

Benefits Advantage



Choose your health plan

- Change from one health plan to another:
 - Medicare Supplemental Plan, if eligible for Medicare;¹
 - Standard Plan;²
 - Savings Plan, if not eligible for Medicare; or
 - TRICARE Supplement Plan for eligible members of the military community.
- Enroll yourself or any eligible dependents in health coverage.
- Drop health coverage for yourself or any dependents.

If you are changing health plans, review the chart on Page 2. Note any differences in copayments, deductibles and coinsurance.

¹Claims for covered family members who are not eligible for Medicare, but who are insured through the Medicare Supplemental Plan, are paid according to Standard Plan provisions.

²The Carve-out Plan is the Standard Plan for Medicare primary members. Learn more in the *Insurance Coverage for the Medicare-eligible Member* handbook.

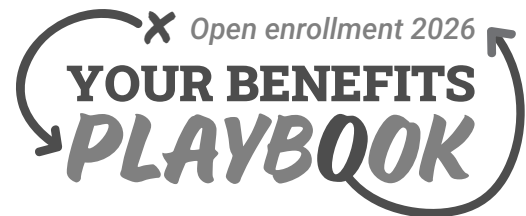


Choose your vision coverage

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

Dental coverage

Changes to existing dental coverage can be made during open enrollment only in odd-numbered years. Your next opportunity to make a change will be October 2027.



Just like any championship team realizes, the key to success is knowing your options and running the right plays. This year's benefits playbook breaks down everything you need to know about your insurance benefit options for 2027. Visit peba.sc.gov/oe to learn more about this year's open enrollment.

Open enrollment is October 1-31, 2026. If you are satisfied with your elections, you don't need to do anything. Your current coverage will continue in 2027. If you are unsure what insurance coverage you have, review your current elections by logging in to MyBenefits at mybenefits.sc.gov.

To the left are the changes you can make during open enrollment this year. Any coverage changes you make will take effect January 1, 2027. Log in to MyBenefits at mybenefits.sc.gov to make your coverage selections. If you would like to make a change with an immediate effective date, such as an address update, you should do so before submitting your open enrollment changes in October.

2027 Monthly premiums

Funded, partially and non-funded retiree, COBRA subscriber, survivor and former spouse health insurance premiums will not increase in 2027. State Vision Plan rates will increase in 2027. Review the 2027 monthly premiums at peba.sc.gov/monthly-premiums. If you worked for an optional employer, verify your rates with your former employer.

Health plans offered for 2027

The following chart is an overview of available plans and is for comparison only. The *Plan of Benefits*, which includes a complete description of the Plan, governs the three plans offered by PEBA. It is available at peba.sc.gov/publications.

Option for Medicare primary members

	Medicare Supplemental Plan
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 of 20%. There is no coinsurance maximum.
Physician's office visits	Plan pays Part B coinsurance of 20%.
Inpatient hospitalization¹	Plan pays Medicare deductible and coinsurance for days 61-150. Medicare benefits could end sooner than day 150 if members have previously used any of their 60 lifetime reserve days. Plan pays 100% beyond 150 days.
Prescription drugs^{2,3} (30-day supply/90-day supply at network pharmacy)	Tier 1: \$13/\$32 Tier 2: \$46/\$115 Tier 3: \$77/\$192 You pay up to \$3,000 in prescription drug copayments. Then, you pay nothing.

Options for non-Medicare primary members

	Standard Plan ⁴	Savings Plan
Annual deductible	You pay up to \$515 per individual or \$1,030 per family.	You pay up to \$4,000 per individual or \$8,000 per family. ⁵
Coinsurance⁶	In network, you pay 20% up to \$3,000 per individual or \$6,000 per family.	In network, you pay 20% up to \$3,000 per individual or \$6,000 per family.
Physician's office visits⁷	You pay a \$15 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^{8,9}	You pay a \$115 copayment (outpatient services) or \$193 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 hospitalization¹⁰	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 drugs² (30-day supply/90-day supply at network pharmacy)	Tier 1: \$13/\$32 Tier 2: \$46/\$115 Tier 3: \$77/\$192 You pay up to \$3,000 in prescription drug copayments. Then, you pay nothing.	You pay the full allowed amount until you meet your deductible. Then, you pay your coinsurance. Drug costs are applied to your coinsurance maximum. When you reach the maximum, you pay nothing.

¹Medi-Call or Companion Benefit Alternatives approval required if hospital stay exceeds 150 days.

²Prescription drugs are not covered at out-of-network pharmacies. Specialty medications are limited to a 30-day supply per fill.

³Medicare rules apply.

