2021

Insurance Summary

Open enrollment and new hire guide

PEBA℠
SC Retirement Systems
and State Health Plan

What's inside

2021 Insurance vendors

South Carolina

Companion BENEFIT ALTERNATIVES

EXPRESS SCRIPTS®

eyeMed®

MetLife

TheStandard®

ASI FLEX

Welcome

There are certain times throughout the year when you may enroll in insurance coverage or make changes to your coverage. Review this summary and use the appropriate worksheet on Pages 26 and 27 to plan the 2021 health coverage and additional benefits that are best for you and your family.

Eligibility

Eligible employees generally are those who:

- Work full-time for and receive compensation from the state, a public higher education institution, a public school district or a participating optional employer, such as a participating county or municipal government; and
- Are hired into an insurance-eligible position.

Generally, an employee must work at least an average of 30 hours per week to be considered employed full time and eligible to participate in the insurance program.

New hires

Your employer 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.

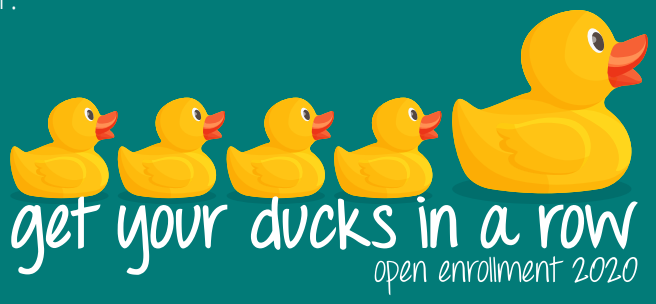
From the date you become eligible, you have 31 days to enroll in your health insurance and other available insurance benefits.

Open enrollment is October 1-31, 2020.

During open enrollment, eligible employees may change their coverage for the following year. Review your current coverage in **MyBenefits** (mybenefits.sc.gov). If you are satisfied with your current elections, the only thing you need to do is re-enroll in MoneyPlus flexible spending accounts. All open enrollment changes take effect January 1, 2021.

Take note of the call-out boxes in each section of this summary reminding you of what you can do this year during open enrollment. Use the worksheet on Page 26 to track any of your changes. You can also visit the open enrollment webpage, **peba.sc.gov/oe**, to learn more.

Log in to MyBenefits (**mybenefits.sc.gov**) to make your coverage selections during open enrollment.



Step 1: Choose your health plan.

Your insurance needs are as unique as you are. You may meet your deductible each year, or maybe you can't remember the last time you saw a doctor. No matter your situation, the State Health Plan gives you two options to cover your expenses: the Standard Plan or the Savings Plan.

The Standard Plan has higher premiums and lower deductibles. The Savings Plan has lower premiums and higher deductibles. Learn more about the plans at **peba.sc.gov/health**.

	Standard Plan	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.[1]
Coinsurance[2]	In network, you pay **20%** up to **$2,800** per individual or **$5,600** per family.	In network, you pay **20%** up to **$2,400** per individual or **$4,800** per family.
Physician's office visits[3]	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℠ *(More details on Page 17)*	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[4,5]	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[6]	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.
Prescription drugs[7,8] *(30-day supply/90-day supply at a 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.
MoneyPlus accounts *(More details on Page 9)*	Medical Spending Account	Health Savings Account Limited-use Medical Spending Account

The TRICARE Supplement Plan provides secondary coverage to TRICARE for members of the military community who are not eligible for Medicare. For eligible employees, it provides an alternative to the State Health Plan.

2021 Monthly premiums

If you work for an optional employer, verify your rates with your benefits office.

	Employee	Employee/spouse	Employee/children	Full family
Standard Plan	$97.68	$253.36	$143.86	$306.56
Savings Plan	$9.70	$77.40	$20.48	$113.00
TRICARE Supplement	$62.50	$121.50	$121.50	$162.50

[1] *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.*

[2] *Out of network, you will pay 40 percent coinsurance, and your coinsurance maximum is different. An out-of-network provider may bill you more than the State Health Plan's allowed amount. Learn more about out-of-network benefits at peba.sc.gov/health.*

[3] *The $14 copayment is waived for routine mammograms and well-child 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's 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.*

[4] *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.*

[5] *The $175 copayment for emergency care is waived if admitted.*

[6] *Inpatient hospitalization requires preauthorization for the State Health Plan to provide coverage. Not calling for preauthorization may lead to a $490 penalty.*

[7] *Prescription drugs are not covered at out-of-network pharmacies.*

[8] *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.*

Tobacco-use premium

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

The premium is automatic for all State Health Plan subscribers unless the subscriber certifies no one he covers uses tobacco or e-cigarettes, or covered individuals who use tobacco or e-cigarettes have completed the Quit For Life® tobacco cessation program. The tobacco-use premium does not apply to TRICARE Supplement subscribers.

What you can do during open enrollment:

- Change from one health plan to another:
  - Standard Plan;
  - Savings Plan; or
  - TRICARE Supplement Plan.
- Enroll yourself or any eligible dependents in health coverage.
- Drop health coverage for yourself or any dependents.

How much will you spend out of pocket on medical care?

Include this amount on the worksheet on Page 11 to determine how much you should contribute to your MoneyPlus account.

Amount $ _____

Step 2: Choose your dental plan.

New hires have two options for dental coverage. 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. Changes to existing dental coverage can be made only during open enrollment in odd-numbered years. Learn more about the plans at **peba.sc.gov/dental**.

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.

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.

	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.*

2021 Monthly premiums

If you work for an optional employer, verify your rates with your benefits office.

	Employee	Employee/spouse	Employee/children	Full family
Dental Plus	$25.96	$60.12	$74.26	$99.98
Basic Dental	$0.00	$7.64	$13.72	$21.34

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 paid 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[4]	$145.00	$177.00	$44.80
Amount paid 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.

What you can do during open enrollment:

- Changes to existing dental coverage can be made during open enrollment only in odd-numbered years. Your next opportunity to add or drop dental coverage will be October 2021.

How much will you spend out of pocket on dental care?

Include this amount on the worksheet on Page 11 to determine how much you should contribute to your MoneyPlus account.

Amount $ _____

Step 3: Choose your vision coverage.

Good vision is crucial for work and play. It is also a significant part of your health. An annual eye exam can help detect serious illnesses. You can have an exam once a year and get either frames/lenses or contacts. Learn more about your vision coverage at **peba.sc.gov/vision**.

