



PEBASM
SC Retirement Systems
and State Health Plan

Insurance Benefits Guide

2027

Serving those who serve South Carolina

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Disclaimer

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

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

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

State Health Plan's grandfathered status

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

As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of certain lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at 803.737.6800 or 888.260.9430.

Notice of non-discrimination

The South Carolina Public Employee Benefit Authority 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; and
 - 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; and
 - 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's Privacy Officer, 202 Arbor Lake Dr., Columbia, SC 29223, 888.260.9430 (phone), 803.570.8110 (fax), or [via email](#). 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](#) 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 on the [U.S. Department of Health and Human Services website](#).

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

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

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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।

ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្លូវភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់អ្នក។ ចូរ ទូរស័ព្ទ 1.888.260.9430



General information

This guide provides an overview of the insurance programs the South Carolina Public Employee Benefit Authority offers and contact information. While the guide provides a general description of many of these benefits, the *Plan of Benefits*, found on our [Publications webpage](#), contains a complete description of State Health Plan benefits. Its terms and conditions govern all health benefits offered by PEBA.

What's new for 2027?

Changes listed below are effective January 1, 2027.

- The 2027 monthly premiums are not printed in this guide. The premiums are available on our [Premiums webpage](#). Premiums for optional employers can vary. To verify your rates, contact your employer.
- Active employee, funded retiree, partially funded retiree, non-funded retiree, COBRA subscriber, survivor and former spouse health insurance premiums will not increase in 2027.
- State Vision Plan premiums will increase in 2027.
- GLP-1s are limited to a 30-day supply per fill for SilverScript members (Medicare primary members).

Eligibility for insurance benefits

Active employees

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, a participating charter school or a participating optional employer, such as a participating county or municipal government; and
- Are hired into an insurance-eligible position.

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

Elected members of participating county and city councils whose members are eligible to participate in one of the retirement systems PEBA administers are considered full-

time employees. Council members should contact their employer to see if they are eligible for benefits. Generally, members of other governing boards are not eligible for coverage. If you work for more than one participating group, contact your benefits administrator for further information. Other eligibility rules are outlined in the *Plan of Benefits*.

Types of employees

Employers are responsible for the classification of employees. Employees fall into these categories:

- New full-time employees whom the employer expects to work at least 30 hours a week. They are eligible for coverage within 31 days of their hire date.
- Permanent, part-time teachers who work between 15 and 30 hours per week.
- New variable-hour, part-time or seasonal employees whom the employer does not expect to average 30 hours a week during the first 12 months they are employed. Because their employer cannot determine their eligibility, they cannot enroll in benefits immediately. Their employer must measure their hours to determine whether these employees work an average of 30 hours a week during the 12 months beginning the first of the month after the employee is hired. If an employee works an average of 30 hours a week during this period, the employee is eligible for coverage during the 12-month period that follows.
- Ongoing employees who have completed their initial measurement period (October 4, 2025, to October 3, 2026). If an ongoing employee worked an average of 30 hours a week during this 12-month period, the employee is eligible for coverage during 2027 even if the employee's hours decrease during 2027. If an ongoing employee worked an average of less than 30 hours a week during this period, the employee is not eligible for coverage during 2027 unless the employee gains coverage through some other provision of the plan.

Benefits in which eligible employees can enroll

Health insurance

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

Dental insurance

- Dental Plus; or
- Basic Dental.

Vision insurance

- State Vision Plan.

Life insurance

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

Long term disability insurance

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

MoneyPlus

- Pretax Group Insurance Premium feature (allows eligible subscribers to pay their premiums for health, including the tobacco-use premium, dental, vision and up to \$50,000 in Optional Life coverage with pretax dollars);
- Medical Spending Account (for those enrolled in the Standard Plan or those who are not enrolled in a health plan through PEBA);
- Dependent Care Spending Account; and

- Limited-use Medical Spending Account (for those enrolled in the Savings Plan).

Health Savings Account

- Health Savings Account (for those enrolled in the Savings Plan).

An eligible retiree

An employee might also be eligible for health, dental and vision coverage in retirement if the employee meets the requirements for such coverage. Eligibility for retiree insurance coverage and funding depends on several factors, including the employee's eligibility for a retirement benefit, the date the employee was hired into an insurance-eligible position with an employer that participates in the State Health Plan, the employee's retirement service credit earned while working for an employer that participates in the State Health Plan and the nature of the employee's last five years of employment with an employer that participates in the State Health Plan.

See Page 135 for more information about retiree insurance eligibility requirements.

An eligible spouse

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

A former spouse can enroll in coverage under their own policy if an active employee or retiree is required by a court order to provide coverage. See the Divorce section on Page 20.

An eligible child

- Must be younger than age 26; and
- Must be the subscriber's natural child, adopted child

(including child placed for legal adoption), stepchild, foster child¹, a child of whom the subscriber has legal custody or a child the subscriber is required to cover due to a court order.²

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

A child ages 19 to 25

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

A parent can cover a child who is eligible for state benefits because the child works for an employer that participates in PEBA insurance benefits. The child can be covered under their parents' health, dental and vision coverage, and may be subject to additional coverage exclusions under the State Health Plan, such as a coverage exclusion for the covered child's infertility treatment, pregnancy or complications from pregnancy or childbirth. If covered by their parent, the child is not eligible for Basic Life, Optional Life, Dependent Life-Child, long term disability insurance, MoneyPlus or a Health Savings Account.

A child who is eligible for coverage under a parent, but who is also eligible for benefits because they work for a participating employer, must choose whether to be covered by their parent as a child or to be covered on their own as an employee. They cannot be covered as a child on one insurance program, such as health, and then enroll for coverage as an employee on another, such as vision. For life insurance purposes, a child who refuses coverage to remain on their parent's plan is ineligible for Dependent Life-Child coverage.

¹ A foster child is a child placed with the subscriber by an authorized placement agency or court.

² A child for whom the subscriber has legal custody is a child for whom the subscriber has guardianship responsibility, not just financial responsibility, according to a court order.

An incapacitated child

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

- The child must be unmarried and must remain unmarried to continue eligibility; and
- The child must be incapable of self-sustaining employment because of mental illness or intellectual or physical disability that occurred prior to turning age 26.
- The child must be principally dependent (more than 50%) on the covered employee, retiree, survivor or COBRA subscriber for support and maintenance; and
- The child must have been covered continuously as a dependent prior to the age of incapacitation and since attaining the age of 26.

You need to establish incapacitation no later than 31 days after the child's 26th birthday, when they are otherwise no longer eligible for coverage as a child, or within 31 days of initial enrollment. For Dependent Life-Child coverage, you need to establish incapacitation no later than 31 days after their 19th birthday if they are not a full-time student.

Generally, letters will be sent 90 days before coverage will be lost. If you receive such a letter, take action as soon as possible to prevent issues from occurring during the transition.

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

PEBA will send your submitted information to Standard Insurance Company for review of the medical information.

Additional medical documentation from the child's physician might be required by The Standard. The Standard will provide a recommendation to PEBA; however, PEBA makes the final decision.

Coverage under Dependent Life-Child insurance

According to state law, only a dependent child ages 19 through 24 who is a full-time student, not married or working full-time can be covered under Dependent Life-Child insurance. A child of any age who has been certified by PEBA as an incapacitated child can continue to be covered under Dependent Life-Child. For more information about eligibility for Dependent Life-Child coverage, see Page 97.

A survivor

Spouses and children covered under the State Health Plan, Dental Plus, Basic Dental or State Vision Plan are classified as survivors when a covered employee or retiree dies. For more information about survivor coverage, see Page 27.

Initial enrollment

Employees

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

Your benefits administrator will initiate the enrollment process. Your coverage starts on the first calendar day of the month in which you become eligible for coverage³ if you

are engaged in active employment⁴ that day.

- If your date of hire is the first working day of the month (the first day that is not a Saturday, Sunday or observed holiday), and it is not the first calendar day, you can choose to have your coverage start on the first day of that month (retroactive premiums may be owed) or the first day of the next month.
- If your date of hire is the first of the month (i.e., March 1), your coverage starts on the first of that month (retroactive premiums may be owed).
- If you become eligible on a day other than the first calendar day or first working day of the month, your coverage starts on the first day of the next month.
- Coverage of your enrolled spouse or children begins on the same day your coverage begins.
- You must make any initial coverage elections within 31 days of the date you become eligible for active benefits.

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

Retirees

If you are an eligible retiree of a participating group, you can enroll in insurance coverage within 31 days of the date you leave covered employment and are eligible to retire, or during open enrollment. You can also enroll your eligible spouse and/or children. A participating group is a state agency, public higher education institution, public school district, county, municipality or other group, including charter schools, that is authorized by statute to participate and is participating in the state insurance benefits program.

³ Life insurance coverage is subject to the Dependent Non-confinement Provision (Page 97) as well as the Actively at Work requirement (Page 94). For more information about initial enrollment in Optional Life Insurance, see Page 95.

⁴ Active employment means performing all the regular duties of an occupation on an employer's scheduled workday. You might be working at your usual workplace or elsewhere, if you are required to travel. You are also considered engaged in active employment while on jury duty, on a paid vacation day or on one of your employer's normal holidays if you were engaged in active employment on the previous regular workday. Coverage will not be delayed if you are absent from work due to a health-related reason when your coverage would otherwise start.

An *Employment Verification Record* form is required for a determination of eligibility and a *Retiree Notice of Election* is required to enroll. Allow additional processing time for paper forms.

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

You can learn more about insurance coverage in retirement, including how to enroll, in the **Retiree group insurance** chapter on Page 135.

Submitting your enrollment

In some cases, such as losing other group coverage, you might not have the appropriate documentation before your enrollment deadline. If the deadline to enroll is nearing, submit your election of benefits without your documentation before the deadline. Then, submit your documentation as soon as it is available. When enrolling in benefits due to marriage, do not wait for your name change documents before submitting your enrollment. Coverage changes are not guaranteed and will not be processed until all documents have been received; however, your effective date will remain the date you experienced your special eligibility situation.

Information you need at enrollment

To enroll in insurance coverage, you will need the information listed below.

	Required information
For you	Social Security number; personal email address; annual salary; date of hire (date you report to work). Use your legal name.
For each family member you want to cover	Social Security number; date of birth. Use legal names.
For you and any family members who are covered by Medicare Part A or Part B	Copy of Medicare card; reason for eligibility; effective date of Medicare coverage.
For each beneficiary of your Basic or Optional Life coverage	Date of birth; Social Security number preferred, but not required.
For a beneficiary that is an estate or a trust	Name; address; date trust was signed.

Documents you need at enrollment

You must provide the documentation listed on the next page to enroll dependents in insurance coverage during open enrollment or as a result of a special eligibility situation. We strongly encourage employees to upload documentation online during the enrollment process or through MyBenefits.

If you choose to mail copies to PEBA, do not highlight or make notes on the documents. Also, do not submit original documents to PEBA, as they cannot be returned. Allow additional time for processing.

	Required information
To cover a spouse	Marriage license
To cover a natural child	Long-form birth certificate showing subscriber as parent
To cover a stepchild	Long-form birth certificate showing name of natural parent; proof that natural parent and the subscriber are married
To cover an adopted child or a child placed for adoption	Long-form birth certificate showing subscriber as parent or legal adoption document from court stating adoption is complete; or a letter of placement from an attorney, an adoption agency, or the South Carolina Department of Social Services stating adoption is in progress
To cover a foster child	A court order or another legal document placing child with subscriber
To cover other children	For all other children for whom subscriber has legal custody, a court order or other legal document granting custody of child to subscriber (document must verify subscriber has guardianship responsibility for child, not just financial responsibility)
To cover an incapacitated child	<i>Incapacitated Child Certification</i> form (see the Incapacitated child section on Page 14 for complete information on the process); plus proof of the relationship
To enroll in the TRICARE Supplement Plan	Subscriber's TRICARE ID card

Any documentation in a language other than English must be completely translated into English and should be certified with a letter of accuracy from the translator.

Completing your initial enrollment

Your benefits administrator will initiate the enrollment process. You will need to provide a valid personal email address to your employer, then make your elections online by following the instructions in the email you receive from PEBA. View the *2027 Insurance Summary* and other online publications, presentations and flyers on [PEBA's website](#) for information about the benefits.

You can upload required documentation during the enrollment process or provide copies of any documents to your benefits administrator who will upload or mail them to PEBA. Original documents mailed to PEBA will not be returned.

PEBA encourages benefits administrators to initiate enrollment online for security and efficiency. For retirees, or if you or your benefits administrator submit a *Notice of Election*:

- Fill out the form completely and write clearly.
- Under each benefit, choose a plan or mark Refuse. When applicable, select a coverage level.
- Be sure to review the form for accuracy, sign it, and include copies of the required documents.

After your initial enrollment

Insurance cards

If you enroll in the State Health Plan Standard Plan, Savings Plan or Medicare Supplemental Plan, BlueCross BlueShield of South Carolina sends health insurance cards for you and your covered family members. Only the subscriber's name will be on the cards, but all covered family members can use them. You will also receive two pharmacy benefits cards from Caremark. Dental Plus subscribers also receive an insurance card from BlueCross, which serves as the dental plan vendor. There are no insurance cards provided to subscribers who elect Basic Dental coverage. State Vision Plan subscribers receive two cards from EyeMed Vision Care.

You can access digital copies of your insurance ID cards from the BlueCross, Caremark and EyeMed mobile apps.

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

Benefits Identification Number

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

The State Health Plan adds a three-letter prefix to your BIN and places this number on your ID card. The BIN, along with the three-letter prefix, is also used on Dental Plus cards. The BIN without the three-letter prefix is used on prescription benefit cards. If you are not covered by a plan that uses the BIN, PEBA will send you your number.

Subscribers need their BIN, without the prefix, to use MyBenefits, PEBA's online insurance benefits enrollment system. If you forget your BIN, go to the [MyBenefits](#) homepage and select Get my BIN.

When medical emergencies occur before you receive your card

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

To do this, go to the [MyBenefits](#) homepage and select Get my BIN. You should then give your BIN to your medical care provider. If you have problems or questions when trying to get verification of your benefits, you or the emergency medical care provider should contact BlueCross for assistance.

Enrolling as a transferring employee

PEBA considers you a transfer if you move from one participating employer to another participating employer with no break in benefits or within 15 calendar days.

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

If you are an academic employee, you are considered a transfer if you complete a school term and move to another participating academic employer at the beginning of the next school term, even if you do not work over the

summer. Your insurance coverage with the employer you are leaving will remain in effect until you begin work with your new employer, typically August 1 or September 1 for academic employees, as long as you pay your premiums. On that date, your new employer will pick up your coverage (on your date of hire). You will need to contact your former employer, however, to continue coverage during the summer. If you do not transfer to another participating academic employer, your coverage ends the last day of the month in which you were engaged in active employment. Your premiums should be deducted from your final wages, or you should arrange to make payment to the employer you are leaving to avoid a break in coverage. Any break in coverage can impact your eligibility for retiree coverage.

Annual open enrollment

During the October open enrollment period, eligible employees, retirees, survivors, COBRA subscribers and former spouses can change their coverage⁵ without needing a special eligibility situation.

Changing plans or coverage during an open enrollment period

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

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

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

coverage for yourself, your eligible spouse and eligible children during open enrollment in odd-numbered years.

- You can add or drop State Vision Plan coverage for yourself, your eligible spouse and eligible children during open enrollment.
- You can enroll in the Pretax Group Insurance Premium feature; or enroll in or reenroll in a MoneyPlus flexible spending account.
- You can enroll in a Health Savings Account, if eligible.

Other changes you make in your coverage, such as changes to life insurance and long term disability, might require medical evidence. Details about what changes you can make are explained prior to each open enrollment.

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

MyBenefits

PEBA's online insurance benefits enrollment system

The easiest way to manage your insurance coverage is through [MyBenefits](#). If you're the subscriber, you can use MyBenefits to:

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

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

claims.

To protect the confidentiality of your insurance information, you must register the first time you use MyBenefits. Some restrictions apply. If you cannot access MyBenefits, contact your benefits administrator.

Special eligibility situations

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

As an active employee, you can make changes using [MyBenefits](#) if you have a special eligibility situation, such as adding a newborn, marriage, divorce or adoption. MyBenefits will display the documentation required for each change, and you can upload the required documents through MyBenefits.

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

- Complete and return to your benefits administrator a *Notice of Election* within 31⁷ days of the event; and
- Upload documentation to [MyBenefits](#) or give documentation to your benefits administrator.

If you are an active employee and are eligible to change your health, dental, vision or Optional Life insurance coverage due to a special eligibility situation, you can also enroll in or drop the Pretax Group Insurance Premium Feature, which is explained on Page 120.

Marriage

If you want to add a spouse to your coverage because you marry, log in to MyBenefits and select the appropriate change reason within 31 days of the date of your marriage. The effective date of coverage, with the exception of Dependent Life-Spouse coverage, is the date of marriage. For information about the effective date of Dependent Life-Spouse coverage added due to marriage, see Page 98. The required documents can be uploaded through MyBenefits.

⁶ A salary increase or decrease, or transfer does not create a special eligibility situation.

⁷ Changes related to Medicaid or the Children's Health Insurance Program (CHIP) must be made within 60 days.

To make the change through your benefits administrator, complete a *Notice of Election* and submit it to your benefits administrator, along with a copy of your marriage license, within 31 days of the date of your marriage.

If you and your eligible dependents are not covered, you can add health, dental and vision coverage for yourself, your existing eligible dependents, your new spouse and new stepchildren within 31 days of the date of your marriage. If you add your new spouse or new stepchildren to your health coverage, you can also change health plans. You can add your new spouse or new stepchildren to dental and State Vision Plan coverage. A copy of the marriage license is required to cover the new spouse. Long-form birth certificates are required for each stepchild you want to cover. Marriage also allows a covered subscriber to enroll in or increase Optional Life coverage up to \$50,000 without medical evidence. For information about eligibility for Dependent Life -Spouse coverage, including amounts in which a newly eligible spouse can enroll without medical evidence, see the Dependent Life insurance section, which begins on Page 96 in the **Life insurance** chapter of this guide.

