued without medical evidence if you apply for and pay the premium within 31 days. If you miss the deadline, you will forfeit your right to convert your life insurance.

If you are not eligible for retiree insurance benefits or have been approved for long term disability benefits, you have 31 days from the date your coverage ends to convert your policy. See your benefits administrator for more information.

Continuation and conversion

You may also split your coverage between term life insurance (continuation) and individual whole life insurance (conversion), but cannot exceed your total coverage amount before retirement.

Long term disability

Disability insurance protects an employee and their family from loss of income due to an injury or an extended illness that prevents the employee from working. When you leave active employment and retire, your Basic Long Term Disability and Supplemental Long Term Disability insurance both end. You cannot continue either policy, and Basic Long Term Disability cannot be converted to individual coverage.

MoneyPlus

MoneyPlus is not available in retirement. When you retire, however, you may be able to continue

your Medical Spending Account (MSA) or Limited-use Medical Spending Account (Limited-use MSA) on an after-tax basis through COBRA. See Page 144 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 or Limited-use MSA, you have 90 days from your last day at work to submit claims for eligible expenses incurred before you left employment.

You cannot continue contributing to your Dependent Care Spending Account after you retire. You can request reimbursement for eligible expenses incurred while you were employed until you exhaust your account or the plan year ends.

The Pretax Group Insurance Premium feature, which allows you to pay health, dental, vision and some life insurance premiums before taxes, is not available in retirement.

Changing coverage

An open enrollment period is held every October. Eligible employees, retirees, survivors and COBRA subscribers may enroll in or drop their own health coverage and add or drop their eligible spouse and children without regard to special eligibility situations. Eligible subscribers also may change health plans. This includes changing to or from the Medicare Supplemental Plan if the subscriber is retired and enrolled in Medicare. Eligible members of the military community may change to or from the TRICARE Supplement Plan if they are not eligible for Medicare. Eligible subscribers also can enroll in the State Vision Plan. During open enrollment periods held in odd-numbered years, eligible subscribers may add or drop Dental Plus and Basic Dental.

PEBA provides an open enrollment publication, the *Benefits Advantage*, for retirees, survivors, and COBRA subscribers and former spouses.

More information about open enrollment is found on Page 20 in the **General information** chapter.

Dropping a covered spouse or child

If a covered spouse or child becomes ineligible, you need to drop him from your health, dental and vision coverage. This may occur because of divorce, a covered dependent gains coverage under the State Health Plan. To drop a spouse or child from your coverage, complete and submit to PEBA a *Retiree Notice of Election* form and provide documentation within 31 days of the date your spouse or child becomes ineligible.

When your child becomes ineligible for coverage because of age, PEBA will automatically drop them from coverage. If they are your last covered child, your level of coverage will change.

Returning to work in an insurance-eligible job

If you return to work for a participating employer and are eligible for enrollment in the State Health Plan, and you, your spouse or your children are covered under retiree group insurance, you must elect active coverage or refuse all PEBA-sponsored coverage. There is one exception to this rule. Retirees who are not eligible for Medicare and who retired from an employer that does not participate in the state's Retiree Health Insurance Trust Fund can remain on retiree coverage if they return to work in an insurance-eligible position. Contact your previous employer if you are unsure whether it participates in the Retiree Health Insurance Trust Fund.

If you leave work and return to retiree group coverage before age 65, be sure to contact the SSA within 90 days of turning 65 to enroll in Medicare Part A and Part B when you become eligible.

All employees who are eligible for enrollment in the State Health Plan (the Standard Plan and Savings Plan) are also eligible for these programs:

- Dental Plus and Basic Dental;
- 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); and
- MoneyPlus, including the Pretax Group Insurance Premium feature, Medical Spending Account, Dependent Care Spending Account and, for employees enrolled in the Savings Plan, Health Savings Account and Limited-use Medical Spending Account.

Retirees who continued life insurance

Retirees hired in an insurance-eligible job

If you continued your Optional Life coverage as a retiree, you will have the option to keep your continued policy and pay premiums directly to MetLife, or to enroll in Optional Life as a newly hired active employee with a limit of three times your annual salary without medical evidence, up to a maximum of $500,000. You cannot do both. Contact MetLife within 31 days of returning to work to cancel your continued coverage if you decide to enroll in active coverage. If you refuse to enroll as an active employee, you also refuse the $3,000 Basic Life benefit, Optional Life and Dependent Life coverage. Your active group coverage will become effective only if you discontinue the retiree continuation coverage.