	In-network member cost	Out-of-network reimbursement
	You pay:	You receive:
Exam, with dilation if necessary	A **$10** copay.	Up to $35.
Retinal imaging	Up to **$39**.	No reimbursement.
Frames	**80%** of balance over **$150** allowance.	Up to $75.
Standard plastic lenses	A **$10** copay.	Up to $55.
Standard progressive lenses	A **$35** copay.	Up to $55.
Premium progressive lenses	**$35**–**$80** for Tiers 1–3. For Tier 4, you pay copay and **80%** of cost less **$120** allowance.	Up to $55.
Standard contact lenses fit & follow-up	A **$0** copay.	Up to $40.
Premium contact lenses fit & follow-up	A **$0** copay and receive 10% off retail price less **$40** allowance.	Up to $40.
Conventional contact lenses	A **$0** copay and 85% of balance over **$130** allowance.	Up to $104.
Disposable contact lenses	A **$0** copay and balance over **$130** allowance.	Up to $104.

2021 Monthly premiums

If you work for an optional employer, verify your rates with your benefits office.

	Employee	Employee/spouse	Employee/children	Full family
Vision	$5.80	$11.60	$12.46	$18.26

What you can do during open enrollment:

- Enroll in or drop State Vision Plan coverage for yourself and/or your eligible dependents.

How much will you spend out of pocket on vision care?

Include this amount on the worksheet on Page 11 to determine how much you should contribute to your MoneyPlus account.

Amount $ _____

Step 4: Choose your additional life insurance coverage.

You are automatically enrolled in Basic Life insurance at no cost if you enroll in health insurance. This policy provides $3,000 in coverage. You'll also get a matching amount of Accidental Death and Dismemberment (AD&D) insurance. You may elect more coverage for yourself, spouse and/or children. Learn more about your life insurance options and value-added services at **peba.sc.gov/life-insurance**.

	Coverage level	Coverage details
Optional Life with AD&D	Elect in **$10,000** increments up to a maximum of $500,000.	• Lesser of three times annual earnings or $500,000 of coverage guaranteed within 31 days of initial eligibility. • Includes matching amount of AD&D insurance. • Coverage reduces to 65% at age 70, to 42% at age 75 and to 31.7% at age 80 and beyond.
Dependent Life-Spouse with AD&D	Elect in **$10,000** increments up to a maximum of $100,000 or 50% of your Optional Life amount, whichever is less.	• If you are not enrolled in Optional Life, spouse coverages of $10,000 or $20,000 are available. • $20,000 of coverage guaranteed within 31 days of initial eligibility. • Includes matching amount of AD&D insurance.
Dependent Life-Child	**$15,000** per child.	• Coverage guaranteed. • Children are eligible from live birth to ages 19 or 25 if a full-time student. • Child can be covered by only one parent under this Plan.

2021 Monthly premiums

Optional Life and Dependent Life-Spouse

Your premiums are determined by your or your spouse's age as of the previous December 31 and the coverage amount. Rates shown per $10,000 of coverage. Remember to review your premium, even if you don't change your coverage levels. Your monthly premium will change when your age bracket changes.

Age	Rate
Under 35	$0.58
35-39	$0.78
40-44	$0.86
45-49	$1.22
50-54	$1.94
55-59	$3.36

Age	Rate
60-64	$6.00
65-69	$13.50
70-74	$24.22
75-79	$37.50
80 and over	$62.04

Dependent Life-Child

$1.26 per month; you pay only one premium for all eligible children.

What you can do during open enrollment:

- Enroll in or increase Optional Life coverage up to $50,000 without medical evidence.
- Enroll in or increase Optional Life (over $50,000) or Dependent Life-Spouse coverage with medical evidence.
- Drop or decrease Optional Life or Dependent Life-Spouse coverage.
- Enroll in or drop Dependent Life-Child coverage.

Step 5:
Choose your additional long term disability coverage.

You are automatically enrolled in Basic Long Term Disability at no cost if you enroll in health insurance. The maximum benefit is $800 per month. You may elect more coverage for added protection. Learn more about long term disability coverage at **peba.sc.gov/long-term-disability**.

Supplemental Long Term Disability

The Supplemental Long Term Disability (SLTD) benefit provides:

- Competitive group rates;
- Survivor's benefits for eligible dependents;
- Coverage for injury, physical disease, mental disorder or pregnancy;
- Return-to-work incentive;
- SLTD conversion insurance;
- Cost-of-living adjustment; and
- Lifetime security benefit.

SLTD benefits summary

	Benefit
Benefit waiting period	**90** or **180** days
Monthly SLTD benefit[1]	Up to **65%** of your predisability earnings, reduced by your deductible income
Minimum benefit	**$100** per month
Maximum benefit	**$8,000** per month

[1] *Basic Long Term Disability and Supplemental Long Term Disability benefits are subject to federal and state income taxes. Check with your accountant or tax adviser about your tax liability.*

2021 Monthly premium factors

Multiply the premium factor for your age and plan selection by your monthly earnings to determine your monthly premium.

Age preceding January 1	90-day waiting period	180-day waiting period
Under 31	0.00062	0.00049
31-40	0.00086	0.00067
41-50	0.00170	0.00129
51-60	0.00343	0.00263
61-65	0.00412	0.00316
66 and older	0.00504	0.00387

What you can do during open enrollment:

- Enroll in Supplemental Long Term Disability coverage without medical evidence.
- Change your benefit waiting period from 180 days to 90 days for existing coverage without medical evidence.
- Change your benefit waiting period from 90 days to 180 days for existing coverage without medical evidence.
- Drop coverage.

Step 6: Choose your MoneyPlus elections.

Are you leaving money on the table? MoneyPlus is a tax-favored accounts program that allows you to save money on eligible medical and dependent care costs. You fund the accounts with money deducted pretax from your paycheck. Learn more about your MoneyPlus options at **peba.sc.gov/moneyplus**.[1]

Standard Plan members

Medical Spending Account

Your Standard Plan works great with a Medical Spending Account (MSA). Use your MSA to pay for eligible medical expenses, including copayments and coinsurance. As you have eligible expenses, you can use a debit card for your account or submit claims for reimbursement. You can carry over into 2022 up to $550 in unused funds from your account. You forfeit funds over $550 left in your account after the reimbursement deadline. You must re-enroll each year.

Savings Plan members

Health Savings Account

Your Savings Plan is designed to go hand in hand with a Health Savings Account (HSA). With an HSA, you can save up to $875 a year in taxes.[2]

- Pay for out-of-pocket medical expenses, such as deductibles and prescriptions.
- Carry over all funds from one year to the next.
- You own the account and keep it if you leave your job or retire.
- While there is an annual contribution limit, there's no limit to how much you can save in your account.
- You can invest funds to earn investment income tax-free.