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

Divorce

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

Because former spouse coverage is linked to the sponsor (employee or retiree), if the sponsor loses coverage, the former spouse also loses coverage.

To cover a former spouse, the former spouse must complete a *Former Spouse Notice of Election* within 31 days from the date the divorce is finalized and submit it to PEBA along with a copy of the divorce decree ordering you to cover your former spouse.

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

To make the change through your benefits administrator, complete a *Notice of Election* and submit a complete copy of your divorce decree within 31 days of the date stamped on the divorce decree. If the *Notice of Election* isn't submitted within 31 days of date of divorce, former spouse coverage cannot be elected. Coverage for your former spouse and former stepchildren will end the last day of the month after the date stamped on the divorce decree. If you drop your former spouse or former stepchildren from coverage after 31 days of the date stamped on the court order or divorce decree by the court, the change in coverage is effective the first of the month after your signature on a completed *Notice of Election* dropping your former dependents.

You cannot continue to cover your former spouse or former stepchildren under Dependent Life insurance under any circumstances. Dependent Life coverage ends the last date of the month in which the divorce is final.

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

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

Former spouses and former stepchildren who lose coverage due to a qualifying event, such as divorce, might be eligible to continue coverage under COBRA. For more information, contact the subscriber's benefits administrator or PEBA within 60 days after the event or from when coverage would have been lost due to the event, whichever is later.

Adding children

Eligible children can be added through [MyBenefits](#) by selecting the appropriate change reason. You can upload the required documents through [MyBenefits](#). To make the change through your benefits administrator, complete a *Notice of Election*. The change must be submitted to PEBA within 31 days of:

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

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

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

An employee also can enroll in Dependent Life-Child insurance.

Children must be enrolled individually to be covered, even if you already have full family or employee/children coverage. You must also submit a copy of the child's long-form birth certificate. Notification to Medi-Cal of the delivery of your baby does not add the baby to your health insurance. See Page 97.

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

To add a child younger than age 18 who is adopted or

placed for adoption, submit one of the following:

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

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

To add a foster child, submit a copy of a court order or another legal document placing the child with you, the subscriber. A foster child is not eligible for Dependent Life coverage.

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

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

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

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

Dropping a spouse or children

If a covered spouse or child becomes ineligible (i.e., because of divorce), you must drop them from your health, dental, vision and Dependent Life coverage. To drop a spouse or child from your coverage, log in to [MyBenefits](#) and select the appropriate change reason within 31 days of the date they become ineligible and upload documentation.

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

Eligibility for Dependent Life-Child coverage ends at age 19 unless the child is a full-time student or an incapacitated child. The subscriber is responsible for removing an ineligible child from Dependent Life-Child coverage.

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

Gaining other coverage

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

If you, your spouse or children gain coverage outside of insurance benefits through PEBA, and you want to drop your PEBA insurance coverage for yourself or any dependents, you have 31 days to cancel the type of coverage gained. You must complete a *Notice of Election* and return it to your benefits office with proof of the other coverage. To document gaining coverage, you must present documentation that includes the effective date of coverage, names of all individuals covered and the types of coverage gained (e.g., letter on letterhead, email from benefits office, copy of insurance card, etc.). Only those

who gained coverage can be dropped. If you fail to cancel coverage within 31 days, you must wait until the next open enrollment period. For more information, contact your benefits administrator or PEBA.

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

Gaining Medicare coverage

If you are an active employee, and you, your spouse or your child gains Medicare coverage, the family member who gained coverage can drop health coverage through PEBA within 31 days of when Part A becomes effective.⁸ Attach a copy of the Medicare card to a *Notice of Election* and give it to your benefits administrator within 31 days of the date on the confirmation letter from the Social Security Administration. Coverage will be canceled on the effective date of the Medicare Part A coverage or, in some circumstances, the first of the month after gaining Medicare.

A retiree, spouse or survivor who gains Medicare Part A coverage can enroll in the Medicare Supplemental Plan by submitting a *Notice of Election* within 31 days of the gain of Medicare Part A coverage. If you are a retiree who is not eligible for Medicare, but your spouse or child is, you have the option to enroll in the Medicare Supplemental Plan. Family members who are not eligible for Medicare will be covered under the Standard Plan provisions. A COBRA subscriber who gains Medicare coverage is ineligible to continue COBRA coverage.

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

For more information, see the *Insurance Coverage for the Medicare-eligible Member* handbook, available on our [Publications webpage](#) under Health.

⁸ Active employees or their dependents who become eligible for Medicare cannot enroll in the Medicare Supplemental Plan.

Loss of other coverage

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

- If you are the employee or retiree and you lose other group health coverage, and you are not already covered by health insurance through PEBA, you can enroll yourself and your eligible dependents in health, dental and vision coverage. If you are already covered by health insurance, you cannot make changes.
- If your hours were reduced and you lost coverage while not in a stability period, and you are otherwise eligible to be covered as a spouse or a child on your spouse's or parent's plan, you can enroll in health, dental and vision coverage.
- If you are the employee or retiree and have a spouse or child who loses other group health coverage, you can enroll the eligible spouse and children in health, dental and vision coverage. If you are not already covered, you must enroll yourself with the individual who lost coverage. Other dependents who did not lose health insurance coverage cannot be enrolled. If you are already covered as an employee or retiree, you can change health plans (i.e., Savings Plan to Standard Plan) when you add the spouse or children who lost health insurance coverage. Contributions toward your deductible will start over.
- If you, your spouse or children lose dental coverage, vision coverage or both but do not lose health coverage, then you, your spouse or children who lost the dental or vision coverage can enroll in the type of coverage that was lost. If you are not already covered, you must enroll yourself with the individual who lost coverage.
- If you refused coverage because you were covered under your parent's plan and you lose that coverage, you can enroll yourself and your eligible family members in health, dental and vision coverage. Optional Life, Dependent Life-Spouse and/or Supplemental Long Term Disability insurance requires

medical evidence. Dependent Life-Child can be added throughout the year without medical evidence. To enroll, contact your benefits administrator.

- Loss of TRICARE coverage is a special eligibility situation that permits an eligible employee or retiree and their eligible dependents to enroll in health, dental and vision coverage.
- If you, your spouse or children are released from incarceration, the released person has experienced a loss of coverage and is eligible to elect coverage within 31 days.

You must complete a *Notice of Election* within 31 days of the date the other coverage ends. To enroll because of a loss of coverage, you must give your benefits office documentation that includes the names of those covered and the date coverage was lost (e.g., letter on letterhead, email from benefits office, copy of insurance card, etc.). You must also submit a completed *Notice of Election* and copies of appropriate documents showing how any added family member is related to you. If a subscriber, spouse or child loses health coverage, they also can enroll in vision or dental coverage, even if they did not lose that coverage.

Coverage under Medicaid or the Children's Health Insurance Program

Gaining Medicaid or CHIP coverage

If you or your covered family members become eligible for Medicaid or CHIP coverage, you have 60 days from the date of notification to drop coverage through PEBA. An employee can cancel health, dental or vision coverage if they gain Medicaid coverage. If a spouse or a child gains Medicaid, only the family member who gained coverage can be dropped. A copy of the Medicaid approval letter must be attached to the *Notice of Election*.

Eligibility for premium assistance through Medicaid or CHIP

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

Loss of Medicaid or CHIP coverage

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

Leaves of absence

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

Premiums while on unpaid leave

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

If you are on unpaid leave and in a stability period, your insurance will continue as long as you pay premiums. If you fail to make payment for the health plan in which you are enrolled through PEBA, your employer can terminate all your coverage with PEBA as a voluntary termination. Because you are voluntarily dropping coverage, neither you nor any of your dependents will be eligible for continued coverage under COBRA. If you drop coverage, you will be permitted to reenroll only during open enrollment or within 31 days of gaining eligibility under a provision of the Plan, such as a special eligibility situation. You should consult with your employer to confirm your stability status.

If your coverage is canceled due to failure to pay premiums, you will not be eligible for COBRA continuation coverage, and you will not be eligible to reenroll in benefits with your employer until the next open enrollment period, if you are eligible, or within 31 days of gaining eligibility under a provision of the Plan. For more information on continuation of coverage under COBRA, see Page 25.

A period of unpaid leave might also affect your eligibility for retiree health insurance coverage if you are not earning retirement service credit at any point during the leave. Retirement service credit purchased for an approved leave of absence is not considered earned service in a PEBA-administered retirement plan, except in certain

circumstances. If you have questions about how a period of unpaid leave might affect your eligibility for retiree health insurance coverage, contact PEBA. For more information about eligibility for retiree group insurance, see Page 135.

Life insurance while on unpaid leave

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

Supplemental Long Term Disability insurance while on paid or unpaid leave

Your Supplemental Long Term Disability insurance will end 31 days from your last day worked. There is no option to continue SLTD; however, you can convert your SLTD coverage. Learn more on Page 115 or contact your benefits administrator.

Family and Medical Leave Act leave

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

Military leave

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

Workers' compensation

If you are on approved leave and receiving workers' compensation benefits under state law, you can continue your coverage if you pay the required premium. Insurance offered through PEBA is not meant to replace workers' compensation and does not affect any requirement for coverage for workers' compensation insurance. It is not

intended to provide or duplicate benefits for work-related injuries that are within the Workers' Compensation Act. If you need more information, contact your benefits office.

When coverage ends

Your coverage will end:

- The last day of the month in which you were engaged in active employment, unless you are transferring to another participating group;
- The last day of the month in which you become ineligible for coverage (i.e., your working hours are reduced from full-time to part-time while not in a stability period);
- The day after your death;
- The date the coverage ends for all subscribers; or
- The last day of the month in which your premiums for all coverage were paid in full. You must pay the entire premium, including the tobacco-use premium, if it applies.

Coverage for your spouse and children will end:

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

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

A *Certificate of Creditable Coverage* is available upon request. It lists the dates of your active coverage, names of covered individuals and types of coverage. Contact [PEBA Customer Service](#) to submit a request.

Continuation of coverage

Eligibility

COBRA, the Consolidated Omnibus Budget Reconciliation Act, requires that continuation of group health, vision, dental or Medical Spending Account coverage⁹ be offered to you and your covered spouse and children if you are no longer eligible for coverage due to a qualifying event.

Qualifying events include:

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

PEBA serves as the benefits administrator for COBRA subscribers of state agencies, public higher education institutions, public school districts and charter schools that participate in both insurance and retirement. COBRA subscribers from participating optional employers or charter schools that participate in insurance only keep the same benefits administrator.

Selman & Company offers continuation coverage for TRICARE Supplement Plan subscribers. Terminated employees can continue coverage until age 65. Subscribers will receive a termination letter about the option of continuation on a direct bill portability basis, and subscribers will be direct billed by Selman & Company.

When continued coverage will not be offered

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

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

⁹ Individuals eligible for continued coverage under COBRA can continue to participate in a Health Savings Account as long as they remain covered by the Savings Plan and meet other eligibility requirements.

request; or

- When a member is otherwise deemed ineligible.

How to continue coverage under COBRA

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

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

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

Example COBRA scenario

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

How continued coverage under COBRA might end

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

1. A subscriber fails to pay the full premium on time;
2. A qualified beneficiary becomes entitled to Medicare;
3. An event occurs that would cause PEBA to end the coverage of any subscriber, such as the subscriber commits fraud;
4. A qualified beneficiary gains coverage under another

group health plan;

5. During a disability extension, the Social Security Administration determines the qualified beneficiary is no longer disabled; or
6. PEBA no longer provides group health coverage.

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

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

When benefits provided under COBRA run out

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

Extending continued coverage

If you enroll in continued coverage under COBRA due to termination or a reduction in hours, an extension of the maximum period of coverage might be available if you, as a qualified beneficiary, are disabled or a second qualifying event occurs. You must notify your COBRA administrator, within certain time frames, of a disability or a second qualifying event to extend the period of continued

coverage. Failure to provide timely notice of a disability or a second qualifying event might affect the right to extend the period of continued coverage under COBRA.

Other coverage options

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

Death of a subscriber or covered spouse or child

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

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

If your covered spouse or child dies, contact your benefits administrator. PEBA serves as the benefits administrator for retirees of state agencies, public higher education institutions, public school districts and charter schools that participate in both insurance and retirement.

Retiree subscribers of participating optional employers and charter schools that participate in insurance only keep the same benefits administrator from their former employer.

Survivors

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

When a covered employee dies, their spouse and children who are covered under the State Health Plan are eligible as survivors to receive a one-year waiver of their health

insurance premiums, including the tobacco-use premium, if it applies.

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

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

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

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

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

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

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

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

Ongoing eligibility and open enrollment for survivors

A surviving spouse can continue coverage until the spouse remarries. A child can continue coverage until they are no longer eligible. See the Eligible children section on Page 13 for more information. Notify PEBA within 31 days of loss of eligibility for coverage. A person who is no longer eligible for coverage as a survivor might be eligible to continue coverage under COBRA. Contact PEBA for details.

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

If a survivor drops health, vision and dental insurance, they are no longer eligible as a survivor and cannot reenroll in coverage, even during open enrollment.

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

Appeals of eligibility determinations

What if I disagree with a decision about eligibility?

Below is a summary of the eligibility rules for benefits offered through PEBA, but eligibility determinations are subject to the provisions of the *Plan of Benefits* and to federal and state law.

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

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

If you disagree with the decision, you can appeal by sending an [Appeal Request Form](#) to PEBA within 90 days of notice of the decision. Include a copy of the decision letter with your appeal. Send the request to:

IAD@peba.sc.gov

or

S.C. PEBA

Attn: Insurance Appeals Division

202 Arbor Lake Drive

Columbia, SC 29223

Appeals can be brought only by the covered person at issue, their legal representative (who cannot be, including but not limited to, a provider, medical device manufacturer, pharmaceutical manufacturer, employer, or a representative or agent of any of the foregoing), or a licensed attorney admitted to practice in South Carolina.

PEBA will make every effort to process your appeal within

180 days of the date it receives your appeal information. However, this time might be extended if additional material is requested or you ask for an extension. PEBA will send you status updates. When PEBA's review of your appeal is complete, you will receive a written determination.

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



Health insurance

Your State Health Plan choices

The State Health Plan offers the Standard Plan, the Savings Plan and, if you are retired and eligible for Medicare, the Medicare Supplemental Plan. Eligible members of the military community can enroll in the TRICARE Supplement Plan (Page 65).

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

Standard Plan

The Standard Plan has higher premiums but lower annual deductibles than the Savings Plan. When one family member meets their deductible, the Standard Plan will begin to pay benefits for them, even if the family deductible has not been met. When you buy a prescription drug with the Standard Plan, you pay only the required copayment rather than paying the full allowed amount. An allowed amount is the most a health plan allows for a covered service or product, whether it is provided in network or out of network. When providers join the network, they agree to provide prescriptions when members provide only a copayment.

Savings Plan

As a Savings Plan subscriber, you save money through lower premiums and take greater responsibility for your healthcare costs through a higher annual deductible. You pay the full allowed amount for covered medical benefits, including behavioral health benefits such as mental health and substance use benefits, as well as prescription drug benefits, until you reach the deductible. With the Savings Plan, the family deductible must be met before any member receives payment for benefits. The Savings Plan's status as a tax-qualified, high-deductible health plan means it offers the advantage of a Health Savings Account. HSAs are available only when you meet the following criteria:

- You are enrolled in the Savings Plan;
- You are not enrolled in any other plan, except in cases in which the other plan is also a high-deductible plan (Medicare is not a high deductible plan); and
- You are not claimed as a dependent on another

person's tax return.

Funds in an HSA can be used to pay qualified medical expenses for the subscriber and dependents, and funds can roll over from one year to the next.

Medicare Supplemental Plan

To learn about how the Medicare Supplemental Plan works with Medicare, see the *Insurance Coverage for the Medicare-eligible Member* handbook on our [Publications webpage](#) under Health.

Comparing the plans

The chart on Page 32 illustrates how your deductible, copayments and coinsurance work together, as well as other features of the Standard Plan and Savings Plan.

This overview is for comparison only. The *Plan of Benefits*, which includes a complete description of the Plan, governs the Standard, Savings and Medicare Supplemental plans offered by PEBA. It is available on our [Publications webpage](#).

Comparison of health plans¹

	Standard Plan ²	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. ³
Coinsurance⁴ Maximum excludes copayments and deductible	In network, you pay 20% up to \$3,000 per individual or \$6,000 per family. Out of network, you pay 40% up to \$6,000 per individual or \$12,000 per family.	In network, you pay 20% up to \$3,000 per individual or \$6,000 per family. Out of network, you pay 40% up to \$6,000 per individual or \$12,000 per family.
Physician's office visit⁵	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^{6,7}	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 hospitalization⁸	You pay the full allowed amount until you meet your deductible. Then, you pay your coinsurance.	You pay the full allowed amount until you meet your deductible. Then, you pay your coinsurance.
Chiropractic	\$2,000 limit per covered person	\$500 limit per covered person
Prescription drugs⁹ 30-day supply/90-day supply ¹⁰ at a network pharmacy	Tier 1 (generic): \$13/\$32 Tier 2 (preferred brand): \$46/\$115 Tier 3 (non-preferred brand): \$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 annual deductible. Then, you pay your coinsurance. Drug costs are applied to your coinsurance maximum. When you reach the maximum, you pay nothing.
Tax-favored accounts	Medical Spending Account	Health Savings Account Limited-use Medical Spending Account

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

2 See the *Insurance Coverage for the Medicare-eligible Member* handbook, located on the [Publications webpage](#), for information on how this Plan coordinates with Medicare.

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

4 An out-of-network provider can bill you for more than the State Health Plan's allowed amount. Learn more about out-of-network benefits on Page 42.

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

6 The \$115 copayment for outpatient facility services is waived for emergency room services, oncology services, dialysis clinic visits, partial hospitalizations, intensive outpatient services, electroconvulsive therapy and psychiatric medication management.

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

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

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

10 You will pay a lower copayment for a 90-day supply of prescription drugs at your local network pharmacy that participates in the Retail90 Network than if you purchased the medication one month at a time.