If you are considered a new hire, see the **Life insurance** chapter, which begins on Page 107.

If you or a member of your family is covered by Medicare

According to federal law, Medicare cannot be the primary insurance for you or any of your covered family members while you are covered as an active employee. To comply with this regulation, you are required to suspend your retiree group coverage and enroll as an active employee with Medicare as the secondary payer, or refuse all PEBA-sponsored health coverage for yourself and your eligible family members and have Medicare coverage only.

If you enroll in active group coverage, you must notify the SSA, because Medicare will pay after or secondary to your active group coverage. You may remain enrolled in Medicare Part B and continue paying the premium, and Medicare will be the secondary payer. You may also delay or drop Medicare Part B without a penalty while you have active group coverage. Contact the SSA for additional information.

When you stop working and your active group coverage ends, you may re-enroll in retiree group coverage within 31 days of the date you leave active employment. You must also notify the SSA that you are no longer covered under an active group so that you can re-enroll in Medicare Part B if you dropped it earlier.

If your new position does not make you eligible for benefits, your retiree group coverage continues and Medicare remains the primary payer.

When your retiree insurance coverage ends

Your coverage will end:

- If you do not pay the required premium when it is due.
- The date it ends for all employees and retirees.

- The day after your death.
- The date your optional employer withdraws from participation.

Coverage of your family members will end:

- The date your coverage ends.
- The date coverage for spouses or children is no longer offered.
- The last day of the month your spouse or child is no longer eligible for coverage. If your spouse or child's coverage ends, they may be eligible for continuation of coverage under COBRA (see Page 28).

If you are dropping a spouse or child from your coverage, you must complete a *Retiree Notice of Election* form within 31 days of the date the spouse or child is no longer eligible for coverage.

Death of a retiree

If a retiree dies, a surviving family member should contact PEBA to report the death and end the retiree's insurance coverage. If the deceased retired from employment with a participating optional employer, contact the benefits administrator who works in the benefits office of his former employer. If a retiree continued or converted his life insurance, a surviving family member should also contact MetLife at 800.638.6420 to initiate a claim.

Survivors of a retiree

Spouses or children who are covered as dependents under the State Health Plan, Basic Dental or the State Vision Plan are classified as survivors when a covered employee or retiree dies. Survivors of funded retirees of a state agency, public higher education institution or public school district may be eligible for a one-year waiver of health insurance premiums. Survivors of a partially funded retiree will be responsible for 50 percent of the employer premium during the one-year waiver period. Survivors of non-funded retirees may continue their coverage; however, they must pay the full premium.

Participating optional employers are not required to but may waive the premiums of survivors of retirees. A survivor may continue coverage at the full rate for as long as they are eligible. If you are a retiree of a participating optional employer, check with your benefits administrator to see whether the waiver applies.

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

After the first year, a survivor who qualifies for the waiver must pay the full premium to continue coverage. At the end of the waiver, health coverage can be canceled or continued for all covered family members. If coverage is continued, no covered family members can be dropped until an annual open enrollment period or within 31 days of a special eligibility situation.

If you and your spouse are both covered as subscribers through employment, or are funded retirees at the time of death, your surviving spouse is not eligible for the premium waiver.

Vision premiums are not waived. Dental premiums are not typically waived; dental premiums are waived only for survivors of an active or retired employee who was killed in the line of duty after December 31, 2001, while working for a state agency, higher education institution or public school district. However, survivors, including survivors of a subscriber enrolled in the TRICARE Supplement Plan, dental or vision coverage, can

continue coverage by paying the full premium.

As a surviving spouse, you can continue coverage until you remarry. If you are a child, you can continue coverage until you are no longer eligible. If you are no longer eligible for coverage as a survivor, you may be eligible to continue coverage under COBRA. If your spouse retired from a state agency, public higher education institution or public school district, contact PEBA for more information. If your spouse retired from an optional employer, contact the benefits administrator at his former employer.

A surviving spouse or child of a military retiree should contact Selman & Company about TRICARE coverage.