Limited-use Medical Spending Account

If you have a Health Savings Account, you can also use a Limited-use Medical Spending Account to pay for those expenses the Savings Plan does not cover, like dental and vision care. You can carry over into 2022 up to $550 in unused funds from your account. You forfeit funds over $550 left in your account after the reimbursement deadline. You must re-enroll each year.

Account type	Plan	Funds available	Medical expenses	Dental, vision expenses	Balance carries from year to year	Invest funds	Re-enroll each year
MSA	Standard	January 1	✓	✓	Up to $550		✓
HSA	Savings	As deposited	✓	✓	✓	✓	
Limited-use MSA	Savings	January 1		✓	Up to $550		✓

[1] *Contributions made before taxes 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.*

[2] *Based on a hypothetical individual with an income of $40,000 per year, taxed at 25 percent, who contributes $3,500 to his HSA in 2021.*

Step 6 continued

All members

Pretax Group Insurance Premium feature

This feature allows you to pay insurance premiums before taxes for health, vision, dental and up to $50,000 of Optional Life coverage. You do not need to re-enroll each year.

Dependent Care Spending Account

You can use a Dependent Care Spending Account (DCSA) to pay for daycare costs for children and adults. It cannot be used to pay for dependent medical care. You submit claims for reimbursement as you have eligible expenses. The funds can be used only for expenses incurred January 1, 2021, through March 15, 2022. You forfeit funds left in your account after the reimbursement deadline. You must re-enroll each year.

Monthly fees	
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

What you can do during open enrollment:

- Enroll in or drop the Pretax Group Insurance Premium feature.
- Enroll in, re-enroll in or drop flexible spending accounts:
  - Medical Spending Account.
  - Limited-use Medical Spending Account.
  - Dependent Care Spending Account.
- Enroll in or drop a Health Savings Account.

2021 Contribution limits

Account	Limit
Medical Spending Account	$2,750
Health Savings Account	$3,600 (self-only coverage) $7,200 (family coverage) $1,000 (catch-up for age 55 or older)
Limited-use Medical Spending Account	$2,750
Dependent Care Spending Account[2,3]	$2,500 (married, filing separately) $5,000 (single, head of household) $5,000 (married, filing jointly)

[2] These are 2020 limits; contribution limits for 2021 will be released by the IRS at a later date.
[3] Contribution limit for highly compensated employees is $1,700.

2021 Reimbursement deadlines

Account	Grace period	Deadline
Medical Spending Account	None	March 31, 2022
Limited-use Medical Spending Account	None	March 31, 2022
Dependent Care Spending Account	March 15, 2022	March 31, 2022

If you enroll in an HSA, you must open a bank account with Central Bank and enter a validation code in MyBenefits. Visit schsa.centralbank.net to open an account.

Changes allowed by COVID-19 Relief Bill

The information in this summary includes details for normal plan provisions. The COVID-19 Relief Bill, which was signed December 27, 2020, allows for changes to flexible spending accounts. View the **COVID-19 Relief Bill summary for FSAs in 2021** document for more details about the changes.

MoneyPlus worksheet

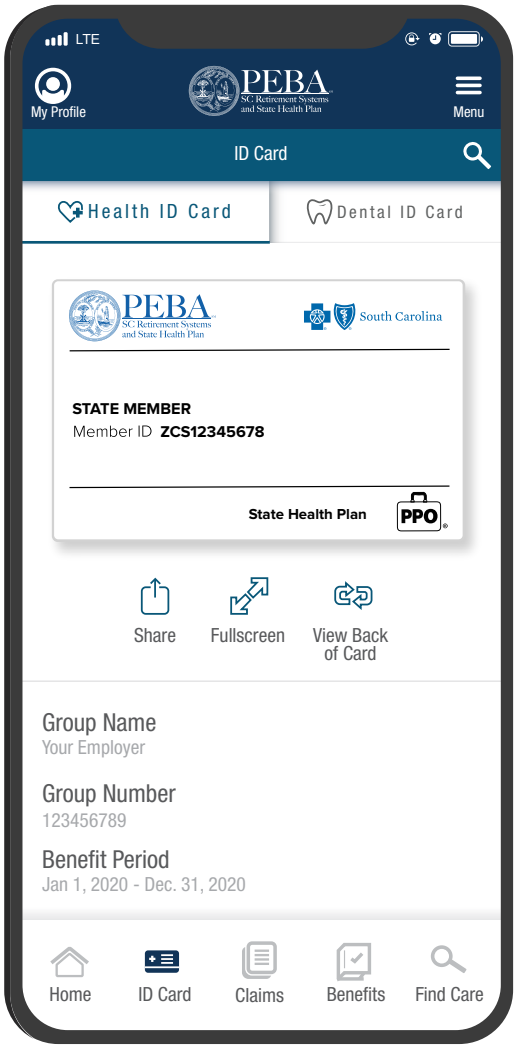
Include the amounts you listed in Steps 1-3 on the worksheet below to calculate the amount you may wish to contribute to an MSA or a DCSA. Be conservative in your planning. Remember that any unclaimed funds cannot be returned to you. You can, however, carry over up to $550 of unused MSA funds into the 2022 plan year. You cannot carry over DCSA funds, and you cannot transfer funds between flexible spending accounts. Refer to Page 10 for annual contribution limits.

Medical Spending Account	
Estimate your eligible out-of-pocket medical expenses for the plan year.	
Medical expenses	
Health insurance deductible	$
Copayments and coinsurance	$
Prescription drugs	$
Dental care	$
Vision care	$
Travel costs for medical care	$
Other eligible expenses	$
Annual contribution	**$**

Dependent Care Spending Account	
Estimate your eligible dependent care expenses for the plan year.	
Child care expenses	
Day care services	$
In-home care/au pair services	$
Nursery/preschool	$
After-school care	$
Summer day camps	$
Elder care expenses	
Day care center services	$
In-home care services	$
Annual contribution	**$**

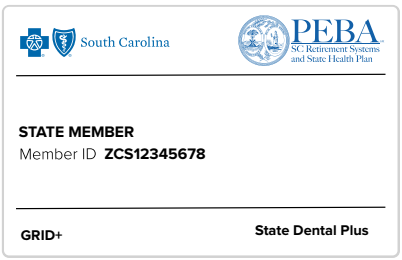
You're covered with membership ID cards.