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 with no maximum.
Physician's office visit	Plan pays Part B coinsurance of 20%.
Inpatient hospitalization/ nursing facility care	Inpatient hospital stays Plan pays Medicare deductible, coinsurance for days 61-150 (Medicare benefits might end sooner if the member has previously used any of their 60 lifetime reserve days); Plan pays 100% beyond 150 days (Medi-Call approval required). Skilled nursing facility care Plan pays coinsurance for days 21-100; plan pays 100% of approved days beyond 100 days, up to 60 days per year.
Prescription drugs^{11,12} 30-day supply/90-day supply at a network pharmacy	Tier 1 (generic): \$13/\$32 Tier 2 (preferred brand): \$46/\$115 Tier 3 (non-preferred brand): \$77/\$192 You pay up to \$2,000 in prescription drug copayments. Then, you pay nothing.

11 Prescription drugs are not covered at out-of-network pharmacies. Part B prescriptions covered under the medical benefit might require prior authorization by CMS. Medicare primary members should use a network pharmacy that accepts Medicare.

12 Medicare rules apply.

Your online State Health Plan tools

These websites cover information specific to your health and dental benefits. Learn more about online tools for your prescription benefits on Page 68 and State Vision Plan benefits on Page 86.

StateSC.SouthCarolinaBlues.com

The BlueCross website for State Health Plan subscribers offers:

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

My Health Toolkit®

Register and log in so you can:

- Update other health and dental insurance information;
- See how much of your deductible and coinsurance maximum you have satisfied;
- Use the Find Care tool for locating network providers, including behavioral health and dental providers;
- Check the status of claims, prior authorizations and bills for health and dental providers;
- View your Explanation of Benefits online rather than by a mailed paper copy;
- Request a benefits ID card;
- Complete a personalized health assessment in Personify Health Personal Health to enroll in the No-Pay Copay program if you have a qualifying chronic condition;
- Connect with a care manager and access wellness information; and
- Send questions to BlueCross Customer Service.

You can also download the My Health Toolkit mobile app to access your benefits on-the-go.

Personify Health

Personify Health is a digital health platform available to eligible State Health Plan members with certain chronic conditions. The program offers personalized tools, activities and resources designed to help members manage their chronic condition, build healthy habits and improve their overall health. Participation in Personify Health provides access to the No-Pay Copay program, which helps eligible members save money on certain prescription drugs by completing required program activities.

Companion Benefit Alternatives

On the Member section of [Companion Benefit Alternatives' website](#), you can find:

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

Blue CareOnDemandSM

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

Blue CareOnDemand is not available to Medicare primary members.

Medical visits

Blue CareOnDemand participating doctors are trained to treat patients through virtual technology, following strict protocols specific to video visits and using best practices for website manner. As part of these protocols, the provider panel treats common urgent care diagnoses including

sinusitis, respiratory infection, bronchitis, pink eye and cough as opposed to more severe conditions requiring comprehensive care. If a video visit isn't the right type of service for you, you will be referred to a more appropriate point of service and assisted to ensure you get needed care. Blue CareOnDemand permits doctors to see patient-supplied background information prior to consultations, and it connects with BlueCross' membership system to confirm your eligibility and determine the correct amount of your patient cost share.

This video visit option is covered as a traditional office visit under each Plan. For example, if you have the Standard Plan, a visit before you meet your deductible can total \$65, and after you meet your deductible can total \$28. If you have the Savings Plan, a visit before you meet your deductible can total \$65, and after you meet your deductible can total \$13.

Behavioral health visits

Don't let emotional difficulties affect your well-being. Video chat with a licensed counselor, therapist, psychologist or psychiatrist from the comfort of your home. And, help doesn't have to stop after your first consultation. Continue follow-up visits as long as you need to. Appointments are available at the time and frequency that are right for you. You pay a \$15 copayment,¹³ plus the remaining allowed amount until you meet your deductible. Visit the [Blue CareOnDemand website](#), or download the free app today to schedule your first appointment.

MUSC Health Virtual Care

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

Members ages 18 and older can create an account. Visits for dependent children younger than age 18 must be completed by a parent. You do not need to be a South

Carolina resident; however, you must be in the state at the time of the visit.

Learn more about [MUSC Health Virtual Care](#).

How the State Health Plan pays for covered benefits

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

- BlueCross serves as the medical claims processor, handling health claims, behavioral health and dental claims. Medi-Call, a division of BlueCross, provides medical prior authorization and case management services. For more information about Medi-Call, see Page 44.
- Companion Benefit Alternatives, a wholly owned subsidiary of BlueCross, is the behavioral health manager, handling mental health and substance use treatment prior authorization, case management, and provider networks. For more information, see Claims.

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

Allowed amount

The allowed amount is the maximum amount a plan will pay for a covered service. Network providers accept the allowed amount as their total fee, leaving you responsible only for copayments and any coinsurance after your annual deductible is met. Savings Plan subscribers do not pay copayments, but rather the full allowed amount until the deductible is met. For out-of-network services, you pay more in coinsurance, and the provider might charge more than the allowed amount. See balance billing on Page 42.

¹³ Savings Plan members do not pay copayments for any visits but will pay the full allowed amount until meeting their deductible.

Paying healthcare expenses with the Standard Plan

Annual deductible

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

- \$515 for individual coverage; and
- \$1,030 for family coverage.

Families enrolled in the Standard Plan have the same deductible, no matter how many family members are covered. The family deductible can be met by any combination of two or more family members' covered medical expenses as long as they total \$1,030. For example, if four people each have \$257.50 in covered expenses, the family deductible has been met, even if no one person has met the \$515 individual deductible. If only one person has met the \$515 individual deductible, the Plan will begin paying a percentage of the cost of that person's benefits but not a percentage of the cost of the rest of the family's benefits until the family deductible has been met. No family member's claims can contribute more than \$515 toward the family deductible.

If the subscriber and the subscriber's spouse, who is also covered on their own plan as an employee or retiree, select the same health plan, they share the family deductible. Both spouses will need to be listed on the same *Notice of Election* in this case.

Payments for non-covered services, copayments and penalties for not calling Medi-Call, Evolent or Companion Benefit Alternatives for the appropriate prior authorization do not count toward the annual deductible.

Copayments

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

Standard Plan subscribers pay these copayments:

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

The copayment for each visit to a professional provider's office is \$15. This copayment is waived for routine Pap tests, routine mammograms, adult well visits, well woman visits and well child care visits.

The example on Page 37 uses a physician's office visit that has a \$56 allowed amount in the Standard Plan.

The copayment for outpatient facility services, which includes outpatient hospital services other than emergency room visits and ambulatory surgical center services, is \$115. This copayment is waived for oncology services, dialysis clinic visits, partial hospitalization, intensive outpatient services, electroconvulsive therapy and psychiatric medication management. The copayment for each emergency room visit is \$193. This copayment is waived if you are admitted to the hospital.

A prescription drug copayment is a fixed total amount a Standard Plan subscriber pays each time a prescription is filled at a network pharmacy. The prescription drug copayment maximum for each family member covered is \$3,000. Prescription drug copayments do not apply to the annual deductible or the coinsurance maximum. For more information, see Page 69.

Annual deductible has not been met

Allowed amount	\$56.00
Copayment	- \$15.00
Remaining allowed amount	\$41.00
Applies to annual deductible	
Copayment	\$15.00
Amount applied to deductible	+ \$41.00
Your total payment	\$56.00

Annual deductible has been met

Allowed amount	\$56.00
Copayment	- \$15.00
Remaining allowed amount	\$41.00
Applies to annual deductible	
	x 20% ¹⁴
Coinsurance	\$8.20
Copayment	\$15.00
Coinsurance	+ \$8.20
Your total payment	\$23.20

Coinsurance

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

If you use out-of-network providers, the Plan pays 60% of the Plan's allowed amount for your covered medical and behavioral health benefits. You pay 40% of the allowed amount as coinsurance, which applies to your out-of-network coinsurance maximum. An out-of-network provider can bill you more than the allowed amount. Any charge above the Plan's allowed amount for a covered medical or behavioral health benefit is your responsibility. See Page 42 to learn more about balance billing and the out-of-network differential.

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

¹⁴ In this example, the Standard Plan paid 80%, or \$32.80, of the \$41 allowed amount remaining after the copayment.

Coinsurance maximum

The coinsurance maximum is the amount in coinsurance a subscriber must pay for covered benefits each year before they are no longer required to pay coinsurance. For the Standard Plan, it is \$3,000 for individual coverage and \$6,000 for family coverage for network services, and \$6,000 for individual coverage and \$12,000 for family coverage for out-of-network services.

Note the coinsurance for network services does not apply to the out-of-network coinsurance maximum. The coinsurance for out-of-network services does not apply to the in-network coinsurance maximum. For example, if you have individual coverage, the network coinsurance maximum is \$3,000, and you have paid \$2,000 for network coinsurance and \$1,000 for out-of-network coinsurance, you have not met your network coinsurance maximum.

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

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

Paying healthcare expenses with the Savings Plan

Annual deductible

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

- \$4,000 for individual coverage and
- \$8,000 for family coverage.

There is no individual deductible if more than one family

member is covered. If the subscriber and spouse, who is also covered as an employee or retiree, select the same health plan, they will share the family deductible. The deductible is not met for any covered individual until the total allowed amount paid for covered benefits exceeds \$8,000. For example, even if one family member has paid \$4,001 for covered medical benefits, the Plan will not begin paying a percentage of the cost of their covered benefits until their family has paid \$8,000 for covered benefits. However, if the subscriber has paid \$3,999 for covered benefits, the spouse has paid \$3,001 for covered benefits, and a child has paid \$1,000 for covered benefits, the Plan will begin paying a percentage of the cost of the covered benefits for all family members.

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

Copayments

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

Coinsurance

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

If you use out-of-network providers, the Plan pays 60% of the Plan's allowed amount for your covered medical and behavioral health benefits. You pay 40% of the allowed amount as coinsurance. An out-of-network provider can bill you more than the allowed amount. Any charge above the Plan's allowed amount for a covered medical or behavioral health benefit is your responsibility. See Page 42 to learn more about balance billing and the out-of-network differential. Prescription drug benefits are paid only if you use a network pharmacy.

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

Coinsurance maximum

The coinsurance maximum is the amount in coinsurance a subscriber must pay for covered benefits each year before they are no longer required to pay coinsurance. Under the Savings Plan, it is \$3,000 for individual coverage or \$6,000 for family coverage for network services; it is \$6,000 for individual coverage or \$12,000 for family coverage for out-of-network services.

Note the coinsurance for network services does not apply to the out-of-network coinsurance maximum. The coinsurance for out-of-network services does not apply to the network coinsurance maximum. For example, if you have individual coverage and have paid \$2,000 for network coinsurance and \$1,000 for out-of-network coinsurance, you have not met your network coinsurance maximum.

Payments for non-covered services and deductibles do not count toward the coinsurance maximum.

Paying healthcare expenses if you're eligible for Medicare

To learn more about how the Carve-out Plan and the Medicare Supplemental Plan work with Medicare, see the *Insurance Coverage for the Medicare-eligible Member* handbook on our [Publications webpage](#) under Health.

Coordination of benefits

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

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

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

- The plan that covers a person as an employee typically pays before the plan that covers the person as a

dependent.

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

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

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

- For a medical or behavioral health claim, you or your provider files the *Explanation of Benefits* from your primary plan with BlueCross.
- The State Health Plan will pay the lesser of:
 - What it would pay if it were the primary payer; or
 - The balance after the primary plan's network discounts and payments are deducted from the total charge.
- The State Health Plan's prohibition on balance billing does not apply. Because of this, consider using a provider in your primary plan's network.
- You also will be responsible for the State Health Plan copayments, deductible and coinsurance (if the coinsurance maximum has not been met).

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

Coordination of benefits questionnaire

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. Log in to your My Health Toolkit account to update this information. You can also call BlueCross at 803.736.1576 or 800.868.2520.

End stage renal disease

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

The coordination period might be different for covered dependent children with ESRD or who have had a kidney transplant. Learn more on the Medicare website.

Using State Health Plan provider networks

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

If you use an out-of-network medical or behavioral health

provider, or your physician sends your lab tests to an out-of-network provider, you will pay more for your care.

Note that even if you are at a network hospital or a network provider's office, the provider might employ out-of-network contract providers or technicians. If an out-of-network provider renders services, even in a network facility, it can still balance bill you, and you will still pay the out-of-network differential. The [federal No Surprises Act](#) limits when an out-of-network provider can balance bill. For more information, see Page 42.

Finding a medical or behavioral health network provider

To view the online provider directory, go to the [BlueCross state-specific website](#), log in to your My Health Toolkit account, select Resources, then Find Care. Here you can:

- Search for a provider by name, location and specialty;
- Search for emergency room alternatives, which are places you can go for care other than an emergency room, such as urgent care centers and walk-in clinics; and
- If you do not have a My Health Toolkit account, registering is easy. Search My Health Toolkit in your app store. In the app, select Sign Up. Or you can visit the [BlueCross state-specific website](#) and select Create An Account. Then, enter your benefits ID number on your State Health Plan ID card, as well as your date of birth. Follow the steps to complete your account set up.

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

Companion Benefit Alternatives serves as the behavioral health benefits manager, including mental health and substance use benefits. For behavioral health providers, you can use the Find Care tool under Resources in your My Health Toolkit account on the [BlueCross state-specific website](#). For help selecting a provider, call Companion Benefit Alternatives at 800.868.1032.

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

Finding a network provider out of state or overseas

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

Within the United States

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

1. Locate nearby doctors and hospitals by visiting the [BlueCross state-specific website](#).
2. Log in to your My Health Toolkit account, select Resources, then Find Care, or call BlueCard Access at 800.810.2583.
3. Call Medi-Call within 48 hours of receiving emergency care. The toll-free number is on your State Health Plan ID card.

The provider should file claims with the BlueCross affiliate in the state where the services were provided. You should not need to complete any claim forms nor pay up front for medical services other than the usual out-of-pocket expenses (deductibles, copayments, coinsurance and non-covered services). BlueCross will mail an Explanation of Benefits to you.

For information about out-of-network benefits, see Page 42.

Outside the United States

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

Note that Medicare does not offer benefits outside the United States. Because the State Health Plan's Medicare Supplemental Plan does not allow benefits for services not covered by Medicare, Medicare Supplemental Plan subscribers do not have coverage outside the United States;

however, these subscribers have access to BlueCross BlueShield Global Core. See PEBA's *Insurance Coverage for the Medicare-eligible Member* handbook on the [Publications webpage](#) for more information.

Here's how to take advantage of the [BlueCross BlueShield Global Core program](#):

1. If you have questions before your trip, call the phone number on the back of your State Health Plan ID card to check your benefits and for prior authorization, if necessary. Your healthcare benefits might be different outside of the United States
2. The BlueCross BlueShield Global Core Service Center can help you find providers in the area where you are traveling. It can also provide other helpful information about healthcare overseas. Go to the website listed above. You must accept the terms and conditions and log in with the first three letters of your BIN. Then you can Select a Provider Type. You also can choose a specialty, city, nation and distance from the city. You can call toll-free at 800.810.2583 or collect at 804.673.1177, as toll-free numbers do not always work overseas.
3. If you are admitted to the hospital, call the BlueCross BlueShield Global Core Service Center toll-free at 800.810.2583 or collect at 804.673.1177 as soon as possible.
4. The BlueCross BlueShield Global Core Service Center will work with your plan to arrange direct billing with the hospital for your inpatient stay. When direct billing is arranged, you are responsible for the out-of-pocket expenses (non-covered services, deductibles, copayments and coinsurance) you normally pay. The hospital will submit your claim on your behalf.
5. Note if direct billing is not arranged between the hospital and your plan, you must pay the bill up front and file a claim. For outpatient care and doctor visits, pay the provider when you receive care and file a claim.
6. To file a claim for services you paid for when you received care or paid to providers that are not part of the BlueCross BlueShield Global Core network, complete a *BlueCross BlueShield Global Core International Claim Form* and send it to the

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

7. The claim form is on the [BlueCross website](#) under Resources, then Forms and Documents. Then, select the international claim form. You can also call the service center toll-free at 800.810.2583 or collect at 804.673.1177. The address of the service center is on the claim form. BlueCross BlueShield Global Core will arrange billing to BlueCross.

If you need proof of insurance for overseas travel, request it from PEBA in writing. You can do this by going to the [Contact webpage](#) or writing a letter. The request must be made at least 10 working days in advance to ensure you receive it by the desired time.

Concierge care

Some State Health Plan network providers might offer concierge care as part of their approach to patient care. Concierge care could be referred to as concierge medicine, retainer-based medicine, boutique medicine, platinum practice or direct care. Providers who offer concierge care generally charge an annual membership fee before accepting patients or seeing patients for care. The State Health Plan does not cover these membership fees, and network providers cannot make paying a membership fee a condition of accepting you as a patient or of your receiving care under your State Health Plan benefits. As a network provider, they must follow all Plan rules, including accepting the Plan's allowed amounts for services and not charging extra for covered services. This means a provider's membership fee cannot include additional charges for services or items the State Health Plan normally covers.

Prescription drug provider network

For more information about your prescription drug provider network, see Page 70.

Out-of-network benefits

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

Before the State Health Plan will pay 100% of the Plan's allowed amount for out-of-network benefits, Standard Plan subscribers will need to meet their annual deductible, and then meet the \$6,000 individual out-of-network coinsurance maximum or \$12,000 family out-of-network coinsurance maximum. Savings Plan subscribers will need to meet their annual deductible, and then meet the \$6,000 individual coinsurance maximum or \$12,000 family coinsurance maximum. Subscribers to both plans also might need to complete claim forms.

Note that no benefits can be paid for advanced radiology services (CT, MRI, MRA or PET scans) that are not preauthorized by Evolent.

There is no coverage available for prescription drugs filled at an out-of-network pharmacy in the United States. Limited drug coverage is offered to members enrolled in the State Health Plan Prescription Drug Program who become ill while traveling overseas. For more information, see Page 70.

Balance billing

If you use a provider that is not part of the network, you might be balance billed. When the State Health Plan is your primary coverage, network providers are prohibited from billing you for covered benefits except for copayments, coinsurance and the deductible. However, an out-of-network provider can bill you for more than the Plan's allowed amount for the covered benefit (up to the provider's charges), which will increase your out-of-pocket cost.¹⁵ The difference between what the out-of-network provider charges and the allowed amount is called the balance bill. The balance bill does not contribute toward meeting your annual deductible or coinsurance maximum.