⁴Standard Plan is the Carve-out Plan for Medicare primary members. Learn more in the *Insurance Coverage for the Medicare-eligible Member* handbook, available at peba.sc.gov/publications.

⁵If more than one family member is covered, no family member will receive benefits, other than preventive benefits, until the \$8,000 annual family deductible is met.

⁶Out of network, you will pay 40% coinsurance, and your coinsurance maximum is different. An out-of-network provider may bill you more than the Plan's allowed amount. Learn more about out-of-network benefits and surprise billing protections at peba.sc.gov/health.

⁷The \$15 copayment is waived for routine mammograms, adult well visits, well woman visits and well child visits.

⁸The \$115 copayment for outpatient facility services is waived for dialysis services, partial hospitalizations, intensive outpatient services, electroconvulsive therapy and psychiatric medication management.

⁹The \$193 copayment for emergency care is waived if admitted.

¹⁰Inpatient hospitalization requires prior authorization for the State Health Plan to provide coverage.

Open enrollment made easy

Use MyBenefits to make your changes

MyBenefits is the fastest, most convenient way for subscribers covered by PEBA-administered insurance programs to manage their benefits. Log in to MyBenefits at mybenefits.sc.gov to make your coverage changes during open enrollment and ensure prompt transmission of your coverage changes. If you are a first-time user, select Register to create an account.

How to make changes

- 1 Log in to your account to view your current coverage and premiums.
- 2 Select Make Change, then Open Enrollment. Here you will see the coverage options available to you during open enrollment. The 2027 premiums for the coverage options will also be listed. Former employees of optional employers should contact their former employer to verify their premiums.
- 3 Select the changes you want and choose Next. You will then see a summary page comparing your current coverage to your new choices.
- 4 If you are happy with your elections, choose Apply. To submit your changes, you must enter the last four digits of your Social Security number and select Sign. Your changes are not complete until you submit your electronic signature.

Follow up on your changes

In December 2026, log in to MyBenefits at mybenefits.sc.gov to review your changes. Select Coverage to see your 2027 benefits.

If you notice any discrepancies, contact PEBA if you retired from a state agency, public higher education institution, public school district or charter school that participates in insurance and retirement. If you retired from an optional employer or charter school that participates in insurance only, contact your former employer.

You should also download or print a copy of the *Summary of Change* for your records. If you change your mind about your coverage selections, you have until 11:59 p.m. on Saturday, October 31, to make additional changes in MyBenefits.

Some coverage changes, including enrolling a dependent who is not covered under any benefit, require supporting documentation. You can upload documents through MyBenefits. Keep in mind, PEBA must receive the documents by Tuesday, December 1, to approve the changes.

Returning to work in an insurance-eligible job after retirement

If you return to work for a participating employer and are eligible to enroll in insurance benefits, 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 are two exceptions 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, and part-time teachers who are not

eligible for Medicare can choose to stay on retiree group insurance coverage. Contact your previous employer if you are unsure if it participates in the Retiree Health Insurance Trust Fund. When you stop working, and your active group coverage ends, you can reenroll in retiree group coverage within 31 days of the date you leave active employment by submitting a *Retiree Notice of Election* to PEBA.

Learn more in the Retiree group insurance chapter of the *Insurance Benefits Guide* at peba.sc.gov/publications.

Important reminders when you qualify for Medicare

As a retiree, you can qualify for Medicare due to age or a disability. Here are some important things to remember when you enroll in Medicare:

- Be sure to enroll in Medicare Part A and Part B. If you do not enroll in Part B, you will have to pay the part of your healthcare costs that Part B would have paid.
- You or one of your dependents might qualify for Medicare because of a disability. If so, you should enroll in the Medicare Supplemental Plan. To enroll, submit a *Retiree Notice of Election*. You need to submit the form within 31 days of Medicare Part A eligibility. Be sure to include a copy of your Medicare card with your form.
- PEBA automatically enrolls Medicare-eligible retirees in the State Health Plan Medicare Prescription Drug Program. PEBA also enrolls Medicare-eligible dependents in this program.
- For Medicare primary members, Part B prescriptions covered under the medical benefit might require prior authorization by Centers for Medicare and Medicaid Services. Medicare primary members should use a network pharmacy that accepts Medicare.
- If you are diagnosed with end stage renal disease and become eligible for Medicare, you must enroll in Medicare Parts A and B. There is a 30-month coordination period during which the State Health Plan will be primary. At the end of the 30-month ESRD coordination period, Medicare will become your primary insurance, regardless of your employment status. If you do not enroll in Medicare, you will have to pay the part of your healthcare costs Medicare would have paid. The 30-month ESRD coordination period also applies to members already enrolled in Medicare due to age or disability.