You receive insurance cards for health, prescription, dental and vision benefits. You can also access your digital identification cards from the BlueCross, Express Scripts and EyeMed apps. Only the subscriber's name will be on the cards, but all covered family members can use them.



State Health Plan

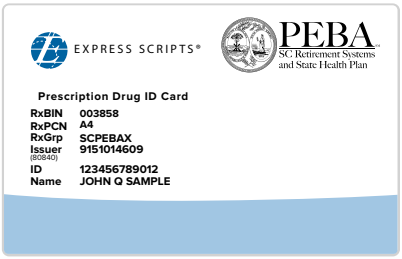
For help accessing your card, call BlueCross at **800.868.2520** or log in to **My Health Toolkit**.



Dental Plus

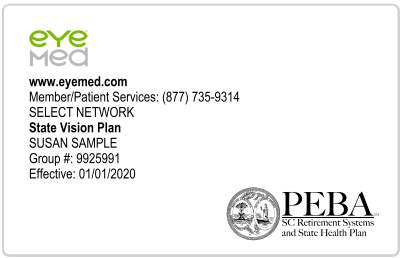
For help accessing your card, call BlueCross at **888.214.6230** or log in to **My Health Toolkit**.

If you need a Basic Dental card, contact your benefits administrator.



Prescription drug

For help accessing your card, call Express Scripts at **855.612.3128** or visit **www.Express-Scripts.com**.



Vision care

For help accessing your card, call EyeMed at **877.735.9314** or visit **www.EyeMed.com**.

You can also contact vendors to order a replacement card.

Your benefits on the go

Did you know your phone can be your go-to resource for accessing your insurance benefits information? Mobile apps are available for your health, dental, prescription, vision and flexible spending benefits.

BlueCross BlueShield of South Carolina

Search for My Health Toolkit.

Health and dental benefits

- Learn about your coverage.
- Find a provider.
- Check status of claims.
- Access your identification card.

Express Scripts

Search for Express Scripts.

Prescription benefits

- Check if a drug requires prior authorization and compare drug prices.
- Locate a network pharmacy.
- Refill and renew mail order prescriptions.
- Access your identification card.

EyeMed

Search for EyeMed Members.

Vision benefits

- Learn about your coverage.
- Search for network providers.
- Set eye exam and contact lens change reminders.
- Access your identification card.

ASIFlex

Search for ASIFlex Self Service.

Flexible spending accounts

- Submit and view status of a claim.
- Submit documentation.
- View account details.
- Read secure account messages.

Manage your health and pharmacy benefits with My Health Toolkit.

When you're a member of the State Health Plan, you have one convenient place for managing your health and pharmacy benefits. My Health Toolkit is your one-stop destination.

Using the My Health Toolkit app is easy.

Learn more about your coverage.

Look up your medical coverage, deductible and out-of-pocket spending.

Check medical claims.

View the status of a current or previous medical claim, the date of service, the amount charged by your provider and the amount you may owe.

Check dental claims.

Look up your dental coverage, deductible and out-of-pocket spending on dental care.

View or replace your identification card.

Access an electronic version of your card or order a replacement card by visiting the full site.

Manage your prescriptions.

You're just a click away from all your medication details. Select the **full site** link to access your Express Scripts account. You can see prescription drug claims and payment history, find and compare drug prices, check to see if a medication is subject to clinical rules, see your prescription order status, order a temporary ID card and much more.

Find a provider.

Use the **find care** link to view a list of network doctors and medical facilities or dentists in your area. Filter your search and compare results side by side. You can even view feedback from other members about a specific provider.

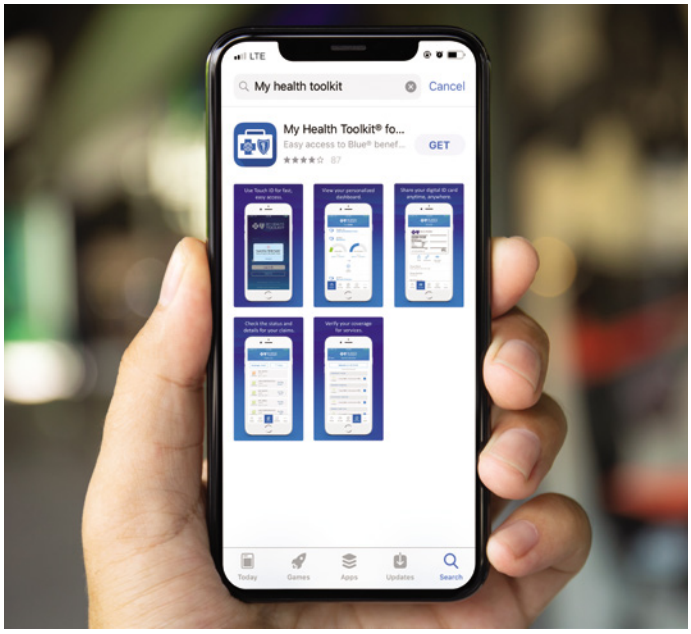
Get started by signing up today.

It's easy to sign up for **My Health Toolkit**. Follow these steps to have everything you need at your fingertips.

1. Search My Health Toolkit in your app store.
2. In the app, select **Sign Up**.
   You can also visit www.StateSC.SouthCarolinaBlues.com and select Create An Account.
3. Enter your member identification number on your State Health Plan identification card and your date of birth.
4. Choose a username and password.
5. Enter your email address and choose to go paperless.

If you have not created an Express Scripts account, you'll be prompted to create one the first time you access your pharmacy benefits through My Health Toolkit.

If you have any questions about your My Health Toolkit account, call BlueCross at **800.868.2520**.



Don't pay more than you should.

Be a smart health care consumer. Look at your Explanation of Benefits (EOB) after you receive services and compare your provider's bill to the amount listed on your EOB.

What's an EOB?

This is a report that's created whenever the health and dental plans process 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).