Out-of-network differential

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

In both examples on the following page, you have subscriber-only coverage under the State Health Plan and you have not met your deductible. The allowed amount is \$5,000. The provider charged \$6,000 for the service.

¹⁵ The [federal No Surprises Act](#) limits when an out-of-network provider can balance bill.

Standard Plan

In-network provider	
Billed charge	\$6,000.00
Allowed amount¹⁶	\$5,000.00
Annual deductible	<u>- \$515.00</u>
Remaining allowed amount	\$4,485.00
	<u>x 20%¹⁷</u>
Coinsurance	\$897.00
Applies to the coinsurance maximum	
Copayment¹⁸	\$15.00
Annual deductible	+ \$515.00
Coinsurance	+ \$897.00
Your total payment	\$1,427.00

Out-of-network provider	
Billed charge	\$6,000.00
Allowed amount	<u>- \$5,000.00</u>
Balance bill¹⁹	\$1,000.00
Allowed amount	\$5,000.00
Annual deductible	<u>- \$515.00</u>
Remaining allowed amount	\$4,485.00
	<u>x 40%²⁰</u>
Coinsurance	\$1,794.00
Applies to coinsurance maximum	
Copayment	\$15.00
Annual deductible	+ \$515.00
Coinsurance	+ \$1,794.00
Balance bill	+ \$1,000.00
Your total payment	\$3,324.00

16 Network providers are not allowed to charge more than the allowed amount.

17 The Standard Plan paid 80% of the \$4,485 allowed amount after the deductible, totaling \$3,588.

18 Example assumes the service is an office visit.

19 Out-of-network providers can charge you any amount they choose above the allowed amount and bill you the balance above the allowed amount.

20 The Standard Plan paid 60% of the \$4,485 allowed amount after the deductible, totaling \$2,691.

Savings Plan

In-network provider	
Billed charge	\$6,000.00
Allowed amount²¹	\$5,000.00
Annual deductible	<u>- \$4,000.00</u>
Remaining allowed amount	\$1,000.00
	<u>x 20%²²</u>
Coinsurance	\$200.00
Applies to the coinsurance maximum	
Annual deductible	\$4,000.00
Coinsurance	+ \$200.00
Your total payment	\$4,200.00

Out-of-network provider	
Billed charge	\$6,000.00
Allowed amount	<u>- \$5,000.00</u>
Balance bill²³	\$1,000.00
Allowed amount	\$5,000.00
Annual deductible	<u>- \$4,000.00</u>
Remaining allowed amount	\$1,000.00
	<u>x 40%²⁴</u>
Coinsurance	\$400.00
Applies to the coinsurance maximum	
Annual deductible	\$4,000.00
Coinsurance	+ \$400.00
Balance bill	+ \$1,000.00
Your total payment	\$5,400.00

21 Network providers cannot charge more than the allowed amount.

22 The Savings Plan paid 80% of the \$1,000 allowed amount after the deductible, totaling \$800.

23 Out-of-network providers can charge you any amount they choose above the allowed amount and bill you the balance above the allowed amount.

24 The Savings Plan paid 60% of the \$1,000 allowed amount after the deductible, totaling \$600.

Getting prior authorization for your medical care

Healthcare prior authorization

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

Note that in addition to regular health coverage, some behavioral healthcare services as well as radiology (imaging service) and prescription drug benefits also require prior authorization.

See Page 45 for behavioral health, Page 46 for radiology and Page 72 for prescription drugs.

Lab work prior authorization

Certain lab services require prior authorization and require that your provider request Avalon Healthcare Solutions (Avalon)²⁵ review these services prior to performing the services. Requests can be submitted for prior authorization to Avalon by fax at 888.791.2181 or phone at 844.227.5769, 8 a.m. to 8 p.m., Eastern Standard Time. Once Avalon receives the request, it will be reviewed by Avalon's clinical staff, and they will notify your provider of the determination. An authorization for lab work does not guarantee payment.

Treatment prior authorization

Medi-Call numbers are:

- 803.699.3337 or 800.925.9724.
- 803.264.0183 (fax).

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

²⁵ Avalon is an independent company that performs outpatient lab services on behalf of BlueCross. Avalon does not review requests for services provided in an emergency room, surgery center or hospital inpatient place of service.

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

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

- Any type of inpatient care in a hospital, including admission to a hospital to have a baby;²⁶
- A preauthorized outpatient service that results in a hospital admission – you must call again for the hospital admission;
- Outpatient surgery for a septoplasty (surgery on the septum of the nose);
- Outpatient or inpatient surgery for a hysterectomy;
- Sclerotherapy (vein surgery) performed in an inpatient, outpatient or office setting;
- A new onset of chemotherapy or radiation therapy (one-time notification, then annually);
- A radiology (imaging) procedure (See Page 46 for more information);
- Pregnancy – you are encouraged to notify Medi-Call within the first three months of your pregnancy (see Page 52 for more information);
- Birth of a child (if you plan to file a claim for any birth-related expenses);²⁷
- Baby has complications at birth;

²⁶ For behavioral health services, you must call Companion Benefit Alternatives at 800.868.1032. See Page 45 for more information.

²⁷ Contacting Medi-Call for the delivery of your baby does not add the baby to your health insurance. You must add your child by logging in to MyBenefits, requesting the change and uploading the required documentation, a long-form birth certificate, within 31 days of birth for benefits to be payable.

- Are going to be, or have been, admitted to a long-term acute care facility, skilled nursing facility or need home healthcare, hospice care or an alternative treatment plan;
- Need durable medical equipment;
- Undergoing in vitro fertilization, GIFT, ZIFT or any other infertility procedure – this includes you and your covered spouse;
- Need to be evaluated for a transplant – includes you or your covered spouse or family member; and
- Need inpatient rehabilitative services and related outpatient physical, speech or occupational therapy.

Admission to a hospital in an emergency, including emergent care related to the birth of a child, must be reported within 48 hours or the next working day after a weekend or holiday admission.

A prior authorization request for any procedure that might be considered cosmetic must be received in writing by Medi-Call seven days before surgery. Procedures in this category include but are not limited to, blepharoplasty, reduction mammoplasty, augmentation mammoplasty, mastopexy, TMJ or other jaw surgery, panniculectomy, abdominoplasty, rhinoplasty or other nose surgery, etc. Your physician should include photographs, if appropriate.

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

Behavioral health service prior authorization

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

Services that need prior authorization²⁸

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

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

To preauthorize services, your provider must call Companion Benefit Alternatives at 800.868.1032 before you are admitted. In an emergency, your provider must call within at least 24 hours. For professional services listed above, your provider must call before services are rendered. To assess medical necessity, Companion Benefit Alternatives will require clinical information from the behavioral health provider treating you. Your provider can submit the clinical information online through the [CBA's Forms Resource Center](#) or fax the information to 803.714.6456.

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

Penalties for not calling for needed behavioral health service prior authorizations

If a network South Carolina provider does not request prior authorization for behavioral health outpatient services that require prior authorization (i.e., applied behavior analysis therapy and psychological/neuropsychological testing), the

²⁸ For behavioral health services, you must call Companion Benefit Alternatives at 800.868.1032.

provider will not be paid for the service, and it cannot bill the subscriber for the service. If a subscriber or a covered family member receives behavioral health outpatient services that require prior authorization from an out-of-network provider in South Carolina or from any provider outside of South Carolina without prior authorization, BlueCross will not pay the provider and the subscriber will be responsible for the entire bill.

Advanced radiology prior authorization: Evolent

The State Health Plan has a process for obtaining prior authorization for CT, MRI, MRA and PET scans. Network South Carolina physicians, radiology (imaging) centers and outpatient hospital radiology centers are responsible for requesting advanced radiology prior authorization from Evolent prior to completing a test.

Doctors can get more information on the [BlueCross website](#) or by calling 800.444.4311. To request prior authorization online, providers can visit the [Evolent website](#) or call 866.500.7664, Monday through Friday, from 8 a.m. to 8 p.m.

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

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

You can check the status of an Evolent prior authorization request online through your My Health Toolkit® account at [BlueCross' website](#).

Penalties for not calling

If a network South Carolina physician or radiology center

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

Managing your health

PEBA Perks

If the State Health Plan is your primary health insurance coverage, PEBA offers value-based benefits at low-to-no cost to you at network providers and pharmacies. These benefits can help make it easier for you and your family to stay healthy. Learn more about [PEBA Perks](#) online.

Adult vaccinations

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

Flu vaccine

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

Behavioral health

Meru Health offers a 12-week treatment program at no cost to State Health Plan primary members ages 13 and older to reduce anxiety, stress, depression and burnout. It combines therapist and psychiatrist support, a biofeedback training device, anonymous peer support, meditation practices and

habit-changing activities. Learn more about the program and enroll at [Meru Health's website](#). Members can also take advantage of health coaching at no cost through BlueCross. Learn more about the available health programs on Page 51.

Cervical cancer screening

The State Health Plan covers only the cost of the lab work associated with a Pap test each calendar year. Eligible Standard and Savings Plan female members take advantage of the annual well woman visit at no cost, and they can also receive an annual adult well visit at no cost. You should consider contacting the provider before scheduling an office visit to determine the cost of the exam and related services. The amount the member pays for additional non-covered services does not count toward her annual deductible.

Based on the recommendation of the United States Preventive Services Task Force, the Plan will pay a benefit for human papillomavirus testing once every five years for women ages 30–65, or as otherwise recommended by the USPSTF.

Colorectal cancer screenings

Colorectal cancer screenings, both diagnostic and routine, are provided at no cost to members at network providers for State Health Plan primary members. Covered screenings include colonoscopies and a fecal occult blood test.

Routine colonoscopies and some fecal occult blood tests are covered within the age ranges recommended by the USPSTF.

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

Diabetes management

Virta is a program that can help you reverse Type 2 diabetes while naturally lowering and controlling your average blood sugar (HbA1c). The program is available at no cost to eligible State Health Plan primary members. Learn more and apply

on [Virta's website](#).

Diabetes health education through certified diabetes educators is also offered at no cost to State Health Plan primary members at a network provider. Diabetes education trains diabetics to manage their condition to avoid disease-related complications. People who receive diabetes education are more likely to use primary care and preventive services; take medications as prescribed; and control their blood glucose, blood pressure and cholesterol levels. Visit a network provider for more information. Learn more on Page 51.

Healthy weight

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

Wondr Health will teach you it's not what you eat, but when and how you eat that will help you lose weight. Plus, you will reduce your risk for chronic diseases like diabetes and heart disease while increasing your chances of living a longer, healthier life. The program offers an easy-to-use website, welcome kit and video coaching from clinical experts. It is a 12-week, online program that uses weekly video lessons and interactive tools to teach the behavioral skills necessary to lose weight and keep it off long-term. Each week, you will watch lessons at your convenience on your computer, or smartphone and tablet through the iPhone or Android apps.

Following the first 12 weeks, you will automatically be enrolled in the next personalized weekly lessons and six months of continued support, as needed. This program features simplicity, convenience and an engaging member experience that leads to sustainable health improvement. Learn more on [Wondr Health's website](#).

BlueCross also offers health coaching to help you meet your weight management goals. Learn more about the available programs on Page 51.

Heart health

Hello Heart is an easy-to-use program that helps you track, understand and manage your heart health from the privacy

of your phone. The Hello Heart program is available at no cost to eligible State Health Plan primary members and includes a free blood pressure monitor that connects to an app on your smartphone. It's engaging and rewarding! Enroll and get started on [Hello Heart's website](#).

You can also work with a BlueCross health coach who can help you better understand your heart condition and how to manage it. Learn more about health coaching on Page 51.

Mammography

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

- One baseline mammogram (four views) for women ages 35 through 39; and
- One routine mammogram (four views) every year for women older than age 40.

Consider scheduling your mammogram after your birthday to help you remember it every year. You can find a mammography network provider in the Find Care tool located under the Resources tab in your My Health Toolkit account. You can also call BlueCross at 803.736.1576 or 800.868.2520 for assistance. Additionally, the Plan also covers any diagnostic mammograms.

Charges for routine mammograms performed by South Carolina providers are not covered unless the provider participates in the BlueCross mammography network, even if the provider participates in the State Health Plan's network. Routine mammograms performed outside of South Carolina are not covered unless the provider participates in a BlueCross network in the state where the provider is located. Out-of-network providers are free to charge you any price for their services, so you might pay more.

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

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

Maternal health

Members can enroll in Coming Attractions, a maternal health program, and learn how to receive certain electric or manual breast pumps at no member cost.

No-Pay Copay

The No-Pay Copay program gives eligible²⁹ State Health Plan primary members with high blood pressure, high cholesterol, congestive heart failure, cardiovascular disease, or coronary artery disease the opportunity to earn a copayment waiver for certain generic drugs that treat these conditions.³⁰ The program gives eligible State Health Plan members with diabetes a copayment waiver for certain lower-priced brand drugs and supplies and a lower copayment for higher-priced brand drugs and supplies that treat diabetes. The program encourages members to be more engaged in their health and saves them money. Participants qualify for the program annually. By completing certain activities during the year, they can receive certain generic drugs and lower-priced diabetic supplies at no cost and certain higher-priced brand diabetic supplies for a lower copayment for the remainder of the current year and the next year.

The copayment waiver ends when a No-Pay Copay participant enrolls in Medicare as their primary insurance.

29 Employees, retirees, COBRA subscribers, survivors and their covered spouses, and former spouses are eligible to qualify if the State Health Plan is their primary insurance. If a subscriber is enrolled in the Medicare Supplemental Plan but covers a spouse who is not eligible for Medicare, the spouse is eligible for the program. Dependent children are not eligible, regardless of age. If a member qualifies for No-Pay Copay and then becomes Medicare eligible, the waiver will end when the member becomes Medicare primary and enrolls in SilverScript Employer PDP, the State Health Plan's Medicare Part D program. Enrollment in SilverScript means the waiver ends immediately.

30 Lower-priced brand diabetes testing supplies (test strips, control solution, lancet, syringes, pen needles, etc.) purchased at a network pharmacy are also covered at no cost. A glucometer will be provided by the manufacturer separately. Certain higher-priced diabetes supplies, such as continuous glucose monitors and their associated supplies, are covered at a lower copayment.

This is the case regardless of whether the member is enrolled in SilverScript coverage.

For detailed information about the No-Pay Copay program, go to the [BlueCross website](#) or call BlueCross Customer Service at 800.868.2520. If you think you qualify for the program but have not been notified of your eligibility, call 855.838.5897. BlueCross administers the program, but you can call Caremark, the pharmacy benefits manager, at 833.291.3646 for more information about eligible generic prescriptions.

Preventive screenings

This benefit is provided at no cost to employees, retirees, COBRA subscribers and their covered spouses and dependent children who are age 19 or older, and former spouses if their primary coverage is the Standard Plan or the Savings Plan. This type of screening typically costs nearly \$500. The screening includes blood work, a health risk appraisal, height and weight measurements, blood pressure and lipid panels.

After the screening, you will receive a confidential report with your results and recommendations for improving your health. Taking this report to your doctor might eliminate the need for tests. In addition to taking part in a screening at your workplace, there are other options for taking advantage of this benefit. You are also encouraged to share your results with BlueCross so they automatically upload into the Personify Health Personal Health Assessment. Learn more about Personify Health on Page 34.

Attend a regional preventive screening

If your worksite doesn't offer a screening, or if you missed it, you can register for a regional screening on PEBA's [Upcoming events](#) page.

Visit a participating screening provider

Visit one of our participating screening providers to have a preventive screening. A list of providers, as well as a voucher to take with you when you visit for a screening is available on our [PEBA Perks webpage](#).

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

In addition to the required tests and appraisals, participating screening providers might offer optional

tests for an additional fee. You can contact the screening provider about out-of-pocket expenses associated with these tests. Note that optional tests can vary based on screening provider.

Tobacco cessation

The tobacco cessation program offers a variety of evidence-based strategies for quitting all forms of tobacco and vaping. After taking a one-minute assessment to understand more about the participant's tobacco use along with program engagement preferences, members will be matched with one of the available tobacco cessation vendors in the tobacco cessation network. This personalized approach ensures members are paired with the vendor that best meets their needs. Program offerings include, but are not limited to, tobacco cessation coaching, interactive live online sessions, community support, on-demand educational library, games and mindfulness apps.

The tobacco cessation program is offered at no cost to State Health Plan primary subscribers, covered spouses and covered dependents. For eligible members ages 18 and older, the program also provides free nicotine replacement therapy, such as patches, gum or lozenges, if appropriate.

To enroll, log in to My Health Toolkit and go to the Wellness & Care Management, Wellness Programs, then My Health Novel. There you'll take the assessment to be placed in the right program for you. Tobacco cessation drugs, such as bupropion or generic Chantix, are also available through the State Health Plan's prescription drug coverage to primary members at no cost to the member when obtained from a network provider.

Well adult benefits (adult well visit and vaccinations)

State Health Plan primary members are eligible for one adult well visit each year at no member cost. Well visits can be a key part of preventive care. They can reassure members they are as healthy as they feel or prompt them to ask questions about their health. Evidence-based services, based on A or B recommendations from the [United States Preventive Services Task Force](#), are included as part of an adult well visit under the State Health Plan (Standard and Savings Plans).

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

practice, family practice, pediatrics, internal medicine or gerontology. Eligible female members can also receive an annual adult well woman visit at no cost. Women can take advantage of the well woman benefit at a network provider specializing in obstetrics and gynecology, or they can have a well woman exam in conjunction with or in addition to their annual well visit with a network provider specializing in general practice, family practice, internal medicine or gerontology. A female member can receive both an adult well visit and a well woman visit in the same plan year, but the USPSTF-recommended services will not be covered more than once per plan year. Additionally, female members cannot receive the same service at both an adult well visit and a well woman visit in the same plan year; duplicate services will be denied.

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. Learn how to coordinate your PEBA Perks benefits with your adult well visit below.