The benefits offered by the Medicare Supplemental Plan and Carve-out Plan vary. This is especially true in how each plan coordinates with Medicare. The *Insurance Coverage for the Medicare-eligible Member* handbook includes a plan comparison. This handbook is also useful in determining which plan best suits your needs. You can find the handbook at peba.sc.gov/publications. You can also learn how the Medicare Supplemental Plan coordinates with traditional Medicare in the *Traditional Medicare and the Medicare Supplemental Plan* flyer at peba.sc.gov/nyb.

Benefit consultations

There are three ways to receive a benefits consultation, and you'll receive the same service, regardless of the type of consultation you choose. You can also call us from 8:30 a.m. to 5 p.m., Monday through Friday, at 803.737.6800 or 888.260.9430. Calls are answered in the order in which they are received. Visit peba.sc.gov/consultations.

Avoid costs by getting the green light for your care

If the State Health Plan is your primary coverage, some medical and behavioral health services need prior authorization for the Plan to provide coverage. This means you or your provider needs to make a phone call. Prior authorization does not guarantee payment.

Medical services

For prior authorization of your medical treatment, call Medi-Call at **800.925.9724** at least two business days before:

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

Pregnancy

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

Emergencies

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

Radiology services

For prior authorization of your radiology services, call Evolent at **866.500.7664**:

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

Behavioral health services

For prior authorization of your behavioral health services, call Companion Benefit Alternatives at **800.868.1032**.

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

Some outpatient behavioral health services might not be covered by the Plan if you don't receive prior authorization.

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 healthcare options.

Primary care physician

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

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

Your primary care physician might offer telehealth services, too. Contact your provider for more information.

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.
- Pink eye.
- Rashes and other skin irritations.
- Seasonal allergies.
- Sinus or respiratory infections.
- Urinary tract infections.

Blue CareOnDemand A State Health Plan primary member can log in to My Health Toolkit to connect with a doctor who can diagnose your symptoms and call in a prescription to your local pharmacy, if needed.

MUSC Health Virtual Care Visit muscvirtualcare.zipnosis.com to start a visit. A doctor will diagnose your symptoms and call in a prescription to your local pharmacy, if needed. You must be in South Carolina at the time of the visit.

Emergencies

Go to the ER or call 911 for 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, or sudden loss of speech or vision.

You pay a \$15 copayment¹ plus the remaining allowed amount until you meet your deductible. Then, you pay the copayment plus your coinsurance.

For Blue CareOnDemand, you pay a \$15 copayment¹ plus the remaining allowed amount until you meet your deductible. Then, you pay the copayment plus your coinsurance.

MUSC virtual visits are available at no cost for all State Health Plan members, including Medicare primary members.

You pay a \$193 copayment¹ plus the remaining allowed amount until you meet your deductible. Then, you pay the copayment plus your coinsurance.

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

Manage your health and pharmacy benefits with My Health Toolkit

When you're a member of the State Health Plan, even if you're a Medicare-primary member, you have a 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.

Update other insurance information.

Complete a questionnaire to let BlueCross know if you have any other health or dental insurance coverage.

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 might 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 Caremark 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, access your digital ID card and 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.

Coordination of benefits

Log in to your [My Health Toolkit account](#) early in the calendar year to update this information. Select My Plan & Benefits, then Health, then Other Health Information.

All State Health Plan benefits are subject to coordination of benefits, a process 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. To ensure benefits are paid correctly, members must complete a coordination of benefits questionnaire every year. BlueCross will not process or pay claims until it receives your information.

Get started today

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

- 1 Search for **My Health Toolkit®** in your app store.
- 2 In the app, select **Sign Up**.
Or, visit www.StateSC.SouthCarolinaBlues.com and select **Create An Account**.
- 3 Enter the member identification number on your State Health Plan ID 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 a Caremark 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**.

2027 Insurance vendor contact information

BlueCross BlueShield of South Carolina

State Health Plan

P.O. Box 100605 | Columbia, SC 29260-0605

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

Medi-Call

Medical prior authorization

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 100605 | Columbia, SC 29260-0605

- Customer Service: 803.736.1576 or 800.868.2520
- Precertification: 800.868.1032
- Case management, behavioral health coaching: 800.868.1032, ext. 25835
- www.CompanionBenefitAlternatives.com

Evolent

Advanced radiology prior authorization

- 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

Caremark

State Health Plan Prescription Drug Program, SilverScript (Medicare Prescription Drug Program)

Claims: Caremark Claims Department

P.O. Box 52136 | Phoenix, AZ 85072-2136

Medicare members: SilverScript Insurance Company

P.O. Box 30016 | Pittsburgh, PA 15222-0330

- Caremark Customer Care: 833.291.3646
- SilverScript Customer Care: 833.293.4859
- www.Caremark.com