As long as a survivor remains covered by health, dental or vision insurance, 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 an open enrollment period in an odd-numbered year or within 31 days of a special eligibility situation. **If a survivor has health, dental and vision coverage, and drops all three, he is no longer eligible for survivor coverage and cannot re-enroll, not even during an annual open enrollment period.**

If a surviving spouse becomes an active employee of a participating employer, he can switch to active coverage. When the surviving spouse 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 Page 36.

Helpful terms

Here are definitions for some terms used in the *Insurance Benefits Guide*. For more information, refer to the pages listed or contact your benefits administrator.

Allowed amount The maximum amount the plan allows for a covered service, procedure or supply. Network providers have agreed to accept the Plan's negotiated rates as their total fee.

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 at peba.sc.gov/forms.

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.

Benefits administrator A staff member who works at your employer and assists with insurance enrollment, changes, retirement and terminations. Benefits administrators are not agents of PEBA.

Change in status An event, such as marriage, divorce or birth of a child that may allow a change to a Medical Spending Account or a Dependent Care Spending Account. For more information, see Page 21.

Coinsurance A percentage of the cost of health care a member pays after his deductible has been met. Under the State Health Plan, the coinsurance rate is different for network services, services at a BlueCross BlueShield of South Carolina-affiliated patient-centered medical home, out-of-network services, infertility treatment and fertility drugs.

Coinsurance maximum The amount of coinsurance a member is required to pay each year before he is no longer required to pay coinsurance.

Coordination of benefits A system to determine how claims are handled when a person is covered under more than one insurance plan. For information about how health claims are coordinated, see Page 44. For information about how dental claims are coordinated, see Page 95.

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 Page 41.

Coverage review A blanket term for the different types of processes the State Health Plan uses to ensure the safe and effective use of prescription drugs and to encourage the use of lower-cost alternatives when possible.

Deductible Generally, the amount a member must pay yearly for covered health care before the plan begins to pay a portion of the cost of his care. The deductible may not apply to all services.

Drug quantity management A type of coverage review the State Health Plan uses to make sure prescriptions are filled at levels the U.S. Food and Drug Administration (FDA) considers safe.

Explanation of Benefits (EOB) A report created whenever your insurance plan processes a claim. An EOB shows you:

- How much your provider charged for services.
- How much the Plan paid.
- The amount you will be responsible for, such as your copayment, deductible and coinsurance.
- The total amount you may owe the provider

(does not include any amount you've already paid).

Exclusion A condition for which, or a circumstance under which, an insurance plan will not pay benefits.

Formulary A pharmacy benefits manager's (PBM) network list of preferred drugs, including generics and brand-named drugs. The PBM's Pharmacy and Therapeutics Committee of physicians and pharmacists continually reviews and compares the medications on a pharmacy network's formulary. As a result, some safe and effective drugs become "preferred," and others may become "non-preferred." The formulary guides the copayment you pay for a prescription drug.

Individual whole life insurance A permanent form of life insurance.

Itemized statement An Explanation of Benefits, bill or receipt from a health care or dependent care provider that shows the provider name and address, name of person receiving the care, description of the service or supply, date the service was provided (regardless of when it was paid) and the dollar amount of the service/supply.

Member A person covered by a health, dental or vision plan.

National Preferred Formulary The formulary, or list of preferred medications, used by Express Scripts, the State Health Plan's pharmacy benefits manager. Preferred medications are those determined to be safe and effective but may cost less than alternatives.

Negotiated rate The maximum amount you may pay a network provider for a covered service. Network providers have agreed to accept the Plan's negotiated rates as their total fee. The negotiated rate is the same as the allowed amount.

Network A group of providers, facilities or suppliers under contract to provide care for people covered by a health, dental or vision plan.

Optional employer Any participating group other than a state agency, public higher education institution or public school district. Pursuant to Section 1-11-720 of the Code of Laws, optional participation in the state insurance benefits program is available to political subdivisions of the state of South Carolina, such as counties, municipalities, and special purpose districts, as well as governmental agencies or instrumentalities of such political subdivisions.

Out-of-network differential A State Health Plan member pays 40 percent coinsurance, rather than 20 percent, when he uses a provider that is not in the network. For more information, see Page 48.

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 83-84.