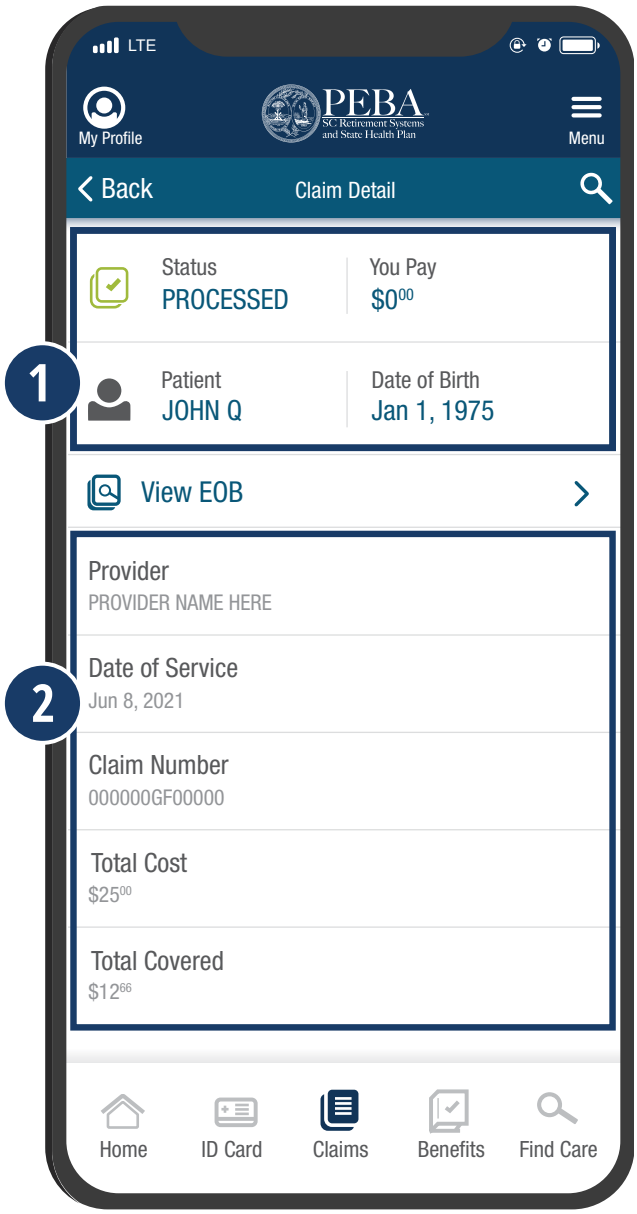
EOB

1. Summary information

This is a view of the status of your claim and the amount you may owe or have already paid to providers.

2. Detailed information

Here you'll see the provider's name, the service date and the claim number. You'll also find the total charge for the claim from the provider and the amount covered by the Plan.



Go green!

View your EOBs on the My Health Toolkit app! Plus, you can choose paperless notifications, and we'll email you whenever a new EOB is ready to view.

1. Log in to your account via the mobile app.
2. Select the **My Profile** link under the menu.
3. Select **Contact Preferences**.
4. Set your preferences to email, text or both.

Resources for a better you

Are you ready to get on track with your health but not sure where to start? The good thing is you don't have to figure it out on your own. The State Health Plan offers a variety of resources to you, most of which are available at no cost.

Behavioral health visits through Blue CareOnDemand

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,[1] 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.

Health coaching

A health coach can help you with behavioral health issues, chronic conditions, healthy lifestyles and maternity support. Health coaching is available online or via phone at no cost to State Health Plan subscribers and their covered adult family members. To learn more, visit **peba.sc.gov/health-coaching**.

Naturally Slim®

Learn the skills to lose weight and keep it off while still eating your favorite foods in this 10-week, clinically-proven online program. Naturally Slim will teach you it's not what you eat, but when and how you eat that will help you lose weight. Naturally Slim is available at no cost to you. Learn more at **www.naturallyslim.com/PEBA**.

Patient-centered medical homes

A patient-centered medical home (PCMH) offers a team approach to care to help you reach your goals for better health. Plus, you can save money when you use a PCMH. Standard Plan members do not pay the $14 copayment for a PCMH office visit. Plus, Standard Plan and Savings Plan members pay a 10 percent coinsurance, rather than 20 percent, after meeting their deductible. Visit **www.StateSC.SouthCarolinaBlues.com** to find a PCMH near you.

Quit For Life

If you want to quit using tobacco or e-cigarettes, the confidential Quit For Life tobacco cessation program can help you meet your goals. The program is available at no cost to State Health Plan members and covered dependents ages 13 or older. To learn more and enroll, visit **www.quitnow.net/SCStateHealthPlan**.

Rally®

Sign up for Rally, a digital health platform that makes it easier for you to improve and maintain your overall health. Based on your responses to a quick health survey, you'll get personalized recommendations to help you move more, eat better and feel great. Log in to your **My Health Toolkit** account to sign up for Rally.

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

Save money and get the care you need.

Your primary care physician should be your first call for routine medical care. But what if your doctor's office is closed? Or it's an emergency? Avoid needless worry, out-of-pocket expenses and hours sitting in the emergency room by knowing your health care options.

Primary care physician

Your primary care physician, or regular doctor, is the best option for medical care, such as:

- Managing your chronic condition.
- Prescription refills.
- Cold and flu symptoms, including fever, coughing, sore throat and mild nausea.
- Migraines.
- Minor cuts and bruises.
- Pinkeye.
- Rashes, insect bites, sunburn and other skin irritations.
- Seasonal allergies.
- Sinus or respiratory infections.
- Sprained muscles.
- Urinary tract infections.

You pay a $14 copayment,[1] plus the remaining allowed amount until you meet your deductible. Then, you pay the copayment plus your coinsurance.

Telehealth

If your doctor's office is closed, you're traveling or you feel too sick to drive, use a video visit for non-emergency health issues, such as:

- Cold and flu symptoms.
- Pinkeye.
- Rashes and other skin irritations.
- Seasonal allergies.
- Sinus or respiratory infections.
- Urinary tract infections.

Blue CareOnDemand

Search Blue CareOnDemand in your app store. You can see a doctor who can diagnose your symptoms and call in a prescription to your local pharmacy, if needed.

You pay a $14 copayment,[1] plus the remaining allowed amount until you meet your deductible. Then, you pay the copayment plus your coinsurance.

MUSC Health Virtual Care

Visit www.MUSChealth.org/virtual-care to start a visit. A doctor will diagnose your symptoms and call in a prescription to your local pharmacy, if needed.

This service is available at no cost for all State Health Plan members, including Medicare primary members.

Emergency room

Go to the ER or call 911 for very serious or life-threatening conditions, such as:

- Coughing up or vomiting blood.
- Heavy, uncontrolled bleeding.
- Loss of consciousness or sudden dizziness.
- Major injuries, such as broken bones or head trauma.
- Severe allergic reactions.
- Signs of a heart attack, such as chest pain that lasts more than two minutes.
- Signs of stroke, such as numbness, sudden loss of speech or vision.