EyeMed

State Vision Plan

Group number: 9925991

Claims: OON Claims

P.O. Box 8504 | Mason, OH 45040-7111

- Customer Care Center: 877.735.9314
- www.eyemedvisioncare.com/pebaoe

MetLife

Basic, Optional and Dependent Life

Policy number: 200879-1-G

MetLife Recordkeeping and Enrollment Services

P.O. Box 14401 | Lexington, KY 40512-4401

- Claims: 800.638.6420, Option 2
- Continuation for retirees: 888.507.3767
- Conversion: 877.275.6387
- Conversion Fax: 866.545.7517
- www.metlife.com/scpeba

Selman & Company

TRICARE Supplement Plan

P.O. Box 29151 | Hot Springs, AR 71903

- Customer Service: 866.637.9911, Option 1
- <https://info.selmanco.com/peba>

The Standard

Long term disability

Group No.: 621144

P.O. Box 2800 | Portland, OR 97208-2800

- Customer Service: 800.628.9696
- Continued benefits (conversion): 800.378.4668
- www.standard.com/mybenefits/scpeba

Have you moved?

If you have recently moved or you plan to move soon, log in to MyBenefits at mybenefits.sc.gov to update your address on file with PEBA. *To ensure this address change has an immediate effective date, you should submit the change before submitting your open enrollment changes in MyBenefits.* It is particularly important you keep your address up to date because it ensures you receive benefits information, including IRS Form 1095. You will receive

Form 1095 by January 31, 2027. The form shows you have minimum essential health insurance coverage. The federal Affordable Care Act requires you to have this coverage.

Keep in mind, updating your address in MyBenefits does not update your address for retirement benefits administered by PEBA. Log in to Member Access at online.retirement.sc.gov to update your address for retirement benefits.

How much health insurance do you need?

Do you have more than one Medicare supplement plan? You need only one supplement to traditional Medicare. Having too much health insurance can cost you more. It can also cause claims issues as insurance companies try to determine who the primary payer is.

Are you eligible for Medicare and TRICARE for Life? If so, you don't need the State Health Plan Medicare Supplemental Plan. Open enrollment is the perfect time to drop unneeded insurance. You can keep your dental and vision coverage even if you don't enroll in health insurance.

Members enrolled in the Medicare Supplemental Plan do not need to enroll in a Medicare Advantage plan. The two plans do not coordinate, and Medicare Supplemental Plan members have prescription drug coverage included in their plan.

If changes occur, you can always reenroll in the Medicare Supplemental Plan. You can do so within 31 days of the change. You can also switch to the Medicare Supplemental Plan during any open enrollment period. Changes made during open enrollment are effective the following January 1.

If you are considering joining another Part D plan, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. If you join a Medicare prescription drug plan other than the one sponsored by PEBA, you will lose your prescription drug coverage provided through your health plan with PEBA, and your premiums will not decrease.

Learn more in the IBG

The 2027 *Insurance Benefits Guide* describes the insurance programs in detail and contains information about all PEBA-sponsored insurance benefits. The guide will be available online by Thursday, October 1, at peba.sc.gov/publications.

Resources for a better you

State Health Plan coverage includes behavioral health benefits for adults and children. Companion Benefit Alternatives provides behavioral health management services, and some services require prior authorization by CBA. For general questions, such as if a service requires prior authorization, call CBA at 800.868.2520.

Finding a provider

For help finding a behavioral health provider or treatment program, call BlueCross at 877.505.7390. Representatives are available during normal business hours. You can also search for a provider at peba.sc.gov/find-care.

Federally mandated notices

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.

Summaries of Benefits and Coverage

The 2027 *Summaries of Benefits and Coverage* for the Standard and Savings Plans are available at peba.sc.gov/publications. To request a copy, call PEBA at 803.737.6800 or 888.260.9430.

Notice of Privacy Practices

Effective: April 14, 2003 | Revised: February 12, 2026

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

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

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

S.C. Public Employee Benefit Authority
Attn: HIPAA Privacy Officer
202 Arbor Lake Drive
Columbia, SC 29223
Phone: 803.737.6800 | Fax: 803.570.8110
Email: privacyofficer@peba.sc.gov