1. **Get your preventive screening.** You can receive a biometric screening at no cost, which will minimize cost to the Plan at your adult well visit. Learn more about what's included in a screening on Page 49.
2. **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.
3. **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 an adult well visit. Sharing your results will minimize the cost of your adult well visit for you and to the Plan.
4. **Follow your doctor's recommendations and stay engaged with your health.** We encourage you to take advantage of the other PEBA Perks available to you. If you're eligible, sign up for No-Pay Copay to receive some generic drugs at no cost to you. Learn more on Page 48.

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 the [United States Preventive Services Task Force](#) website. Other services, including a complete blood count, EKG, PSA test and basic metabolic panel are covered only if ordered by your physician to treat a specific condition and are subject to the copayment, deductible and coinsurance, as well as normal Plan provisions. Follow-up visits and services as a result of your well visit are also subject to normal Plan provisions.

Learn more about services included in the adult well visit at our [Adult well visits webpage](#).

Well child care benefits

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

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

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

The well child care exam must occur after the child's birthday, but does not have to be 365 days from the previous year's visit.

When these services are received from a State Health Plan network doctor, benefits will be paid at 100% of the allowed amount. The State Health Plan will not pay for services from out-of-network providers.

Some services might not be considered part of well child care. For example, if during a well child visit a fever and sore throat were discovered, the lab work to verify the diagnosis would not be part of the routine visit. These charges, if covered, would be subject to the copayment, deductible and coinsurance, as would any other medical expense.

Care management

The available health coaching programs are designed to help Standard Plan and Savings Plan subscribers and their covered adult family members who have certain behavioral or chronic medical conditions manage their symptoms, and delay or even prevent many of the complications of these diseases. For help enrolling in a program, call BlueCross at 877.505.7390 during normal business hours.

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

As a participant in the health coaching program(s), you will receive educational materials and a welcome letter that will provide the name of and contact information for your BlueCross health coach. Your health coach will be a healthcare professional who will help you learn more about your condition and how to manage it. Your health coach will also help you work with your physician to develop a plan to take charge of your illness, contacting you by phone. You can contact your health coach as often as you like with questions or to ask for advice. To connect with a coach, call 855.838.5897 and select Option 2.

As a State Health Plan member, you can use My Health PlannerSM, the free app that connects you with a team of care management nurses, therapists and other health workers.

When you need help, this app:

- Puts you in control of your health;
- Helps you understand what you need to do to feel your best;
- Keeps track of what you need to do between doctor visits; and

- Lets you stay in touch with your care management team.

To access My Health Planner, search for My Health Planner in the App Store or Google Play and use the access code SCStartVisit. After downloading the My Health Planner app, select Create New Account.

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

Care Calls

Care Calls is a short-term program that helps members recover safely after surgery and feel confident taking care of themselves. A care manager contacts the member to make sure they are healing. Members get easy-to-understand information about how to take care of themselves at home, which might include how to care for their wound, take their medicine and follow their doctor's instructions.

The care manager also teaches members about possible issues that could arise. Members learn what warning signs to look for and when to call their doctor or get help. The program also helps prevent issues by making sure members have what they need, such as follow-up visits, medicine or other support.

Behavioral health

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

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

Chronic conditions

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

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

Healthy lifestyles

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

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

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

Maternity

Whether you're expecting your first baby or you're an experienced mom, you are encouraged to enroll and participate in the free maternal health services. Medi-Call administers PEBA's comprehensive maternal health program, Coming Attractions. This program supports mothers throughout their pregnancy and postpartum care. It also assists with Neonatal Intensive Care Unit infants or other babies with special needs until they are one year old. Once enrolled in the Coming Attractions program, expectant mothers will receive a welcome mailer and educational materials throughout their pregnancy and postpartum period. You do not have to wait until you have been seen by your physician to enroll in Coming Attractions, and enrollment is easy.

There are three ways to enroll:

1. Download the My Health Planner App from the App Store or Google Play. Select Create New Account and enter the access code MATCARE to get started
2. Visit the [BlueCross website](#) and log in to your My Health Toolkit account. Select Wellness, then Care Management. Select the Member Portal link, then Assessments, and complete the maternity health screening, which is listed as Enroll in the Maternity Program.
3. Call Medi-Call at 803.699.3337 or 800.925.9724 to talk to a maternity nurse or health coach and complete a brief maternity health screening.

Once enrolled you will gain access to educational materials throughout your pregnancy and postpartum period. As part of your benefit, you also have access to the My Health Planner app. This app provides an interactive program timed to where you are in your pregnancy. It will allow you to securely communicate with your maternity care team in between calls and your doctor appointments.

If no risks are identified during your pregnancy, you are encouraged to call with any changes in your condition or reach out by secure text on My Health Planner. If risk factors are identified, you will receive periodic calls from a maternity nurse. Our specialized maternity team is here to help you navigate your benefits, assist with coordinating care with your healthcare provider, and offer support during your pregnancy journey.

Coming Attractions will be there to help you with both routine and special needs throughout your pregnancy and beyond.

For more information about maternity benefits, including coverage of some breast pumps, see Pregnancy and pediatric care on Page 58.

Medical case management programs

The case management programs available to State Health Plan members facing serious illnesses or injuries are intended to help them locate support and treatment information. Each program includes teams of specially trained nurses and doctors. They aim to assist participants in coordinating, assessing and planning healthcare, and do so by giving a patient control over their care and respecting their right to knowledge, choice, a direct relationship with

their physician, privacy and dignity. None of the programs provide medical treatment.

For more information on any of these programs, call 800.925.9724 and ask to be connected to a case manager.

BlueCross Medi-Call case management program

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

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

The case manager works with the patient and providers to assess, plan, implement, coordinate, monitor and evaluate ways of meeting a patient's needs, reducing readmissions and enhancing quality of life.

A Medi-Call nurse stays in touch with the patient, caregivers and providers to assess and reevaluate the treatment plan and the patient's progress. All communication between BlueCross and the patient, family members or providers complies with Health Insurance Portability and Accountability Act privacy requirements.

If a patient refuses medical case management, Medi-Call will continue to preauthorize appropriate treatment.

For more information, call 800.925.9724 and ask to be connected to a case manager.

Complex care management program

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

The complex care management program provides you with

information and support through a case manager, who is a registered nurse.

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

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

Oncology case management program

Oncology case management is available to select State Health Plan members receiving active cancer treatment. This program's nurses provide education and care coordination that might help prevent acute illnesses, complications and hospitalizations.

When a member who is in active cancer treatment is referred to the program, a nurse contacts the member to confirm they are a good candidate for oncology case management. The nurse, who has many years of cancer care experience, provides education and helps coordinate care.

As the link between you, your providers and oncology team, the nurse identifies your needs through medical record reviews and consultations with you, your family and your healthcare team. Needs might be medical, social, behavioral, emotional and financial. The nurse coordinates services based on long-term needs and incorporates these needs into a plan agreed on by you, your physician(s), the oncology team and other providers. Your nurse will call you

frequently and receive updates from your providers.

Renal disease case management program

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

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

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

Blue365® and member discounts

Blue365 is a discount program available to State Health Plan subscribers and offered by BlueCross. The program has a network of licensed acupuncturists, massage therapists and fitness clubs that can be used at lower fees, often as much as a 25% discount. Blue365 also offers discounts on health centers, weight loss and nutrition programs, wearable health-trackers and much more.

For more information on Blue365 or member discounts, log in to the My Health Toolkit app or go to [BlueCross' website](#), log in to your My Health Toolkit account, select Resources, then select Blue 365 Discounts, or call BlueCross Customer Service at 800.868.2520.

Additional State Health Plan benefits

The Standard Plan and the Savings Plan pay benefits for treatment of illnesses and injuries if the *Plan of Benefits* defines the treatment as medically necessary. While this section provides a general description of many of these benefits, the *Plan of Benefits* on our [Publications webpage](#) contains a complete description of all benefits. Its terms

and conditions govern all health benefits offered by PEBA.

Earlier in this chapter, value-based benefits, including preventive benefits such as immunizations and benefits specific to women and children, are covered in their own section. Behavioral health benefits are also featured in their own section. Prescription drug benefits, dental benefits and vision benefits are covered in later chapters. Some services and treatment require prior authorization from Medi-Call, Evolent, Companion Benefit Alternatives or Caremark. For details read the Medi-Call section beginning on Page 44, the behavioral health section on Page 45 and the Evolent section on Page 46.

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

- Medically appropriate to identify or treat an existing condition, illness, disease or injury; and
- Provided for the direct care and treatment of the condition, illness, disease or injury; and
- Prescribed or ordered by a physician; and
- Rendered in accordance with recognized, appropriate medical and surgical practices prevailing in the medical specialty or field of medicine at the time rendered; and
- Not primarily for the convenience of the patient, the patient's family or the patient's provider; and
- Not experimental, investigational or cosmetic in purpose

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

Advanced practice registered nurse

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

Alternative treatment plan

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

Ambulance service

Ambulance service, including air ambulance service, is covered to the nearest hospital to obtain medically necessary emergency care. Ambulance service also might be covered to transport a member to the nearest hospital that can provide medically necessary inpatient services when those services are not available at the current facility, if preauthorized. All non-emergent ambulance services must be preauthorized. All claims for ambulance service are subject to medical review.

Ambulance services are reimbursed at 80% of the allowed amount; however, non-participating providers can balance bill you up to the total of their charge for the service. Note all ambulance services, including air ambulance service, might not be in-network. If you have any questions about whether an ambulance service is in-network, contact BlueCross. For information on balance billing, see Page 42.

Autism spectrum disorder benefits

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

Behavioral health benefits

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

Some services require prior authorization by Companion Benefit Alternatives, the behavioral health manager. For more information, see Page 45. Your behavioral health provider will be required to conduct periodic medical necessity reviews, similar to Medi-Call for medical benefits.

For customer service and information about claims for behavioral healthcare, call BlueCross at 800.868.2520. For help finding a behavioral health provider, call BlueCross at 877.505.7390. Representatives are available during normal business hours.

Behavioral health case management

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

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

For more information, call 800.868.1032, ext. 25835.

Bone, stem cell and solid organ transplants

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

All transplant services must be approved by Medi-Call (see Page 44). You must call Medi-Call, even before you or a covered family member is evaluated for a transplant.

Through the Blue Distinction Centers for Transplants network, State Health Plan members have access to the leading organ transplant facilities in the nation. Contracts are also in effect with local providers for transplant services so members can receive transplants at those facilities. You will save a significant amount of money if you receive your transplant services at a Blue Distinction Centers for Transplants network facility or a South Carolina network

transplant facility. If you receive transplant services at one of these network facilities, you will not be balance billed. You will be responsible only for your deductible, coinsurance, and any charges not covered by the Plan. In addition, these network facilities will file all claims for you.

Transplant services at nonparticipating facilities are covered by the Plan; however, the State Health Plan pays only the State Health Plan-allowed amount for transplants performed out-of-network. If you do not receive your transplant services at a network facility, you could pay substantially more. In addition to the deductible and coinsurance, members using out-of-network facilities are responsible for any amount more than the allowed amount, or balance bill, and pay 40% coinsurance. Costs for transplant care can vary by hundreds of thousands of dollars. For information on balance billing, see Page 42. You can also call Medi-Call for more information.

To learn more about the coordination period with Medicare for end stage renal disease and/or kidney transplants, see Page 39.

Chiropractic care

You are covered for specific office-based services from a chiropractor, including detection and correction by manual or mechanical means of structural imbalance, distortion or subluxation in the body to remove nerve interference and the effects of such nerve interference, where such interference is the result of, or related to, distortion, misalignment or subluxation of or in the vertebral column. Diagnostic X-rays are covered if medically necessary. Both the Standard Plan and Savings Plan are limited to one manual therapy per visit, which is subject to the Plan maximum.

For Standard Plan members, chiropractic benefits are limited to \$2,000 per person each year. With the Savings Plan, chiropractic benefits are limited to \$500 each year for each covered person after the annual deductible has been met. Services of a massage therapist are not covered.

Contraceptives

Routine contraceptive prescriptions, including birth control pills and injectables, filled at a participating pharmacy or through the Plan's mail-order pharmacy, are covered at no cost to State Health Plan primary subscribers, covered

spouses and covered child dependents. Generally, birth control implants and injectables given in a doctor's office are covered as a medical, not pharmacy, benefit. The office visits for contraceptive implants will be processed with applicable copayments, coinsurance and deductibles.

Dental care

Generally, dental care is provided under Dental Plus or Basic Dental, not the State Health Plan. See the **Dental insurance** chapter on Page 76 for more information.

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

Diabetic supplies

Insulin is allowed under the prescription drug program or under the medical plan but not under both. Lower-priced brand diabetic supplies, including syringes, lancets and test strips, are covered at participating pharmacies for a \$13 Tier 1 copayment per item for each supply of up to 30 days. See Page 71 for more information regarding coverage of diabetic supplies and the Caremark formulary. Lower-priced brand drugs to treat diabetes and diabetes testing supplies are covered at no cost for non-Medicare primary Standard Plan members enrolled in the No-Pay Copay program. Higher-priced brand drugs to treat diabetes and higher-priced supplies, such as continuous glucose monitors are covered at a lower copayment for non-Medicare primary Standard Plan members enrolled in No-Pay Copay. Because insulin is not a Tier 1 drug, it is not eligible for the waiver. For more information, see Page 48. Claims for diabetic durable medical equipment, such as insulin pumps, should be filed through your medical coverage.

Note that diabetes education services offered by network providers are covered at no cost to State Health Plan primary members. See Page 47.

Doctor visits

Treatments or consultations for an injury or illness are covered when they are medically necessary within the terms of the Plan and not associated with a service

excluded by the Plan. Some outpatient visits for behavioral healthcare, such as mental health and substance use care, still require prior authorization. For details on behavioral health benefits, see Page 55.

Durable medical equipment

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

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

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

Eating disorder treatment

Equip providers deliver virtual, evidence-based treatment for all eating disorder diagnoses. You receive support from a team that includes a therapist, medical provider, dietician, family mentor and peer mentor, helping you achieve lasting recovery at home. Equip providers are available to State Health Plan primary members, and treatment costs follow normal Plan provisions. Learn more on [Equip Health's website](#) or call 855.538.1465.

For more comprehensive virtual treatment, Within Health offers intensive outpatient and partial hospitalization services, as well as flexible scheduling to accommodate your lifestyle, so you don't have to put your life on hold during treatment. Instead, Within providers help you rebuild a connection with your true self and fully heal.

Within providers are available to State Health Plan primary members, and treatment costs follow normal Plan provisions. Learn more on [Within's website](#) or call 866.559.3073.

Home healthcare

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

Hospice care

The Plan will pay for up to 80 days per person for hospice care for a patient certified by their physician as having a terminal illness. The benefit also includes bereavement counseling, and services must be preauthorized by Medi-Call.

Infertility

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

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

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

Benefits are always payable at 70% of the allowed amount, subject to a 30% coinsurance payment through both the Standard Plan and Savings Plan. The 30% coinsurance payment does not apply to the annual coinsurance maximum.

Prescription drugs for treatment of infertility are also subject to a 30% coinsurance payment through both the Standard Plan and the Savings Plan. This expense does not apply to the \$3,000 per person prescription drug copayment maximum for the Standard Plan. It does apply to the Savings Plan deductible. The 70% Plan payment for prescription drugs for infertility treatments applies to the \$15,000 maximum lifetime payment for infertility treatments. Call Caremark at 833.291.3646 for more information about prescription drugs.

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

Note that when you become pregnant, you are encouraged to enroll in the Coming Attractions maternal health program. See Page 52 for more information.

Inpatient hospital services

Inpatient hospital care, including semiprivate room and board, is covered. In addition to normal visits by your physician while you are in the hospital, you are covered for one consultation per consulting physician for each inpatient hospital stay. Inpatient care must be approved by Medi-Call (Page 44) or Companion Benefit Alternatives. For more information, see Page 45.

Outpatient facility services

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

- Laboratory services;
- X-ray and other radiological services;
- Emergency room services;
- Radiation therapy;
- Pathology services;
- Outpatient surgery;

- Infusion suite services; and
- Diagnostic tests.

If you are covered by the Standard Plan, you will be charged a \$115 outpatient facility services copayment. You will be charged a \$193 copayment for emergency room services. These copayments do not apply to your annual deductible or your coinsurance maximum. The copayment for emergency room services is waived if you are admitted to the hospital.

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

Note that when lab tests are ordered, you might want to talk with your provider about having the service performed at an independent, network lab. Use of an independent lab might be more cost effective, as it would allow you to avoid paying the \$115 copayment for outpatient facility services or the \$15 copayment for a physician office visit.

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

Pregnancy and pediatric care

Maternity benefits are provided to subscribers and their covered spouses. Covered dependent children do not have maternity benefits. Maternity benefits include necessary prenatal and postpartum care, including childbirth, miscarriage and complications related to pregnancy. When you become pregnant, you are encouraged to enroll in the Coming Attractions maternal health program. See Page 52 for information.

Breast pumps

Specific models of breast pumps are covered and available at no cost to female subscribers and covered female spouses of subscribers. To use this coverage, you will need to get the pump through a BlueCross-contracted provider. While a physician prescription is not required,

having a prescription is preferred and will help the order be processed faster. For more information, go to [BlueCross' website](#), then Medical, then PEBA Perks, then Breast Pump.

Length of hospital stay

By federal law, group health plans generally cannot restrict benefits for the length of any hospital stay in connection with childbirth for the mother or the newborn to fewer than 48 hours after a vaginal delivery or fewer than 96 hours after a caesarean section. The Plan might pay for a shorter stay, however, if the attending physician, after consultation with the mother, discharges the mother or newborn earlier.

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

Midwife services

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

Prescription drugs

See the **Prescription benefits** chapter on Page 68 for more information.

Reconstructive surgery after a medically necessary mastectomy

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

- Reconstruction of the breast on which the mastectomy has been performed;

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

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

Rehabilitation care

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

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

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

Rehabilitation benefits are not payable for:

- Vocational rehabilitation intended to teach a patient how to be gainfully employed;
- Cognitive (mental) retraining;
- Community reentry programs; or
- Long-term rehabilitation after the acute phase.