You pay a $175 copayment,[1] plus the remaining allowed amount until you meet your deductible. Then, you pay the copayment plus your coinsurance.

[1] *Standard Plan members who receive care at a PCMH will not pay a copayment. Savings Plan members do not pay copayments for any visits, but will pay the full allowed amount until meeting their deductible.*

Adult well visits and the Standard Plan

Well visits may be a key part of preventive care. They can reassure you that you are as healthy as you feel, or prompt you to ask questions about your health. Learn more about adult well visits and when they are covered at **peba.sc.gov/well-visits**.

How the benefit works

Evidence-supported services, based on United States Preventive Services Task Force (USPSTF) A and B recommendations, are included as part of an adult well visit under the State Health Plan. After talking with your doctor during a visit, the doctor can decide which services you need and build a personal care plan for you. Adult well visits are subject to copayments, deductibles and coinsurance in covered years.

Who is eligible?

The benefit is available to all non-Medicare primary adults ages 19 and older who are covered by the Standard Plan. Adult members can take advantage of this benefit at an eligible network provider.

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 woman visits both doctors in the same covered year, only the first routine office visit received will be covered. Women ages 18-65 can receive a Pap test each calendar year at no member cost through PEBA Perks. In years when you are not eligible for an adult well visit, you can still receive a Pap test at no member cost.

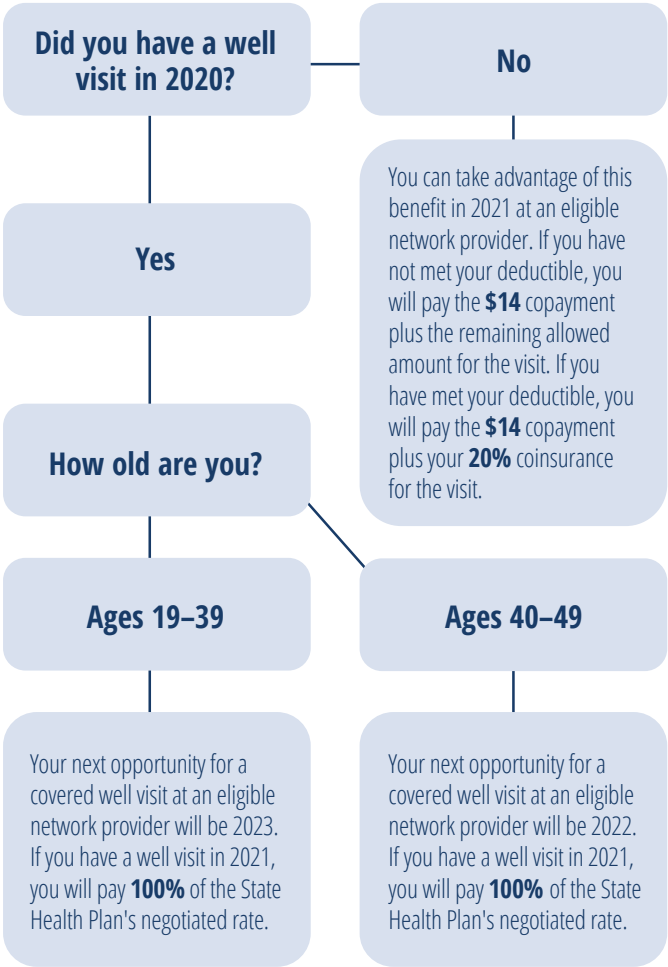
Frequency of visits

The Plan will cover only one visit in covered years, based on the following schedule:

	Once a year	Once every two years	Once every three years
Ages 19–39			✓
Ages 40–49		✓	
Ages 50 and older	✓		

Can you get a well visit in 2021 if you're younger than age 50?

Members ages 50 and older can have a well visit every year. Members younger than age 50 can determine when they may have a well visit below.



In non-covered years, the amount you pay for a well visit will not apply toward your deductible or coinsurance maximum.

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.

Step 1 **Set aside money in your MoneyPlus account.** Estimate how much you will spend on your adult well visit in a covered year or a non-covered year. Include this amount on the worksheet on Page 11 to determine how much you should contribute to your MoneyPlus account. $_____

Step 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.

Step 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.

Step 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.

Step 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 certain generic drugs at no cost to you. Learn more on Page 20.

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, if ordered by your physician to treat a specific condition, may still be covered.

These services are subject to copayments, deductibles 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.

Important note about well visits

The 2021 well visit benefit structure is dependent upon General Assembly approval of the fiscal year 2021 budget. The budget is not finalized at this time. The benefit structure will be available at **peba.sc.gov/well-visits** by October 1, 2020.

Adult well visits and the Savings Plan

Savings Plan members are eligible for one well visit each year at no member cost. Evidence-supported services, based on the USPSTF A and B recommendations, are included as part of an adult well visit. After talking with your doctor during a visit, your doctor can decide which services you need and build a personal care plan for you.

Value-based benefits at no cost to you

It's always better to address a health issue before it becomes a health crisis. Visit a network provider or pharmacy to take advantage of these value-based benefits at no cost to you. These benefits can help make it easier for you and your family to stay healthy. For more details about PEBA Perks, including eligibility, visit **www.PEBAperks.com**.

Preventive screening

Identifying health issues early can prevent serious illness and help save you money. This benefit, worth more than $300, allows you to receive a biometric screening at no cost.

Have your adult well visit after your preventive screening.

Share your results with your network provider to eliminate the need for retesting at a well visit. Sharing your results will minimize the cost of your adult well visit.

Flu vaccine

The flu affects between 5 and 20 percent of the U.S. population each year. An annual flu vaccine is the best way to reduce your risk of getting sick and spreading it to others.

Adult vaccinations

Vaccines are one of the safest ways to protect your health and the health of those around you. The State Health Plan covers adult vaccinations, including the Shingrix vaccine, based on age, interval and medical history recommendations from the Centers for Disease Control and Prevention (CDC).

Well child benefits (exams and immunizations)

This benefit aims to promote good health and prevention of illness in children. Covered children through age 18 are eligible for this benefit. The State Health Plan covers doctor visits based on recommendations from the American Academy of Pediatrics and immunizations based on recommendations from the CDC at network providers.

peba Perks℠
VALUE FOR A HEALTHIER STATE

Colorectal cancer screening

Colorectal cancer is the second-most common cause of cancer deaths in the U.S. The State Health Plan covers the cost for both diagnostic and routine screenings based on age ranges recommended by the United States Preventive Services Task Force (USPSTF). Any facility charges or associated lab work as a result of the screening may be subject to patient liability.