How PEBA may use and disclose protected health information

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

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

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

- **Business Associates.** PEBA may contract with individuals or entities known as Business Associates to perform various functions on PEBA's behalf or to provide certain types of services. For example, PEBA may disclose your protected health information to a Business Associate to process your claims for Plan benefits, pharmacy benefits, or other support services, but the Business Associate must enter into a Business Associate contract with PEBA agreeing to implement appropriate safeguards regarding your protected health information.
- **Treatment alternatives and health-related benefits and services.** PEBA may use and disclose your protected health information to contact you about health-related benefits or services that may be of interest to you. For example, you may be contacted and offered enrollment in a program to assist you in handling a chronic disease, such as high blood pressure.
- **Individuals involved in your care or payment for your care.** PEBA may, in certain circumstances, disclose protected health information about you to your representative, such as a friend or family member who is involved in your health care, or to your representative who helps pay for your care. PEBA may disclose your protected health information to an agency assisting in disaster relief efforts so that your family can be notified about your condition, status and location.
- **Research.** PEBA may use and disclose your de-identified protected health information for research purposes, or PEBA may share protected health information for research approved by an institutional review board or privacy board after review of the research rules to ensure the privacy of your protected health information. For example, a research project may compare the health/recovery of patients who receive a medication with those who receive another medication for the same condition.
- **As required by law.** PEBA will disclose protected health information about you when it is required to do so by federal or South Carolina law. For example, PEBA will report any suspected insurance fraud as required by South Carolina law.
- **To avert a serious threat to health or safety, or for public health activities.** PEBA may use and disclose protected health information about you when necessary to prevent a serious threat to your health and safety, or to the health and safety of the public, or for public health activities.
- **Organ and tissue donation.** If you are an organ donor, PEBA may disclose your protected health information to organizations that handle organ, eye or tissue procurement, transplantation or donation.
- **Coroners, medical examiners and funeral directors.** PEBA may share your protected health information with a coroner/medical examiner or funeral director as needed to carry out their duties.
- **Military and veterans.** If you are a member of the armed forces, PEBA may disclose protected health information about you after the notice requirements are fulfilled by military command authorities.
- **Workers' compensation.** PEBA may disclose protected health information about you for workers' compensation or similar programs that provide benefits for work-related injuries or illness.
- **Health oversight activities.** PEBA may disclose your protected health information to a health oversight agency for authorized activities, such as audits and investigations.
- **Lawsuits and disputes.** PEBA may disclose your protected health information in response to a court or administrative order, a subpoena, discovery request or other lawful process if PEBA receives assurance from the party seeking the information that you have either been given notice of the request, or that the party seeking the information has tried to secure a qualified protective order regarding this information. Substance use disorder treatment records (and testimony regarding the content of those records) shall not be used or disclosed in civil, criminal, administrative, or legislative proceedings against you, unless (1) you provide written consent or (2) a court orders the use or disclosure of the records after you are provided with notice and an opportunity to be heard. A court order authorizing use or disclosure of substance use disorder treatment records must be accompanied by a subpoena or other legal requirement compelling disclosure before the requested records are used or disclosed.
- **Law enforcement.** PEBA may disclose information to a law enforcement official in response to a court order, subpoena, warrant, summons or similar process.
- **National security, intelligence activities and protective services.** PEBA may disclose your protected health information to authorized officials for intelligence, counterintelligence and other national security activities; to conduct special investigations; and to provide protection for the President, other authorized persons or foreign heads of state.
- **Inmates.** If you are an inmate of a correctional institution or are in the custody of a law enforcement official, PEBA may disclose your protected health information if the disclosure is necessary to provide you with health care, or to protect your health and safety or the health and safety of others.

- **Fundraising.** PEBA will not use or release your protected health information for purposes of fundraising activities.
- **Sale or marketing.** Your authorization is required for PEBA's use or disclosure of any protected health information for marketing purposes, or for any disclosure by PEBA that constitutes the sale of PHI.