Rehabilitation – acute

Acute-phase rehabilitation often is done in an outpatient setting. In complex cases, the rehabilitation can be done in

an acute-care facility, and then a sub-acute rehabilitation facility or an outpatient facility. Acute rehabilitation begins soon after the start of the illness or injury and might continue for days, weeks or several months.

Cardiac and pulmonary rehabilitation require prior authorization.

Rehabilitation – long-term

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

Second opinions

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

Skilled nursing facility

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

Speech therapy

Rehabilitative

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

Maintenance

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

Habilitative

The State Health Plan covers habilitation speech therapy services for covered dependents ages 6 and younger.

Speech therapy offered in the member's home requires prior authorization by Medi-Call.

Exclusions

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

- Psychological speech delay ages 7 and older;
- Stammering/stuttering ages 7 and older;
- Behavioral problems;
- Attention disorders;
- Mental handicap;
- Cognitive (mental) retraining;
- Community reentry programs; or
- Long-term rehabilitation after the acute phase of treatment for the injury or illness.

Note that BlueCross might still review speech therapy services after a claim has been paid to determine if the services are indeed a benefit covered by the Plan.

Surgery

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

Other covered benefits

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

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

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

Exclusions – services not covered

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

- Services or supplies that are not medically necessary within the terms of the Plan.
- Routine procedures not related to the treatment of injury or illness, except for those specifically listed in

the preventive benefits section.

- Routine physical exams, checkups (except adult well visits, well woman visits, well child care and preventive benefits according to guidelines), services, surgery (including cosmetic surgery) or supplies that are not medically necessary.
- Routine prostate exams, screenings or related services are not covered under the Plan. A diagnostic prostate exam, screening and lab work will be covered when medically necessary but not as part of an adult well visit. The diagnostic exam will be subject to the State Health Plan's usual deductibles and coinsurance.
- Routine prostate-specific antigen tests.
- Eyeglasses.³¹
- Contact lenses³¹, unless medically necessary after cataract surgery and for the treatment of keratoconus, a corneal disease affecting vision.
- Routine eye examinations.³¹
- Refractive surgery³¹, such as radial keratotomy, laser-assisted in situ keratomileusis vision correction and other procedures to alter the refractive properties of the cornea.
- Hearing aids and examinations for fitting them³².
- Dental services³³, except for removing impacted teeth, treatment within one year of a condition resulting from an accident, treatment made necessary by the loss of teeth due to cancer treatment and treatment necessary as a result of a congenital birth defect.
- Temporomandibular joint syndrome splints, braces, guards, etc. Medically- necessary surgery for TMJ is covered if preauthorized by Medi-Call. TMJ is often characterized by headache, facial pain and jaw tenderness caused by irregularities in the way joints, ligaments and muscles in the jaws work together.
- Custodial care, including sitters and companions or

homemakers/caretakers.

- Admissions or portions thereof for custodial care or long-term care, including:
 - Respite care;
 - Long-term acute or chronic psychiatric care;
 - Care to assist a member in the performance of activities of daily living (i.e., custodial care, including but not limited to: walking, movement, bathing, dressing, feeding, toileting, continence, eating, food preparation and taking medication); and
 - Psychiatric or substance use long-term care, including: therapeutic schools, wilderness/boot camps, therapeutic boarding homes, halfway houses and therapeutic group homes.
- Any item that can be purchased over the counter, including, but not limited to: medicines and contraceptive devices.
- Surgery to reverse a vasectomy or tubal ligation if elective and not medically necessary to treat a preexisting condition.
- Diagnosis or treatment of infertility for a subscriber or a spouse if either member has had a tubal ligation or vasectomy.
- Assisted reproductive technologies (fertility treatment), except as described on Page 57.
- Weight loss treatments and all weight loss surgery, including, but not limited to: medications³⁴; gastric bypass, gastric banding or stapling; intestinal bypass and any related procedures; the reversal of such procedures; and conditions and complications as a result of such procedures or treatment.
- Equipment that has a nontherapeutic use (such as humidifiers, air conditioners, whirlpools, wigs, artificial hair replacement, vacuum cleaners, home and vehicle modifications, fitness supplies, speech augmentation or communication devices, including computers, etc.), regardless of whether the equipment is related to a medical condition or prescribed by a physician.
- Air quality or mold tests.

³¹ Although vision benefits are generally not covered by the State Health Plan, coverage and discounts are available through the State Vision Plan. See the **Vision care** chapter on Page 86.

³² Except as otherwise provided in the *Plan of Benefits* for certain Covered Persons younger than age 18

³³ Dental benefits are available through Dental Plus and Basic Dental. See the **Dental insurance** chapter on Page 77.

³⁴ Medications FDA-approved for weight loss are excluded from coverage, including certain formulations of GLPs and GLP-1s.

- Supplies used for participation in athletics (that are not necessary for activities of daily living), including, but not limited to, splints or braces.
- Physician charges for medicine, drugs, appliances, supplies, blood and blood derivatives, unless they are covered medical benefits under the Plan.
- Medical care by a doctor on the same day or during the same hospital stay in which you have surgery, unless a medical specialist is needed for a condition the surgeon could not treat.
- Physician's charges for clinical pathology, defined as services for reading any machine-generated reports or mechanical laboratory tests. Interpretation of these tests is included in the allowance for the lab service.
- Fees for medical records and claims filing.
- Food supplements, including, but not limited to: infant formula, enteral nutrition, Boost/Ensure or related supplements.
- Services performed by members of the insured's immediate family.
- Acupuncture.
- Chronic pain management programs.
- Transcutaneous (through the skin) electrical nerve stimulation, whose primary purpose is the treatment of pain.
- Complications arising from the receipt of non-covered services.
- Psychological tests to determine job, occupational or school placement, or for educational purposes; milieu therapy; or to determine learning disability.
- Any service or supply for which a covered person is entitled to payment or benefits pursuant to federal or state law (except Medicaid), such as benefits payable under workers' compensation laws.
- Charges for treatment of illness, injury or complications caused by acts of war or military service.
- Cosmetic goods, procedures, surgery or complications resulting from such procedures or services.
- Smoking cessation or deterrence products or services, except for those covered by the Prescription Drug Program or as authorized by the tobacco cessation program for eligible participants in its tobacco cessation program.
- Sclerotherapy (treatment of varicose veins), including injections of sclerosing solutions for varicose veins of the leg.
- Services performed by service or therapy animals or their handlers.
- Abortions, except for an otherwise legal abortion, as allowed by law.
- A covered child's infertility treatment, pregnancy or complications from pregnancy or childbirth.
- Storage of blood or blood plasma.
- Services or charges incurred for, or in connection with, gender reassignment or related procedures.
- Experimental or investigational surgery or medical procedures, supplies, devices or drugs. Any surgical or medical procedures determined by the medical staff of the third-party claims processor, with appropriate consultation, to be experimental or investigational or not accepted medical practice. Experimental or investigational procedures are those medical or surgical procedures, supplies, devices or drugs, which, at the time provided or sought to be provided:
 - Are not recognized as conforming to accepted medical practice in the relevant medical specialty or field of medicine; or
 - The procedures, drugs or devices have not received final approval to market from appropriate government bodies; or
 - Are those about which the peer-reviewed medical literature does not permit conclusions concerning their effect on health outcomes; or
 - Are not demonstrated to be as beneficial as established alternatives; or
 - Have not been demonstrated, to a statistically significant level, to improve the net health outcomes; or
 - Are those in which the improvement claimed is not demonstrated to be obtainable outside the investigational or experimental setting.

Additional limits in the Standard Plan

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

Additional limits and exclusions in the Savings Plan

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

How to file a State Health Plan claim

Services in South Carolina

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

If you did not use a network provider, or if you have a claim for an out-of-network service, you might have to file the claim yourself. You can get claim forms on our [Forms webpage](#) and from BlueCross. You will need a separate claim form for each individual who received care.

To file a claim:

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

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

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

Mail claims to:

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

For more information, call BlueCross at 800.868.2520 or 803.736.1576.

Services outside South Carolina

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

Network providers will file claims to the BlueCross affiliate in the state in which the service was provided. Outside the U.S., you should complete a BlueCross BlueShield Global Core Claim Form and send it to the BlueCross BlueShield Global Core Service Center. This claim form is available on our [Forms webpage](#) and the [BlueCross website](#). If services are received from an out-of-network provider, you could be asked to pay upfront for the full cost of the services received and might also be required to file the claim to BlueCross yourself.

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

Appeals

First level review: Claims and prior authorization appeals to third-party claims processors

Subscribers have the right to appeal decisions made by third-party claims processors contracted by PEBA to administer benefits. The following covers initial appeals to BlueCross for health insurance claims, as well as Medi-Cal for medical prior authorization and Companion Benefit Alternatives for behavioral health benefits prior authorizations. Radiology prior authorization appeals for Evolent are handled differently from other appeal procedures and are also covered in this section.

In the case of BlueCross, Medi-Cal or CBA, you can appeal

an initial claim or prior authorization denial within six months of the decision. If you would like someone else to appeal on your behalf, you can make this request to BlueCross, Medi-Call or CBA in writing. Note that medical providers, including medical device manufacturers, pharmaceutical manufacturers, and representatives or agents of such providers and manufacturers cannot appeal on your behalf. Contact information is provided below if you have questions about how to file an appeal.

BlueCross BlueShield of South Carolina

- [StateSC.SouthCarolinaBlues.com](https://www.StateSC.SouthCarolinaBlues.com).
- 803.736.1576 or 800.868.2520.

Medi-Call

- 803.699.3337 or 800.925.9724.

Companion Benefit Alternatives

- [www.CompanionBenefitAlternatives.com](https://www.www.CompanionBenefitAlternatives.com).
- 803.736.1576 or 800.868.2520.

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

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

Evolent

- www.RadMD.com.
- 866.500.7664.

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

Second level medical review: Claims and prior authorization appeals to third-party claims processors requiring a medical necessity review

If the third-party claims processor, following its initial review, denies the subscriber's request as not medically necessary, the subscriber has the right to request a second level medical review.

In the case of BlueCross, Medi-Call or CBA, you can request a second level medical review within 90 days of notice of the denial. You must include the following information in your written request for a second level medical review:

- Reasons why the claim or prior authorization request should be approved;
- Reasons why the first-level review was in error; and
- Any new or additional medical information pertinent to your claim or prior authorization request.

You can also request an expedited second-level medical review.

If you would like someone to appeal on your behalf, you can make this request to BlueCross, Medi-Call or CBA in writing. Note that medical providers, including medical device manufacturers, pharmaceutical manufacturers, and representatives or agents of such providers and manufacturers cannot appeal on your behalf.

Contact information is provided below if you have questions about how to request a second-level medical review.

BlueCross BlueShield of South Carolina

- [StateSC.SouthCarolinaBlues.com](https://www.StateSC.SouthCarolinaBlues.com)
- 803.736.1576 or 800.868.2520

Medi-Call

- 803.699.3337 or 800.925.9724

Companion Benefit Alternatives

- [www.CompanionBenefitAlternatives.com](https://www.www.CompanionBenefitAlternatives.com)
- 803.736.1576 or 800.868.2520

The third-party claims processor will make its decision within 60 days after the request for the second level medical review is received. If medical records are requested, the decision will be provided no later than 30 days after the requested information is received. If the

requested information is not received within 30 days, the decision will be made on the information available at that time and provided within 30 days.

The second level medical review process must be exhausted for any appeals regarding medical necessity before any appeal to PEBA. The third-party claims processor will send you a written decision stating the specific reasons for its final decision.

Appeals to PEBA: prior authorizations and services that have been provided

If you are still dissatisfied after the third-party claims processor has completed its review process (a first-level review for appeals not requiring a medical review, and a second-level medical review for appeals requiring a medical necessity review) you can request an additional appeal by sending an [Appeal Request Form](#) to PEBA within 90 days of your notice of the third-party claims processor's final denial. Include a copy of the third-party claims processor's previous denial(s) with your appeal to PEBA. Send the request to:

IAD@peba.sc.gov

or

S.C. PEBA

Attn: Insurance Appeals Division

202 Arbor Lake Drive

Columbia, SC 29223

Appeals can be brought only by the covered person at issue, their legal representative (who cannot be, including but not limited to, a provider, medical device manufacturer, employer, or a representative or agent of any of the foregoing), or a licensed attorney admitted to practice in South Carolina.

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

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

TRICARE Supplement Plan

TRICARE is the Department of Defense health benefit program for the retired military community. It consists of TRICARE Prime, a health maintenance organization; TRICARE Select, a fee-for-service plan; and TRICARE Retired Reserve.

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

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

Eligibility

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

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

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

- Military retirees and their spouses or surviving spouses who reside outside the U.S. or its territories (all who are eligible for Medicare must be in Medicare);
- Qualified National Guard and Reserve; and
- Members (TRICARE Reserve Select).

There are limited exceptions to the Age 65 Eligibility Rule. Contact Selman & Company for more information at 800.638.2610, Option 1 or memberservices@selmanco.com.

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

Eligible dependent children

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

How to enroll

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

To enroll

1. Membership in the Government Employees Association is required for enrollment in the TRICARE Supplement Plan. Information about the Government Employees Association is provided in the TRICARE Supplement Plan welcome packet. Dues are included in the Plan's monthly premium. For more information, contact the [Government Employees Association](#) at its website or call 800.446.7600.
2. Complete a *Notice of Election* and check "TRICARE Supplement Plan" in the health plan section. Return the *Notice of Election* to your benefits administrator, along with a copy of your military ID or TRICARE ID card. Also, if you are an active employee, your benefits administrator can enroll you online. As a subscriber, you can enroll through [MyBenefits](#) during open enrollment. See Page 18 for more information. If you are a retired employee of a state agency, public higher education institution or public school district, submit a *Retiree Notice of Election to PEBA*. If you are a participating optional employer retiree, submit a *Retiree Notice of Election* to your former employer's benefits office. See Page 140 for more information. Coverage is not automatic.
3. If you are an eligible subscriber, complete the TRICARE Other Health Insurance form if you were previously enrolled in the State Health Plan. The TRICARE Other Health Insurance form for each region is on the [TRICARE website](#). Fax the completed forms to TRICARE at the number on the form. Remember, the TRICARE Supplement Plan is not considered other health insurance.

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

In addition to enrolling in the TRICARE Supplement Plan, during open enrollment, if you're an eligible subscriber, you can drop TRICARE Supplement Plan coverage for yourself or your dependents, or you can add dependents. See Page 18 for more information.

Plan features

The TRICARE Supplement Plan provides you with additional coverage, which, when combined with the other TRICARE

coverage, usually pays 100% of your out-of-pocket expenses. Some of the plan's features include:

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

Filing claims

Most providers submit TRICARE Supplement Plan claims. If a provider does not, you can submit the claims to Selman & Company. Information and forms for filing doctor/hospital and pharmacy claims are included in the welcome packet and on [Selman & Company's website](#).

Medicare eligibility and the TRICARE Supplement Plan

If, as an active employee, survivor or retiree, you become eligible for Medicare Part A, you must purchase Medicare Part B to remain eligible for TRICARE. Your TRICARE health benefit changes to TRICARE for Life, and your TRICARE Supplement Plan coverage ends. You can continue the supplement plan coverage for your eligible dependents by making premium payments directly to Selman & Company. Let PEBA know if you are eligible for TRICARE for Life so you do not end up with double coverage. Call Selman & Company at 800.638.2610, Option 1, for details. You can also email memberservices@selmanco.com.

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

Loss of TRICARE eligibility

The TRICARE Supplement Plan pays after TRICARE pays. Therefore, if an employee, spouse or dependent child loses TRICARE eligibility, TRICARE Supplement Plan coverage ends. Dependents who lose TRICARE eligibility are not eligible for continued TRICARE Supplement Plan coverage through COBRA or portability. Loss of TRICARE eligibility is a

special eligibility situation that permits an eligible employee or retiree and their dependents, if the dependents are otherwise eligible for PEBA insurance coverage, to enroll in health, dental and vision coverage.

Basic Life insurance and Basic Long Term Disability insurance are provided at no cost to active employees who enroll in the State Health Plan.

Loss of a spouse's TRICARE eligibility

A spouse can lose TRICARE eligibility due to a divorce. When this occurs, they also lose eligibility to continue coverage under the TRICARE Supplement Plan.

Loss of a dependent child's TRICARE eligibility

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

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

More information

For more information about the Government Employees Association TRICARE Supplement Plan, contact [Selman & Company](#) through its website or call 800.638.2610, Option 1.

For more information about [TRICARE for Life](#), visit its website or call 866.773.0404.



Prescription benefits

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

Using generic drugs saves money for you and the Plan. You also can save money and receive the same U.S. Food and Drug Administration approved drugs when you refill prescriptions through the Plan's Retail Maintenance Network or mail-order prescription service. Benefits are paid only for prescriptions filled at network pharmacies or through Caremark's mail-order pharmacy in the United States. Limited coverage is offered outside the United States. For more information on how to file a claim, see Page 74.

Using your prescription benefits

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

Member resources

Helpful information about your State Health Plan prescription drug benefits is available on [Caremark's website](#) and the Caremark mobile app. Create an account to get the most out of these resources. Be sure to have your prescription drug card available when you register. The website and mobile app offer a variety of information and tools:

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

State Health Plan Prescription Drug Program

Standard Plan

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

- Tier 1: \$13
- Tier 2: \$46
- Tier 3: \$77

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

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

Savings Plan

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

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

SilverScript Employer PDP®

If you are enrolled in the Medicare Supplemental Plan and Medicare is your primary payer, PEBA automatically enrolls the member in SilverScript Employer PDP, the State Health Plan's Medicare Part D program. For information about SilverScript, see the *Insurance Coverage for the Medicare-eligible Member* handbook, which is available on [PEBA's Publications](#) webpage under Health.

Pharmacy network

How to find participating pharmacies

You can search for a network pharmacy through the [Caremark website](#) or Caremark mobile app by logging in to your account and selecting Fill at a Pharmacy Near You, then Find a Pharmacy. Because the State Health Plan does not offer out-of-network coverage for prescription drugs in the United States, you should consider using a network provider when possible.

You can also call Caremark at 833.291.3646 for a list of network pharmacies near you.