Cervical cancer screening

Cervical cancer deaths have decreased since the implementation of widespread cervical cancer screenings. The State Health Plan allows women ages 18-65 to receive a Pap test each calendar year at no cost. For women ages 30-65, the Plan covers the HPV test in combination with a Pap test once every five years at no cost.

No-Pay Copay

No-Pay Copay encourages members to be more engaged in their health — and saves them money. By completing certain activities in Rally each quarter, members can receive certain generic drugs the next quarter at no cost. Covered conditions include:

- High blood pressure and high cholesterol.
- Cardiovascular disease, congestive heart failure and coronary artery disease.
- Diabetes.

Mammography

A mammogram is an important step in taking care of yourself. This benefit provides one baseline routine mammogram (four views) for women ages 35-39. Women ages 40 and older can receive one routine mammogram (four views) each calendar year. The State Health Plan also covers diagnostic mammograms, which are subject to patient liability.

Diabetes education

Managing your diabetes can help you feel better. It can also reduce your chance of developing complications. This benefit provides diabetes education through certified diabetes educators.

Tobacco cessation

This benefit provides enrollment in the Quit For Life program at no cost. It also includes a $0 copay for some tobacco cessation drugs to eligible participants.

Breast pump

This benefit gives members certain electric or manual breast pumps at no cost. Members can learn how to get a breast pump by enrolling in the maternity management program, Coming Attractions.

Lactation consultations through Blue CareOnDemand

This benefit allows members to video chat with a lactation consultant at no cost. Get help 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 are right for you. Appointments are available seven days a week.

Health help in the palm of your hand

Text messages are a great way to keep up with kids, friends and appointments. They can help you stay on top of your health, too.

Sign up for secure State Health Plan mobile messages. You'll get benefits information, health and wellness reminders and cost-saving tips.

Learn how to avoid catching a cold. Find out about benefits available at no cost. Get information about healthy lifestyle programs, health coaching and value-based benefits.

Mobile messaging is completely optional, but we encourage you to sign up! It's a simple and secure way to get information you can use.

Sign up for mobile messaging.

1. Call **844.284.5417** from your mobile phone; or
2. Text **PERKS** to 735-29.

Data rates may apply.

Avoid costs by getting the green light for your care.

Some medical and behavioral health services need preauthorization for the State Health Plan to provide coverage. This means you or your provider needs to make a phone call. **Not calling for preauthorization may lead to a $490 penalty.** Preauthorization does not guarantee payment.

Medical services

To preauthorize your medical treatment, call Medi-Call at **800.925.9724** at least two business days before:

- Inpatient care in a hospital, including admission to a hospital to have a baby.
- An outpatient service that results in a hospital admission.
- Outpatient surgery for a septoplasty (surgery on the septum of the nose).
- Outpatient or inpatient surgery for a hysterectomy.
- Sclerotherapy (vein surgery).
- Chemotherapy or radiation therapy.
- Admission to a long-term care facility or nursing facility.
- Ordering durable medical equipment.
- In vitro fertilization or other infertility procedures.
- An organ transplant.
- Inpatient rehabilitation services and related outpatient physical, speech or occupational therapy.

Pregnancy

You should contact Medi-Call at **800.925.9724** within the first three months of a pregnancy.

Emergencies

In a hospital emergency, you should contact Medi-Call at **800.925.9724** to report your admission within 48 hours or the next business day.

Radiology services

To preauthorize your radiology services, call National Imaging Associates at **866.500.7664**.

- CT scan.
- MRI.
- MRA.
- PET scan.

Behavioral health services

To preauthorize your behavioral services, call Companion Benefit Alternatives at **800.868.1032**.

- Inpatient hospital care.
- Intensive outpatient hospital care.
- Partial hospitalization care.
- Outpatient electroconvulsive therapy.
- Repetitive transcranial magnetic therapy.
- Applied behavioral analysis therapy.
- Psychological/neuropsychological testing.

Some outpatient behavioral health services may not be covered by the Plan if you don't preauthorize.

Helpful terms

Insurance lingo can be confusing. But, it's important to understand your benefits and how they work. Here are some terms you may need to know.

Allowed amount 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.

Benefits The items or services covered by your insurance plan.

Claim A request for payment that you or your provider submits after you receive services.

Coinsurance This is a percentage of the cost of health care you pay after you meet your deductible. For example, say the State Health Plan's allowed amount for an office visit is $114 and the member has met his deductible. After a Standard Plan member pays the $14 copayment, his coinsurance payment of 20 percent would be $20. The health plan pays the rest of the allowed amount, or $80.

Coinsurance maximum The amount of coinsurance you are required to pay each year before you are no longer required to pay coinsurance.

Copayment The fixed amount you pay for a covered health care service or drug. Standard Plan members pay prescription drug copayments and copayments for office visits, emergency care and outpatient facility services. Savings Plan members do not pay copayments. Standard Plan members will continue to pay copayments even after meeting their deductible.

Coverage review A blanket term for the different types of processes the Plan uses to ensure the safe and effective use of prescription drugs and to encourage the use of lower-cost alternatives when possible.

Deductible The amount you pay for covered services before your health plan begins to pay.

Dependent An eligible child or spouse covered by your health plan.

National Preferred Formulary The formulary, or list of preferred drugs, used by Express Scripts.

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 facilities, providers and suppliers under contract to provide care for people covered by a health, dental or vision plan.

Out-of-pocket costs These are your costs for expenses that aren't reimbursed by insurance. Out-of-pocket costs include deductibles, coinsurance and copayments for covered services, plus all costs for services that aren't covered.

Preauthorization A decision that a service, prescription drug or piece of equipment is medically necessary. Certain services and medications require preauthorization before you receive them, except in an emergency. You may also hear this referred to as precertification or prior authorization.

Premium The amount you pay for insurance coverage.

Provider This can refer to the medical professional who delivers care or the location where you receive health care services.

Plan your 2021 insurance coverage.

Open enrollment | October 1-31, 2020

During open enrollment, you may change your coverage for 2021. Review your current coverage in **MyBenefits** (mybenefits.sc.gov). If you are satisfied with your current elections, the only thing you need to do is re-enroll in MoneyPlus flexible spending accounts. All open enrollment changes take effect January 1, 2021.

Your next step

Use the open enrollment worksheet on Page 26 to plan your coverage elections.[1] Be sure to review the details about open enrollment changes at **peba.sc.gov/oe**.