Your rights regarding your protected health information

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

- **Right to inspect and copy.** You have the right to request to see and receive a copy of your protected health information or, if you agree to the preparation cost, PEBA may provide you with a written summary. If PEBA maintains an electronic health record containing your protected health information, you have the right to request that PEBA send a copy of your protected health information in an electronic format to you. Some protected health information is exempt from disclosure. To see or obtain a copy of your protected health information, send a written request to: S.C. Public Employee Benefit Authority, Attn: HIPAA Privacy Officer, 202 Arbor Lake Drive, Columbia, SC 29223. PEBA may charge a fee for the costs associated with your request. In limited cases, PEBA may deny your request. If your request is denied, you may request a review of the denial.
- **Right to amend.** If you believe that your protected health information is incorrect or incomplete, you may ask PEBA to amend the information by sending a written request to: S.C. Public Employee Benefit Authority, Attn: HIPAA Privacy Officer, 202 Arbor Lake Drive, Columbia, SC 29223, stating the reason you believe your information should be amended. PEBA may deny your request if you ask it to amend information that was not created by PEBA, the information is not part of the protected health information kept by or for PEBA, the information is not part of the information you would be permitted to inspect and copy or your protected health information is accurate and complete. You have the right to request an amendment for as long as PEBA keeps the information.
- **Right to an accounting of disclosures.** You have the right to request a list of the disclosures of your protected health information PEBA has made. This list will NOT include protected health information released to provide treatment to you, to obtain payment for services or for health care operations; releases for national security purposes; releases to correctional institutions or law enforcement officials as required by law; releases authorized by you; releases of your protected health information to you; releases as part of a limited data set; releases to representatives involved in your health care; releases otherwise required by law or regulation and releases made prior to April 14, 2003. You must submit your request for an accounting of disclosures in writing to S.C. Public Employee Benefit Authority, Attn: HIPAA Privacy Officer, 202 Arbor Lake Drive, Columbia, SC 29223, indicating a time period that may not go back beyond six years. Your request should indicate the form in which you want the list (for example, by paper or electronically). The first list that you request within a 12-month period will be provided free of charge; however, PEBA may charge you for the cost of providing additional lists within a 12-month period.
- **Right to request restrictions of use and disclosure.** You have the right to request a restriction on the protected health information that PEBA uses or discloses. You also have the right to request a limit on the protected health information that PEBA discloses about you to someone who is involved in your care or the payment for your care. Please note that the protected health information collected by PEBA is not used for any other purpose than as necessary for the administration of your benefits as described above and is kept confidential pursuant to the requirements of state and federal law, including the protections under HIPAA and HITECH. PEBA is not required to agree to your request(s). If PEBA does agree, PEBA will comply with your request(s) unless the information is needed to provide you with emergency treatment. In your request, you must specify what information you want to limit and to whom you want the limits to apply. You must make these request(s), in writing, to S.C. Public Employee Benefit Authority, Attn: HIPAA Privacy Officer, 202 Arbor Lake Drive, Columbia, SC 29223.
- **Right to request confidential communications.** You have the right to request that PEBA communicate about your protected health information by alternative means or to an alternative location to avoid endangering you. PEBA will accommodate your request if (a) it is reasonable, (b) you state clearly that failure to communicate your protected health information by the alternative means or to the alternative location could endanger you, and (c) you provide reasonable alternative means or location for communicating with you. You must make these request(s), in writing, to S.C. Public Employee Benefit Authority, Attn: HIPAA Privacy Officer, 202 Arbor Lake Drive, Columbia, SC 29223.
- **Right to restrict release of information for certain services.** Unless the disclosure is required by law, you have the right to restrict the disclosure of information regarding services for which you have paid in full or on an out-of-pocket basis. This information can be released only upon your written authorization.
- **Right to a paper copy of this notice.** You have the right to request a paper copy of this notice at any time by contacting PEBA's HIPAA Privacy Officer at S.C. Public Employee Benefit Authority, Attn: HIPAA Privacy Officer, 202 Arbor Lake Drive, Columbia, SC 29223. You may obtain a copy of this notice at PEBA's website at peba.sc.gov.
- **Right to breach notification.** You have the right to be notified of any breach of your unsecured protected health information.

Complaints

If you believe that your protected health information rights, as stated in this notice, have been violated, you may file a complaint with

PEBA's HIPAA Privacy Officer and/or with the Office for Civil Rights, U.S. Department of Health and Human Services.

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

S.C. Public Employee Benefit Authority
Attn: HIPAA Privacy Officer
202 Arbor Lake Drive
Columbia, SC 29223
Phone: 803.737.6800 | Fax: 803.570.8110
Email: privacyofficer@peba.sc.gov

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

Office for Civil Rights
U.S. Department of Health and Human Services
61 Forsyth Street, S.W., Suite 16T70
Atlanta, GA 30303-8909
Phone: 404.562.7886 | Fax: 404.562.7881
TDD: 404.562.7884

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

Changes to this notice

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

Other uses of protected health information

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

HIPAA Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption or placement for adoption. To request special enrollment or obtain more information, contact your benefits administrator.

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for all stages of reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; prostheses; and treatment of physical complications of the mastectomy, including lymphedema. These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator at 803.737.6800 or 888.260.9430.

Newborn's and Mother's Health Protection Act

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

New Health Insurance Marketplace coverage options and your health coverage

PART A: General information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace (Marketplace). To assist you as you evaluate options for you and your family, this notice provides some basic information

about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

Can I save money on my health insurance premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does employer health coverage affect eligibility for premium savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12% of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit and advance payment of the credit if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.^{1,2}

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution, as well as your employee contribution to employment-based coverage, is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all these factors in determining whether to purchase a health plan through the Marketplace.