Retail pharmacies

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

Retail90 Network

You can buy up to 90-day supplies of prescription drugs at discounted prices at your local network pharmacy that participates in the Retail90 Network. You will pay a lower copayment than if you purchased this medication one month at a time. Be sure to ask your physician to write your prescription for a 90-day supply. The discount applies only to prescriptions filled for a 61-to-90-day supply. Copayments for prescriptions filled for a 1- to 60-day supply will follow the normal retail prices. Note, however, that specialty medications and GLP-1s are limited to a 30-day supply per fill. You can search for a Retail90 Network pharmacy by logging in to your Caremark account on the [Caremark website](#) or on the Caremark mobile app.

Mail order through Caremark Mail Service Pharmacy

The State Health Plan Prescription Drug Program and SilverScript offer home delivery for 90-day supplies of prescriptions through Caremark Mail Service Pharmacy. When you use this service, you receive the same discount on the same FDA-approved prescription drugs that you would receive in the Retail90 network.

Some controlled substances might not be available by mail; call Caremark at 833.291.3646 before submitting your prescription to determine if it is available. Be sure to ask your physician to write your prescription for a 90-day supply.

To place an order, log in to your Caremark account on the [Caremark website](#) or on the Caremark mobile app. Your mail order purchase will be delivered to your home, typically within 10 to 14 business days.

Standard Plan and Medicare Supplemental Plan

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

- Tier 1: \$32
- Tier 2: \$115
- Tier 3: \$192

Mail order is intended to fill 90-day supplies. Specialty medications, GLP-1s and other drugs limited to 30-day supplies per fill are not prorated. The full mail order copayment will be applied if you fill these drugs by mail order.

Savings Plan

You pay the full allowed amount when you order prescription drugs through the mail; however, the cost for a 90-day supply will generally be less if you use the Retail90 Network or Caremark Mail Service Pharmacy.

How to order drugs by mail

1. Ask your doctor to write a prescription or submit a prescription electronically for a 90-day supply of the medication with refills, as appropriate. You can also want to ask them to write a prescription for a 30-day supply of the drug, which you can fill at a retail pharmacy and use until you receive your drugs in the mail.
2. Have your physician e-prescribe the prescription to

Caremark mail order. You can pay by check, money order or major credit card. If you would like to pay by credit card, you might want to sign up for Caremark's automatic payment program. If you have already created a Caremark account, the method of payment can be selected in advance, and Caremark will send you an email when it receives your new prescription and can begin dispensing.

You can also complete a home delivery order form, available at our [Forms webpage](#) under Prescription benefits. Mail the prescription, the order form and payment to Caremark at the address indicated on the form.

How to fill a prescription by fax

1. Ask your doctor to write a new prescription or submit a prescription electronically for a 90-day supply of the medication with refills, as appropriate. Give your doctor your member ID number, which you can find on the front of your State Health Plan Prescription Drug Program ID card.
2. Ask your doctor to fax your prescription to 800.378.0323.

If your doctor has questions about faxing your prescription, they can call Caremark at 800.378.5697 or SilverScript at 800.459.1907.

Prescription copayments and formulary

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

Tier 1: generic

\$13 copayment

Generic drugs can differ in color, size or shape, but the FDA requires that the active ingredients be the chemical equivalent of the brand-name alternative and have the

same strength, purity and quality. Because generic drugs have a lower copayment, you typically get the same health benefits for less. You might want to ask your doctor to mark "Substitution Permitted" on your prescription. If they do not, your pharmacist will have to provide you the brand-name drug if that's the drug your doctor wrote on the prescription.

Tier 2: preferred brand

\$46 copayment

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

Tier 3: non-preferred brand

\$77 copayment

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

A list of drugs by tier is available by logging in to your Caremark account on [Caremark's website](#) or on the Caremark mobile app.

Non-covered formulary drugs

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

Pay-the-difference policy

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

As a Standard Plan or Medicare Supplemental Plan member¹, if you purchase a Tier 2 or Tier 3 drug over a Tier

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

1 drug, you will be charged the generic copayment plus the difference between the allowed amounts for the brand drug and the generic drug.

If the total amount is less than the Tier 2 or Tier 3 copayment, you will pay the brand copayment. Only the copayment for the Tier 1 drug will apply toward a member's annual prescription drug copayment maximum.

Savings Plan members do not pay copayments; however, they usually save money by buying generic drugs, because these drugs typically cost less. With the Savings Plan, if you purchase a Tier 2 or Tier 3 drug over a Tier 1 drug, only the allowed amount for the generic drug will apply toward your deductible. After you have met your deductible, only the 20% share of the allowed amount for the generic drug will apply toward your coinsurance maximum.

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

This is what you pay for a Tier 2 drug when a Tier 1 drug is not available.

	Tier 1	Tier 2
Allowed amount for drug		\$125
Generic copayment		N/A
Your total payment²		\$46

This is what you pay for a Tier 2 drug when a Tier 1 drug is available.

	Tier 1	Tier 2
Allowed amount for drug	\$65	\$125
Generic copayment	\$13	N/A
Amount you pay if you choose the generic drug	\$13	
Your total payment³		\$73

Specialty pharmacy programs

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

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

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

- Requires special handling and administration.

Members who fill prescriptions for specialty medications must use the Plan's custom credentialed specialty network.⁴ The network includes South Carolina independently owned specialty pharmacy accredited pharmacies and CVS Specialty, Caremark's specialty pharmacy. Specialty medications are limited to a 30-day supply per fill. Patients seeking specialty medication should call Caremark at 866.814.5506 for more information.

Coverage reviews

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

Prior authorization

Some medications will be covered by the State Health Plan only if they are prescribed for certain uses. These drugs must be authorized in advance, or they will not be covered under the Plan. Other medications may not be covered by the Plan if there are safe and effective lower-cost alternatives available. You can research whether a drug requires a prior authorization or other type of coverage review by logging in to your Caremark account on [Caremark's website](#) or on the Caremark mobile app. If the prescribed medication requires prior authorization, you, your doctor or your pharmacist can begin the review process by calling Caremark at 800.294.5979.

Drug quantity management

The FDA has guidelines for safety and effectiveness that include quantity limits for certain medications. If you are prescribed a quantity of a medication that does not fall within these guidelines, the Plan may cover a lesser quantity of the medication. You, your doctor or your pharmacist can

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

also begin the coverage review process to see if coverage might be allowed for a higher quantity by contacting Caremark at 800.294.5979.

Step therapy

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

You or your doctor can request a coverage review by calling Caremark at 800.294.5979. As part of the process, you might be required to have tried and failed to successfully use the lower-cost drug. If, as a result of the review, the drug is approved, it will be covered at the appropriate tier. If approval is denied, the Plan will not cover the drug. For more information, call Caremark at 800.294.5979.

Compound prescriptions

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

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

Coordination of benefits

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

pays first is the primary plan. The secondary plan pays after the primary plan. See Page 39 for more information about coordination of benefits.

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

Outpatient hospital observation services are those received at a hospital while the doctor decides whether to admit a patient as inpatient or discharge them from the hospital. Patients can receive observation services in the emergency department or another area of the hospital. Observation can last for up to a 72-hour period. Medicare covers observation services under Medicare Part B. For safety reasons, many hospitals have policies that do not allow patients to bring prescription medications or other drugs from home. These medications are considered self-administered drugs and Medicare defines these medications as drugs a patient would take by mouth or administer to themselves and include, but are not limited to, oral medications, insulin, eye drops and topical treatments. Self-administered drugs are not covered under Medicare Part B.

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

Exclusions

Some prescription drugs, such as those that do not appear on the formulary listing of covered and preferred drugs, are not covered under the Plan. Some covered drugs, including insulin and other self-injectable drugs administered at home, are subject to plan exclusions and limitations when you use a network pharmacy.

Prescription drugs associated with infertility treatments have a different coinsurance rate. See Page 57 for more information about infertility treatments.

Examples of other drugs that are not covered are:

- Drugs in FDA Phase I, II or III testing;
- Prescription drugs used for weight loss; and
- Drugs prescribed by a provider who has lost their prescribing privileges under the Plan.

Drugs that are not covered under the Savings Plan but are covered under the Standard Plan are:

- Non-sedating antihistamines; and
- Drugs for treating erectile dysfunction.

Value-based prescription benefits at no cost to you

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

- Contraceptives for subscribers, covered spouses and covered child dependents.
- Some specific prescription drugs for smoking cessation.
- Adult vaccinations, including the flu shot, as recommended by the Centers for Disease Control and Prevention (CDC). See Page 46 for more information about adult vaccinations.

Filing a prescription drug claim

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

To file a claim for prescription drug expenses incurred

at a participating pharmacy or outside the United States, complete the *Caremark Prescription Reimbursement Claim Form*. The form is available at our [Forms webpage](#). You can also request a copy by calling Caremark at 833.291.3646.

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

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

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

SilverScript Insurance Company
Prescription Drug Plans
Medicare Part D Paper Claim
P.O. Box 52066
Phoenix, AZ 85072-2066

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

Appeals

If Caremark denies prior authorization or coverage for your medication, you will be informed promptly. If you have questions about the decision, check the information in this chapter. You or your prescriber can also call Caremark for an explanation. If Caremark's decision was a non-clinical denial, you can appeal to PEBA as described on the following page.

First reconsideration of clinical denial

If Caremark's decision was denied for a clinical reason, and you believe the decision was incorrect, you can ask Caremark to reexamine its decision.

If you are enrolled in the State Health Plan, your first request for a clinical review should be made in writing within 90 days after notice of the decision to:

Caremark
Fax: 866.443.1172

If you are enrolled in SilverScript, your first request for a clinical review should be made in writing within 90 days after notice of the decision to:

SilverScript

Fax: 855.633.7673

or

SilverScript Insurance Company
Prescription Drug Plans Coverage Decisions and Appeals
Department
P.O. Box 52000, MC 109
Phoenix, AZ 85072-2000
Customer Care: 833.293.4859

You must include reasons why the request for prior authorization or coverage should be approved. You can also request an expedited clinical review.

Caremark will provide its decision within 60 days after it receives your first request for a clinical review. If medical records are requested, the decision will be provided within 30 days after the requested information is received. If the requested information is not received within 30 days of Caremark's request, the decision will be made on the information available at that time. Caremark will send you a written decision containing the specific reasons for its decision.

Second reconsideration of clinical denial

If Caremark, following its initial clinical review, denies the subscriber's request, the subscriber has the right to request a second clinical review.

If you are enrolled in the State Health Plan, your request for a second clinical review should be made in writing within 90 days after notice of the initial clinical review decision to:

Caremark

Fax: 866.443.1172

If you are enrolled in SilverScript, your request for a second clinical review should be made in writing within 90 days after notice of the initial clinical review decision to:

SilverScript

Fax: 855.633.7673

or

SilverScript Insurance Company
Prescription Drug Plans Coverage Decisions and Appeals
Department
P.O. Box 52000, MC 109
Phoenix, AZ 85072-2000

Customer Care: 833.293.4859

You must include reasons why the request for prior authorization or coverage should be approved. You can also request an expedited clinical review.

Caremark will provide its decision within 60 days after it receives your first request for a clinical review. If medical records are requested, the decision will be provided within 30 days after the requested information is received. If the requested information is not received within 30 days of Caremark's request, the decision will be made on the information available at that time. Caremark will send you a written decision containing the specific reasons for its decision.

Appeals to PEBA

If you are enrolled in the State Health Plan and you are still dissatisfied after Caremark has completed its review process, you can ask PEBA to review the matter by sending an [Appeal Request Form](#) to PEBA within 90 days of notice of Caremark's final denial of your appeal. Include a copy of the previous denial(s) with your appeal to PEBA. Send the request to:

IAD@peba.sc.gov

or

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

Appeals can be brought only by the covered person at issue, their legal representative (who cannot be, including but not limited to, a provider, medical device manufacturer, pharmaceutical manufacturer, employer, or a representative or agent of any of the foregoing), or a licensed attorney admitted to practice in South Carolina. PEBA will make every effort to process your appeal within 180 days of the date it receives your claim file from Caremark, as outlined in the Plan. However, this time can be extended if additional material is requested or you ask for an extension. PEBA will send you status updates on your review. When PEBA's review of your appeal is complete, you will receive a written determination.

If the denial is upheld by PEBA, you have 30 days to seek judicial review at the Administrative Law Court, as provided

by Sections 1-11-710 and 1-23- 380 of the S.C. Code of Laws, as amended.

Appeals for Medicare-primary members

If you are enrolled in SilverScript, your appeal rights are through SilverScript, and you cannot appeal to PEBA.



Dental insurance

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

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

- During initial enrollment in PEBA's insurance programs.
- During an open enrollment period in an odd-numbered year. The next two opportunities will be October 2027 and October 2029.
- Within 31 days of a special eligibility situation. Special eligibility situations are explained on Page 19.

Online resources

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

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

Classes of treatment

Dental coverage offers four classes of treatment. Details about the benefits in each class are in the chart on Page 80.

- **Class I: Diagnostic and preventive** Exams; cleaning and scaling of teeth; fluoride treatment; space maintainers (child); X-rays.
- **Class II: Basic** Fillings; extractions; oral surgery; endodontics (root canals); periodontal procedures.
- **Class III: Prosthodontics** Onlays; crowns; bridges;

dentures; implants; repair of prosthodontic appliances.

- **Class IV: Orthodontics** Limited to covered children ages 18 and younger. Correction of malocclusion consisting of diagnostic services (including models and X-rays) and active treatment (including necessary appliances).

Dental Plus

Dental Plus has higher allowed amounts, which are the maximum amounts allowed by the Plan for a covered service. Network providers cannot charge you for the difference in their cost and the allowed amount. The maximum yearly benefit for a person covered by Dental Plus is \$2,000. Not all dental procedures are covered. You will be responsible for any charges related to non-covered services. With Dental Plus, you will receive an additional EOB. See Page 81 for more information.

See the chart on Page 80 for more information.

Dental Plus network

BlueCross offers dentists in South Carolina agreements to participate in the Dental Plus network and accept the lesser of their usual charge or the negotiated allowed amount. Allowed amounts can vary by network dentist and/or the physical location of the dentist. You are responsible only for any deductibles and coinsurance, plus any non-covered services rendered by a network dentist who has accepted BlueCross' agreement. For a list of network dentists, go to [BlueCross BlueShield's website](#) and select Find a Dentist under the Find a Doctor section.

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

Basic Dental

Basic Dental has lower allowed amounts, which are the maximum amounts allowed by the Plan for a covered service. There is no network for Basic Dental; therefore, providers can charge you for the difference in their cost and the allowed amount.

Basic Dental benefits are paid based on the allowed

amounts for each dental procedure listed in the Plan's Schedule of Dental Procedures and Allowed Amounts, found on [BlueCross BlueShield's website](#) under Dental, then Basic Dental. The maximum yearly benefit for a person covered by Basic Dental is \$1,000. Not all dental procedures are covered. You will be responsible for any charges related to non-covered services. See Page 81 for more information. See the chart on Page 80 for more information.

Special provisions of Basic Dental

Alternate forms of treatment

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

An example of when a less costly procedure might apply is when porcelain fused to a predominantly base metal crown is less costly than porcelain fused to a noble metal crown.

Pretreatment estimates

Although it is not required, PEBA suggests you obtain a pretreatment estimate of your non-emergency treatment for major dental procedures. To do this, you and your dentist should complete a *Dental Claim Form* before any work is done. The form can be found on our [Forms webpage](#). The completed form should list the services to be performed and the charge for each one.

Mail the claim form to:

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

Emergency treatment does not need a pretreatment estimate.

You and your dentist will receive a pretreatment estimate, showing an estimate of the expenses your dental plan will

cover. This form can be used to file for payment as the work is completed. Just fill in the date(s) of service, ask your dentist to sign the form and submit it to BlueCross. Your pretreatment estimate is valid for 90 days from the date of the form. The actual date of service might affect the payment allowed. For example, if you have reached your maximum yearly payment when the service is performed or if you no longer have dental coverage, you will not receive the amount that was approved on the pretreatment estimate.

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

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

Comparing Dental Plus and Basic Dental

	Dental Plus	Basic Dental
Diagnostic and preventive Exams, cleanings, X-rays	You do not pay a deductible. The Plan will pay 100% of a higher allowed amount . In network, a provider cannot charge you for the difference in its cost and the allowed amount.	You do not pay a deductible. The Plan will pay 100% of a lower allowed amount . A provider can charge you for the difference in its cost and the allowed amount.
Basic Fillings, oral surgery, root canals	You pay up to a \$25 deductible per person. ¹ The Plan will pay 80% of a higher allowed amount . In network, a provider cannot charge you for the difference in its cost and the allowed amount.	You pay up to a \$25 deductible per person. ¹ The Plan will pay 80% of a lower allowed amount . A provider can charge you for the difference in its cost and the allowed amount.
Prosthodontics Crowns, bridges, dentures, implants	You pay up to a \$25 deductible per person. ¹ The Plan will pay 50% of a higher allowed amount . In network, a provider cannot charge you for the difference in its cost and the allowed amount.	You pay up to a \$25 deductible per person. ¹ The Plan will pay 50% of a lower allowed amount . A provider can charge you for the difference in its cost and the allowed amount.
Orthodontics² 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. ³	\$1,000 per person each year for diagnostic and preventive, basic and prosthodontics services.

Plan comparison examples

Scenario 1: Routine checkup

Includes exam, four bitewing X-rays and adult cleaning

	Dental Plus (in network)	Dental Plus (out of network)	Basic Dental
Dentist's initial charge	\$235.00	\$235.00	\$235.00
Allowed amount⁴	\$145.00	\$180.00	\$75.00
Amount paid by the Plan (100%)	\$145.00	\$180.00	\$75.00
Your coinsurance (0%)	\$0.00	\$0.00	\$0.00
Difference between allowed amount and charge	\$90.00 Dentist writes this off	\$55.00	\$160.00
You pay	\$0.00	\$55.00 Difference in allowed amount and charge	\$160.00 Difference in allowed amount and charge

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.

³ The \$2,000 maximum payment includes payments made under both Dental Plus and Basic Dental.

⁴ Allowed amounts can vary by network dentist and/or the physical location of the dentist.