Then, log in to **MyBenefits** at **mybenefits.sc.gov** by October 31, 2020, to change your coverage for 2021. Your benefits administrator can also assist you.

New hires

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

From the date you become eligible, you have 31 days to enroll in your health insurance and other available insurance benefits.

Your next step

Use the new hire worksheet on Page 27 to plan your coverage elections.[1] Then, follow the link in the email you receive from PEBA to make your elections through MyBenefits. Your benefits administrator can also assist you.

[1] *This is not an election of benefits. You must follow the applicable steps to enroll for 2021. View eligibility information, coverage details and limitations on Pages 1-11.*

Insurance Benefits Guide

The 2021 *Insurance Benefits Guide* is available online at **peba.sc.gov/publications**.

Summaries of Benefits and Coverage

The 2021 *Summaries of Benefits and Coverage* for the Standard Plan and Savings Plan are available online at **peba.sc.gov/publications**. To request a copy, call PEBA at 803.737.6800 or 888.260.9430.

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.

Grandfathered notice

The S.C. 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 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.

Third-party disclosures

These companies provide services on behalf of the South Carolina Public Employee Benefit Authority, which administers the State Health Plan and other insurance benefits. BlueCross BlueShield of South Carolina is the third-party administrator for the State Health Plan and dental benefits. BlueCross BlueShield of South Carolina is an independent licensee of the Blue Cross and Blue Shield Association. Rally is a product of Rally Health Inc., an independent company that offers a digital health platform on behalf of the State Health Plan. The Quit For Life Program is brought to you by the American Cancer Society and Optum. Optum is a registered trademark of Optum, Inc. The American Cancer Society name and logo are trademarks of the American Cancer Society. Optum administers the Quit For Life Program. Naturally Slim is an independent company that provides health information on behalf of the State Health Plan. Companion Benefit Alternatives, Inc. administers behavioral health services. National Imaging Associates administers radiology services. Express Scripts administers pharmacy benefits. EyeMed administers vision benefits. MetLife administers life insurance benefits. The Standard administers long term disability benefits. ASIFlex administers the MoneyPlus program.

Notice of non-discrimination

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

PEBA:

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

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

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

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

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

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

Language assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.888.260.9430

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1.888.260.9430

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1.888.260.9430

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1.888.260.9430 번으로 전화해 주십시오.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1.888.260.9430

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1.888.260.9430.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1.888.260.9430.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1.888.260.9430.

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નઃશુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1.888.260.9430.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1.888.260.9430.

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1.888.260.9430.

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1.888.260.9430まで、お電話にてご連絡ください。

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1.888.260.9430.

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1.888.260.9430 पर कॉल करें।

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212337-09-2020

Clear form

Open enrollment worksheet

get your ducks in a row
open enrollment 2020

Use this worksheet to plan your elections for 2021. This is not an election of benefits. You must follow the applicable steps to enroll for 2021. View eligibility information, coverage details and limitations on Pages 1-11.

Choose your health plan. (Page 2)

- ☐ Standard Plan
  Consider opening a Medical Spending Account.
- ☐ Savings Plan
  Consider opening a Health Savings Account and Limited-use Medical Spending Account.
- ☐ TRICARE Supplement Plan

Coverage level

- ☐ Employee
- ☐ Employee/spouse
- ☐ Employee/children
- ☐ Full family

Choose your dental plan. (Page 4)

Changes to existing dental coverage can be made during open enrollment only in odd-numbered years. Your next opportunity to add or drop dental coverage will be October 2021 for the 2022 plan year.

Choose your vision coverage. (Page 6)

Coverage level

- ☐ Employee
- ☐ Employee/spouse
- ☐ Employee/children
- ☐ Full family

Choose your additional life insurance coverage. (Page 7)

- ☐ Optional Life

  Amount $ _____
  (must be in increments of $10,000)
- ☐ Dependent Life-Spouse

  Amount $ _____
  (must be in increments of $10,000)
- ☐ Dependent Life-Child

Choose your additional long term disability coverage. (Page 8)

Benefit waiting period

- ☐ Enroll in SLTD coverage
  - ☐ 90-day benefit waiting period
  - ☐ 180-day benefit waiting period
- ☐ Change benefit waiting period

Choose your MoneyPlus elections. (Page 9)

Standard Plan members

- ☐ Medical Spending Account

  Amount $ _____

Savings Plan members

- ☐ Health Savings Account

  Amount $ _____
- ☐ Limited-use Medical Spending Account

  Amount $ _____

All members

- ☐ Pretax Group Insurance Premium feature
- ☐ Dependent Care Spending Account

  Amount $ _____

Clear form

New hire worksheet

Use this worksheet to plan your elections. This is not an election of benefits. You must follow the applicable steps to enroll. View eligibility information, coverage details and limitations on Pages 1-11.

Choose your health plan. (Page 2)

- ☐ Standard Plan
  Consider opening a Medical Spending Account.
- ☐ Savings Plan
  Consider opening a Health Savings Account and Limited-use Medical Spending Account.
- ☐ TRICARE Supplement Plan

Coverage level

- ☐ Employee
- ☐ Employee/spouse
- ☐ Employee/children
- ☐ Full family

Choose your dental plan. (Page 4)

Your next opportunity to add or drop dental coverage will be October 2021 for the 2022 plan year.

- ☐ Dental Plus
- ☐ Basic Dental

Coverage level

- ☐ Employee
- ☐ Employee/spouse
- ☐ Employee/children
- ☐ Full family

Choose your vision coverage. (Page 6)

Coverage level

- ☐ Employee
- ☐ Employee/spouse
- ☐ Employee/children
- ☐ Full family

Choose your additional life insurance coverage. (Page 7)

- ☐ Optional Life

  Amount $ _____
  (must be in increments of $10,000)
- ☐ Dependent Life-Spouse

  Amount $ _____
  (must be in increments of $10,000)
- ☐ Dependent Life-Child

Choose your additional long term disability coverage. (Page 8)

Benefit waiting period

- ☐ 90 days
- ☐ 180 days

Choose your MoneyPlus elections. (Page 9)

Standard Plan members

- ☐ Medical Spending Account

  Amount $ _____

Savings Plan members

- ☐ Health Savings Account

  Amount $ _____
- ☐ Limited-use Medical Spending Account

  Amount $ _____

All members

- ☐ Pretax Group Insurance Premium feature
- ☐ Dependent Care Spending Account

  Amount $ _____

PEBA℠
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South Carolina Public Employee Benefit Authority

Serving those who serve South Carolina

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