When can I enroll in health insurance coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace open enrollment period. Open enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual open enrollment period, you can sign up for health insurance if you qualify for a special enrollment period. In general, you qualify for a special enrollment period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child or losing eligibility for other health coverage. Depending on your special enrollment period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

What about alternatives to Marketplace health insurance coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a special enrollment period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit www.healthcare.gov/medicaid-chip/getting-medicaid-chip for more details.

How can I get more information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact your benefits administrator. The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit [HealthCare.gov](https://www.healthcare.gov) for more information, including an online application for

¹ Indexed annually; see <https://www.irs.gov/pub/irs-drop/rp-25-25.pdf> for 2026.

² An employer-sponsored or other employment-based health plan meets the minimum value standard if the plan's share of the total allowed benefit costs covered by the plan is no less than 60% of such costs. For purposes of eligibility for the premium tax credit, to meet the minimum value standard, the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

health insurance coverage and contact information for a Health Insurance Marketplace in your area.

Premium assistance under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2026. Contact your state for more information on eligibility.

ALABAMA - Medicaid

Website: <http://myalhipp.com/>
Phone: 1-855-692-5447

ALASKA - Medicaid

The AK Health Insurance Premium Payment Program Website:
<http://myakhipp.com/>
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
<https://health.alaska.gov/dpa/Pages/default.aspx>

ARKANSAS - Medicaid

Website: <http://myarhipp.com/>
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA - Medicaid

Health Insurance Premium Payment (HIPP) Program
Website: <http://dhcs.ca.gov/hipp>
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO - Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

Health First Colorado Website: <https://www.healthfirstcolorado.com/>
Health First Colorado Member Contact Center:
1-800-221-3943/State Relay 711
CHP+: <https://hcpf.colorado.gov/child-health-plan-plus>
CHP+ Customer Service: 1-800-359-1991/State Relay 711
Health Insurance Buy-In Program (HIBI): <https://www.mycohibi.com/>
HIBI Customer Service: 1-855-692-6442

FLORIDA - Medicaid

Website: <https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html>
Phone: 1-877-357-3268

GEORGIA - Medicaid

GA HIPP Website: <https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp>
Phone: 678-564-1162, Press 1
GA CHIPRA Website:
<https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra>
Phone: 678-564-1162, Press 2

INDIANA - Medicaid

Health Insurance Premium Payment Program All other Medicaid
Website: <https://www.in.gov/medicaid> <http://www.in.gov/fssa/dfr/>
Family and Social Services Administration Phone:
1-800-403-0864
Member Services Phone: 1-800-457-4584

IOWA - Medicaid and CHIP (Hawki) Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	KANSAS - Medicaid Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY - Medicaid Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIP.PPROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	LOUISIANA - Medicaid Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE - Medicaid Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	MASSACHUSETTS - Medicaid Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA - Medicaid Website: https://mn.gov/dhs/health-care-coverage Phone: 1-800-657-3672	MISSOURI - Medicaid Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA - Medicaid Website: http://dphhs.mt.gov/MontanaHealthcarePrograms HIPP Phone: 1-800-694-3084 Email: HSHIPPProgram@mt.gov	NEBRASKA - Medicaid Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA - Medicaid Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	NEW HAMPSHIRE - Medicaid Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY - Medicaid and CHIP Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	NEW YORK - Medicaid Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA - Medicaid Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	NORTH DAKOTA - Medicaid Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA - Medicaid and CHIP Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	OREGON - Medicaid Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075

PENNSYLVANIA - Medicaid and CHIP Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx CHIP Phone: 1-800-986-KIDS (5437)	RHODE ISLAND - Medicaid and CHIP Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rlte Share Line)
SOUTH CAROLINA - Medicaid Website: https://www.scdhhs.gov Phone: 1-888-549-0820	SOUTH DAKOTA - Medicaid Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS - Medicaid Website: https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program Phone: 1-800-440-0493	UTAH - Medicaid and CHIP Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT - Medicaid Website: https://dvha.vermont.gov/members/medicaid/hipp-program Phone: 1-800-250-8427	VIRGINIA - Medicaid and CHIP Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON - Medicaid Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	WEST VIRGINIA - Medicaid and CHIP Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN - Medicaid and CHIP Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	WYOMING - Medicaid Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2026, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1.866.444.EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1.877.267.2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

Medicare Part D creditable coverage letter

Important notice from PEBA about your prescription drug coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with PEBA and your options under Medicare's prescription drug coverage. This information can help you decide whether you want to join a Medicare prescription drug plan other than the State Health Plan's Medicare prescription drug program.

If you are considering joining another Part D plan, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

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

When can you join a Medicare prescription drug plan?

You can join a Medicare prescription drug plan when you first become eligible for Medicare and each year from October 15 to December 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two-month Special Enrollment Period to join a Medicare prescription drug plan.