Please note: The pay-the-difference policy does not apply to Express Scripts Medicare, the State Health Plan's Medicare Part D program.

Plan of Benefits A document establishing eligibility requirements and benefits offered to individuals covered by the State Health Plan.

Preauthorization To require preauthorization is to require that a member get permission from the plan before he receives a particular service, supply or piece of equipment. For example, Medi-Call

preauthorizes some services for State Health Plan members. The term prior authorization is used by the State Health Plan pharmacy benefits program and certain specialty medications covered by the medical benefits program.

Prior authorization A type of coverage review that may be needed when a medication is prescribed for which there is an effective and safe, lower-cost alternative.

Premium The amount a covered person pays for insurance coverage.

Qualifying event A change in a person's life, such as 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 for eligible family members outside an open enrollment period. The coverage change must be made within 31 days of the event.

Step therapy A type of coverage review the State Health Plan uses to encourage use of low-cost prescription drugs of equal effectiveness and safety before trying more expensive alternatives.

Subrogation A claim is subrogated when someone else is responsible for a member's injury. To the extent provided by South Carolina law, health plans offered through PEBA have the right to recover payment in full for benefits provided to a covered person under the terms of the plan when the injury or illness occurs through the act or omission of another person, firm, corporation or organization. If a covered person receives payment for such medical expenses from another who caused the injury or illness, the covered person agrees to reimburse the plan in full for any medical expenses paid by the plan.

Subscriber An individual, such as an employee or a retiree, who is covered by an insurance plan. Because the individual is eligible and covered, members of his family also may be eligible to enroll in the plan.

Term life insurance Life insurance coverage that is provided for a specific period of time. It has no cash value. All life insurance offered through PEBA is term life.

Third-party claims processor (claims processor) A company, such as BlueCross BlueShield of South Carolina, that is under contract to PEBA to process claims for members.

Vendor A company under contract to PEBA.

Contact information

S.C. PEBA

202 Arbor Lake Drive | Columbia, SC 29223

8:30 a.m. - 5 p.m., Monday - Friday

- Customer Contact Center: 803.737.6800 or 888.260.9430
- Retiree billing: 803.734.1696
- peba.sc.gov

2021 Insurance vendors

ASIFlex

MoneyPlus

P.O. Box 6044 | Columbia, MO 65205-6044

- Customer Service: 833.SCM.PLUS (833.726.7587) or asi@asiflex.com
- www.asiflex.com/SCMoneyPlus

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
- StateSC.SouthCarolinaBlues.com

Medi-Call (medical preauthorization)

AF-650 | I-20 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

- Customer Service: 803.736.1576 or 800.868.2520
- Precertification: 800.868.1032
- Case management/behavioral health coaching: 800.868.1032, ext. 25835
- Tobacco cessation: 866.784.8454
- www.CompanionBenefitAlternatives.com.

Health coaching

- 855.838.5897
- Fax: 803.264.4204

National Imaging Associates (advanced radiology preauthorization)

- 866.500.7664
- www.RadMD.com

Dental Plus, Basic Dental

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:
  Express Scripts
  Attn: Commercial Claims
  P.O. Box 14711
  Lexington, KY 40512-4711
- Medicare members:
  Express Scripts
  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:
  EyeMed
  Vision Care OON Claims
  P.O. Box 8504
  Mason, OH 45040-7111
- Customer Care Center: 877.735.9314
- www.eyemedvisioncare.com/pebaoe

MetLife

Basic Life, Optional Life, Dependent Life (Policy No.: 200879-1-G)

MetLife Recordkeeping and Enrollment Services
P.O. Box 14401 | Lexington, KY 40512-4401

- Statement of Health: 800.638.6420, Option 1
- Claims: 800.638.6420, Option 2
- Continuation: 866.492.6983
- Conversion: 877.275.6387
- Fax: 866.545.7517
- www.metlife.com/scpeba

Selman & Company

GEA TRICARE Supplement Plan

P.O. Box 29151 | Hot Springs, AR 71903

- Customer Service: 866.637.9911, Option 1
- Enrollment: 800.638.2610, Option 1
- www.selmantricareresource.com/sc

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: 800.843.7979
- www.standard.com/mybenefits/southcarolina

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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Serving those who serve South Carolina

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