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

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

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

When will you pay a higher premium (penalty) to join a Medicare drug plan?

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

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium.

You may have to pay this higher premium (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For more information about this notice or your current prescription drug coverage

Contact PEBA at the address or telephone number listed below. Note: You will receive this notice each year before the next period you can join a Medicare prescription drug plan and if this coverage through PEBA changes. You also may request a copy of this notice at any time.

For more information about your options under Medicare prescription drug coverage

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

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

For assistance, you may call 800-MEDICARE (800.633.4227). TTY users should call 877.486.2048.

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

Contact PEBA for further information.

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

S.C. Public Employee Benefit Authority
202 Arbor Lake Drive
Columbia, SC 29223
803.737.6800 | 888.260.9430 | peba.sc.gov

Your rights and protections against surprise medical bills

When you get emergency care or are treated by an out-of-network provider at a network hospital or ambulatory surgical center, you are protected from surprise billing. In these cases, you shouldn't be charged more than the State Health Plan's copayments, deductible and coinsurance.

What is surprise billing?

Surprise billing happens when you receive a bill for a service when you can't control who is involved in your care, like when you have an emergency or when you schedule a visit at a network facility but are unexpectedly treated by an out-of-network provider.

You are protected from surprise billing for the following services:**Emergency services**

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is the State Health Plan's network cost sharing amount, such as copayments, deductibles and coinsurance. You can't be charged more than the Plan's allowed amount for these emergency services. This includes services you may get after you're in stable condition unless you give written consent and give up your protections against being charged more than the Plan's allowed amount for these services.

Certain services at a network hospital or ambulatory surgical center

When you get services from a network hospital or ambulatory surgical center, certain providers there may be out of network. In these cases, the most those providers can bill you is the State Health Plan's network cost sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist or intensivist services. These providers can't charge you more than the Plan's allowed amount and may not ask you to give up your protections against surprise billing.

If you get other types of services at these network facilities, out-of-network providers can't charge you more than the Plan's allowed amount unless you give written consent and give up your protections.

You are never required to give up your protections from surprise billing. You also are not required to get out-of-network care. You can choose a provider or facility in the State Health Plan's network.

When you are protected against surprise billing, you also have these protections:

- You're responsible for paying only your share of the cost. This cost includes the copayments, deductibles and coinsurance you would pay if the provider or facility was in network. The State Health Plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, the State Health Plan must:
 - Cover emergency services without requiring you to get approval for services in advance, also known as prior authorization.
 - Cover emergency services by out-of-network providers.
 - Base what you owe the provider or facility (cost sharing) on what it would pay a network provider or facility and show that amount in your Explanation of Benefits.
 - Count any amount you pay for emergency or out-of-network services toward your in-network deductible and out-of-pocket coinsurance maximum.

If you think you've been wrongly billed, contact the United States Department of Health and Human Services at 888.393.2789. The toll-free phone number for information and complaints is 800.985.3059.

You may also receive help through an applicable state consumer assistance program. Visit www.dol.gov for contact information by state. Visit www.dol.gov/agencies/ebsa/laws-and-regulations/laws/no-surprises-act for more information about your rights under federal law.

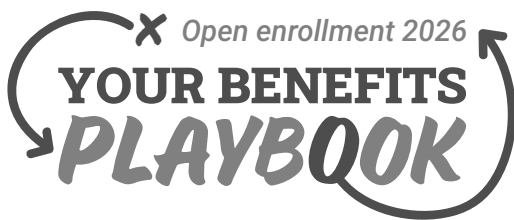
Note: If you choose to use an out-of-network provider, the provider may bill you the difference in its cost and the allowed amount. This is known as a balance bill. Learn more about balance billing at peba.sc.gov/nyb.



PEBASM
SC Retirement Systems
and State Health Plan

202 Arbor Lake Drive
Columbia, SC 29223

Serving those who serve South Carolina



Open enrollment is October 1-31, 2026. During open enrollment, eligible subscribers can change their coverage for the following year. Review your current coverage in MyBenefits at mybenefits.sc.gov.

If you are satisfied with your elections, you don't need to do anything. You will remain enrolled, and your current coverage will continue in 2027. **All open enrollment changes take effect January 1, 2027.**

Follow these steps to learn about open enrollment and make changes:

- 1 Visit the open enrollment webpage, peba.sc.gov/oe, to learn about the changes you can make.
- 2 Download your open enrollment worksheet at peba.sc.gov/oe to plan your coverage for 2027.
- 3 Log in to MyBenefits at mybenefits.sc.gov to review your coverage and make any changes during open enrollment, if necessary.