Scenario 2: Two surface amalgam fillings

	Dental Plus (in network)	Dental Plus (out of network)	Basic Dental
Dentist's initial charge	\$190.00	\$190.00	\$190.00
Allowed amount ^{5,6}	\$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 this off	\$13.00	\$145.20
You pay	\$29.00	\$48.40 20% coinsurance plus difference	\$154.16 20% coinsurance plus difference

⁵ Allowed amounts can vary by network dentist and/or the physical location of the dentist.

⁶ Example assumes the \$25 annual deductible has been met.

Exclusions – dental services not covered

The *Group Dental Insurance Benefit Plan* document lists all exclusions and is on our [Publications webpage](#) under Dental. The list below includes many of the exclusions.

General benefits not offered

- Treatment received from a provider other than a licensed dentist. Cleaning or scaling of teeth by a licensed dental hygienist is covered when performed under the supervision and direction of a dentist.
- Services beyond the scope of the dentist's license.
- Services performed by a dentist who is a member of the covered person's family or for which the covered person was not previously charged or did not pay the dentist.
- Dental services or supplies rendered before the date you are eligible for coverage under the Plan.
- Charges made directly to a covered person by a dentist for dental supplies (i.e., toothbrush, mechanical toothbrush, mouthwash or dental floss).
- Non-dental services, such as broken appointments and completion of claim forms.

- Nutritional counseling for the control of dental disease, oral hygiene instruction or training in preventive dental care.
- Services and supplies for which no charge is made or no payment would be required if the person did not have this benefit, including non-billable charges under the person's primary insurance plan.
- Services or supplies not recognized as acceptable dental practices by the American Dental Association.

Benefits covered by another plan

- Treatment for which the covered person is entitled under any workers' compensation law.
- Services or supplies that are covered by the armed services of a government.
- Dental services for treatment of injuries as a result of an accident received during the first 12 months from the date of the accident. These services are covered under the member's health plan.
- Additional benefits for dental services for natural and artificial teeth, dentures, bridges, etc., made necessary by loss of teeth due to cancer treatment or as a result of a congenital birth defect, are covered under the member's health plan.

Specific procedures not covered

- Space maintainers for lost deciduous (primary) teeth if the covered person is ages 19 or older.
- Investigational or experimental services or supplies.
- Any service or charge for a service not medically necessary.
- Onlays or crowns, when used for preventive or cosmetic purposes or due to erosion, abrasion or attrition.
- Services and supplies for cosmetic or aesthetic purposes, including charges for personalization or characterization of dentures, except for orthodontic treatment as provided for under this Plan.
- Myofunctional therapy (i.e., correction of tongue thrusting).
- Appliances or therapy for the correction or treatment of temporomandibular joint syndrome.
- Services to alter vertical dimension.
- Splinting, including extra abutments for bridges.
- Services for tests and laboratory examinations, including but not limited to, bacterial cultures for determining pathological agents, caries (tooth or bone destruction) susceptibility tests, viral cultures, saliva samples, genetic tests, diagnostic photographs and histopathologic exams.
- Pulp cap, direct or indirect (excluding final restoration).
- Provisional intracoronal and extracoronal (crown) splinting.
- Tooth transplantation or surgical repositioning of teeth.
- Occlusal adjustment (complete). Occlusal guards are covered for certain conditions. The provider should file office records and photo of occlusal surfaces exhibiting wear patterns with the claim for review by the dental consultant.
- Temporary procedures, such as temporary fillings or temporary crowns.
- Rebase procedures.
- Stress breakers.
- Precision attachments.
- Procedures that are performed on the same day and considered part of a more definitive treatment (i.e., an X-ray taken on the same day).
- Inlays (cast metal, composite, resin, porcelain, ceramic). Benefits for inlays are based on the allowance of an alternate amalgam restoration.
- Gingivectomy/gingivoplasty in conjunction with or for the purpose of placement of restorations.
- Topical application of sealants per tooth for patients ages 16 and older.
- CT scans, CAT scans, MRIs or any related services.

Limited benefits

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

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

Prosthodontic and orthodontic benefits

- Benefits are not payable for prosthodontics (i.e., crowns, crowns seated on implants, bridges, partial or complete dentures) until they are seated or delivered. Other exclusions and limitations for these services include:
- Prosthodontics (including bridges, crowns, and implants) and their fitting that were ordered while the person was covered under the Plan, but they were delivered or seated more than 90 days after

termination of coverage.

- Replacement of lost or stolen prosthodontics, space maintainers or orthodontic appliances, or charges for spare or duplicate dentures or appliances.
- Replacement of broken or lost orthodontic appliances or occlusal guards.
- Replacement of existing cast prosthodontics unless otherwise specified in the dental plan document.
- Orthodontic treatment for employees, retirees, spouses or covered children ages 19 and older.
- Payment for orthodontic treatment over the lifetime maximum.
- Orthodontic services after the month a covered child becomes ineligible for orthodontic coverage.
- The only orthodontic services benefit is the lifetime orthodontics payment of \$1,000 for each covered child age 18 and younger.

Coordination of benefits

All dental 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; however, the sum of the combined payments will never be more than the allowed amount for your covered dental procedures.

The allowed amount is the amount Basic Dental lists for each dental procedure in the Schedule of Dental Procedures and Allowed Amounts at [BlueCross BlueShield's website](#). Dental Plus has higher allowed amounts. When your state dental coverage is secondary, it pays up to the allowed amount of your state dental coverage minus what the primary plan paid.

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. Log in to your My Health Toolkit account to update this information.

Certain oral surgical procedures are covered under the State Health Plan and dental plans. The most common of these is the surgical removal of impacted teeth. Benefits are

applied under the State Health Plan, and then coordinated under Dental Plus and Basic Dental if the member is covered by a dental plan. The amount paid under the dental plan could be reduced based on the State Health Plan payment.

You will never receive more from your state dental coverage than the maximum yearly benefit, which is \$2,000 for a person covered by Dental Plus and \$1,000 for a person covered by Basic Dental. The maximum lifetime benefit for orthodontic services is \$1,000, regardless of if covered under Dental Plus or Basic Dental, and it is limited to covered children ages 18 and younger. See the chart on Page 80 for more information.

For more information about coordination of benefits, including how to determine which plan pays first, see Page 39. If your state dental coverage is secondary, you must send the Explanation of Benefits you receive from your primary plan with your claim to BlueCross. To ensure benefits are paid correctly, you must complete a coordination of benefits questionnaire every year. Log in to your My Health Toolkit account to update this information. Select My Plan & Benefits, then Dental, then Other Dental Insurance.

If you have questions, call BlueCross at 888.214.6230 or 803.264.7323, or contact PEBA.

How to file a dental claim

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

If your dentist will not file your claims, you can file to BlueCross. The claim form is available on our [Forms webpage](#) or [BlueCross' website](#). Complete Blocks 4–23 on the claim form and ask your dentist to complete Blocks 1–2,

24–35 and 48–58.

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

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

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

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

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

What if I need help?

You can call BlueCross at 888.214.6230, visit the [BlueCross website](#) or write to BlueCross at the address above.

Appeals

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

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

You should include the reasons why your request should be approved, and you can also request an expedited review.

BlueCross will provide its decision within 60 days after your request for review is received. If medical records are requested, the decision will be provided no later than 30 days after the requested information is received. If the requested information is not received within 30 days, BlueCross's decision will be made on the information available at that time. The notice from BlueCross will state the specific reasons for its determination.

If you are still dissatisfied after BlueCross has completed its review process, you can ask PEBA to review the matter by sending an [Appeal Request Form](#) to PEBA within 90 days of notice of BlueCross' denial of your appeal. Include a copy of the previous BlueCross denial(s) with your appeal to PEBA. Send the request to:

IAD@peba.sc.gov

or

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

Appeals can be brought only by the covered person at issue, their legal representative (who cannot be, including but not limited to, a provider, medical device manufacturer, pharmaceutical manufacturer, employer, or a representative or agent of any of the foregoing), or a licensed attorney admitted to practice in South Carolina.

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

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



Vision care

PEBA offers vision care benefits through the State Vision Plan, a fully insured product provided through EyeMed Vision Care®.

Online vision benefits information

Log in to [EyeMed's website](#) for:

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

State Vision Plan

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

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

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

discounts available under Special Offers for registered members on the [EyeMed website](#). Special offer discounts can be combined with member vision benefits.

Eye exams

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

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

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

Frequency of benefits

The State Vision Plan covers:

- A comprehensive eye exam once a year;
- Standard plastic lenses for eyeglasses or contact lenses once a year;
- Frames once every year; and
- Members with Type 1 or Type 2 diabetes are eligible for office service visits and diagnostic testing once every six months to monitor for signs of diabetic changes in the eye.

Vision benefits at a glance^{1,2}

	In network, you pay:	Out of network, you receive:
Comprehensive exam with dilation as necessary Limited to once per year	A \$10 copayment.	Up to \$35.
Retinal imaging Covered for members with Type 1 or Type 2 diabetes only	Up to \$39 .	No reimbursement.
Retinal imaging discount Optional; not a covered benefit	Up to \$39 .	Not applicable.

Eyeglasses

	In network, you pay:	Out of network, you receive:
Frames Available every year; applies to any frames available at the provider's location	A \$0 copayment and 80% of balance over \$150 allowance. This benefit cannot be used with any promotion.	Up to \$75.
Standard plastic lenses³ (limited to once per year)		
Single vision	A \$10 copayment.	Up to \$25.
Bifocal	A \$10 copayment.	Up to \$40.
Trifocal	A \$10 copayment.	Up to \$55.
Lenticular	A \$10 copayment.	Up to \$55.
Lens add-ons		
UV treatment, tint Solid, gradient; standard scratch coating; and standard polycarbonate lens (under age 19)	A \$0 copayment for each option.	Up to \$5 for each option.
Standard polycarbonate lens (adults)	A \$30 copayment.	Up to \$5.
Standard anti-reflective coating	\$45 .	Not applicable.
Premium anti-reflective coating	See chart below.	Not applicable.
Polarized	20% off retail price.	Not applicable.
Transition plastic lenses	A \$60 copayment.	Up to \$5.
Other add-ons	20% off retail price.	Not applicable.
Additional savings		
Additional pairs of glasses	40% off complete pairs of prescription eyeglasses after using the funded benefit.	Not applicable.

¹ State Vision Plan exclusions and limitations may apply. Refer to Page 90 for details.

² The benefits below are available only under the State Vision Plan. Eyeglasses, contact lenses and exams for the fitting thereof are excluded under the State Health Plan. Refer to Page 91 for details.

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

Progressive lens and anti-reflective coating⁴

	In network, you pay:	Out of network, you receive:
Progressive lenses		
Standard progressive lenses	A \$35 copayment.	Up to \$55.
Premium progressives (scheduled)	\$55–\$80.	Up to \$55.
Other premium progressives (non-scheduled)	A \$35 copayment and 80% of cost less \$120 allowance.	Up to \$55
Anti-reflective coating		
Standard anti-reflective coating	\$45.	Not applicable.
Premium anti-reflective coatings (scheduled)	\$57–\$68.	Not applicable.
Other premium anti-reflective coatings (non-scheduled)	80% of charge.	Not applicable.
Other add-ons and services	20% off retail price.	Not applicable.

Contact lenses⁵

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

	In network, you pay:	Out of network, you receive:
Standard contact lenses fit & follow-up⁶ Available after comprehensive eye exam	A \$0 copayment and service paid in full, including two follow-up visits.	Up to \$40.
Premium contact lenses fit & follow-up⁷ Available after comprehensive eye exam	A \$0 copayment and receive 10% off retail price less \$40 allowance.	Up to \$40.
Conventional	A \$0 copayment and 85% of balance over \$130 allowance.	Up to \$104.
Disposable	A \$0 copayment and balance over \$130 allowance.	Up to \$104.
Medically necessary contact lenses	A \$0 copayment.	Up to \$200.
Additional contact lenses	15% off conventional contact lenses after using the funded benefit.	Not applicable.

⁴ Products listed as premium progressives and premium anti-reflectives are subject to annual review by EyeMed's medical director and might change based on market conditions. The copayment listed applies to particular brand names of lenses. Providers are not required to carry all brands at all levels. Providers can give members names and prices of specific products upon request. A complete list of brands is available on EyeMed's website.

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

⁶ A standard contact lens fitting includes clear, soft, spherical, daily-wear contact lenses for single-vision prescriptions. It does not include extended/overnight-wear lenses.

⁷ A premium contact lens fitting is more complex and might include fitting for bifocal/multifocal, cosmetic color, post-surgical and gas-permeable lenses. It also includes extended-/overnight-wear lenses.

Medically necessary contact lenses

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

- Anisometropia of 3D in meridian powers;
- High ametropia exceeding -10D or +10D in meridian powers;
- Keratoconus where the member’s vision is not correctable to 20/30 in either or both eyes using

standard spectacle lenses; or

- Vision improvement for members whose vision can be corrected two lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

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

Diabetic vision benefits at a glance

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

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

Using the EyeMed provider network

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

To find a network provider

- Check network providers in or near your Zip code on the list that comes with your membership card.
- Go to [EyeMed’s website](#) for the most current directory. Then, enter your Zip code or address.
- Use the Interactive Voice Response system or speak with a representative at the Customer Care Center at 877.735.9314. To speak with a customer service representative, choose your language (1 is for English) and then say, Provider Locator.

- You can also ask your provider if they accept EyeMed coverage.

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

How to order contact lenses online

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

Out-of-network benefits

Your benefits are lower when you use a provider outside the network. To learn what you will be reimbursed if you use an out-of-network provider for covered services and supplies, see the charts on Pages 88-90.

To receive out-of-network services:

- You can file an out-of-network claim electronically. The electronic claim form is located on the [EyeMed Vision Care member website](#). You can also print one on our [Forms webpage](#).
- When you receive services, pay for them and ask your provider for an itemized receipt.
- Send the claim form and a copy of your receipt to:
First American Administrators/EyeMed Vision Care
Attn: OON Claims
P.O. Box 8504
Mason, OH 45040-7111

Your reimbursement will be sent to you.

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

Exclusions and limitations

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

- Orthoptic (problems with the use of eye muscles) or vision training, subnormal vision aids and any associated supplemental testing;
- Aniseikonic lenses (lenses to correct a condition in which the image of an object in one eye differs from the image of it in the other eye);
- Medical or surgical treatment of the eye, eyes or supporting structures;
- Any eye or vision examination or corrective eyewear required by an employer as a condition of employment;
- Safety eyewear;
- Services that would be provided by the government under any workers' compensation law or similar legislation, whether federal, state or local;
- Plano (non-prescription) lenses or contact lenses;
- Non-prescription sunglasses;
- Two pairs of glasses instead of bifocals;
- Services provided by any other group benefit plan offering vision care;

- Services provided after the date the enrollee is no longer covered under the policy, except when vision materials ordered before coverage ended are delivered, and the services are provided to the enrollee within 31 days from the date the materials were ordered;
- Lost or broken lenses, frames, glasses or contact lenses will not be replaced until they are next scheduled to be replaced under Frequency of Benefits;
- A benefit cannot be combined with any discount, promotional offering or other group benefit plans.

Contact EyeMed

You can reach EyeMed's Customer Care Center by calling 877.735.9314. You can also log in to EyeMed's homepage, and select Contact us under Help and Resources. Be sure to have the following information ready:

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

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

Appeals

If a claims question cannot be resolved by EyeMed's Customer Care Center, you can write to:

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

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

subcommittee receives them.

Because the Vision Care Plan is fully insured, you cannot appeal EyeMed determinations to PEBA.

State Vision Plan examples

Example 1

	Average retail price ⁸	State Vision Plan benefit	Your in-network cost
Eye examination	\$130.00	\$10 copayment	\$10.00
Frames	\$200.00	\$0 copay and 20% off balance over \$150 allowance	\$40.00
Lenses			
Single vision	\$90.00	\$10 copayment	\$10.00
Polycarbonate (adult)	\$64.00	\$30 copayment	\$30.00
Premium anti-reflective (Crizal Alize)	\$123.00	\$68 copayment	\$68.00
You pay	\$607.00		\$158.00

Example 2

	Average retail price ⁸	State Vision Plan benefit	Your in-network cost
Eye examination	\$130.00	\$10 copayment	\$10.00
Frames	\$150.00	\$0 copay and 20% off balance over \$150 allowance	\$0.00
Lenses			
Premium progressive (Tier 2)	\$323.00	\$65 copayment	\$65.00
Premium anti-reflective (Crizal Alize)	\$123.00	\$68 copayment	\$68.00
You pay	\$726.00		\$143.00

Example 3

	Average retail price ⁸	State Vision Plan benefit	Your in-network cost
Eye examination	\$130.00	\$10 copayment	\$10.00
Standard contact lens fit and follow-up	\$71.00	\$0 copayment	\$0.00
Disposable contact lenses	\$130	\$130 allowance	\$0.00
You pay	\$328.00		\$10.00

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



Life insurance

PEBA's life insurance program is underwritten by Metropolitan Life Insurance Company. The insurance offered is term life insurance, which means coverage is provided for a specific time period. The policy has no cash value.

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

Eligibility

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

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

Actively at Work requirement

To become insured or to receive an increase in the amount of your life insurance coverage, you must be "Actively at Work." This means you are fully performing your customary duties for your regularly scheduled number of hours at the employer's normal place of business, or at other places the employer's business requires you to travel.

If you are not working due to illness or injury, you do not

meet the Actively at Work requirements. If you are receiving sick pay, short-term disability benefits or long-term disability benefits, you also do not meet the requirements.

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

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

Applications

The *Notice of Election* and an electronic *Statement of Health* you complete to be covered by this Plan are considered your application for life insurance coverage. MetLife can use misstatements or omissions in your application to contest the validity of insurance or deny a claim.

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

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

What's the minimum amount of life insurance you should

have? To help you get an idea of how much to consider, try [MetLife's calculator](#).

Basic Life insurance

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

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

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

Your coverage begins on the first day of the month you are Actively at Work as a full-time employee. If you become eligible on a day other than the first calendar day or first working day of the month, your coverage starts on the first day of the next month. All effective dates of coverage are subject to the Actively at Work requirement (see Page 94).

Optional Life insurance

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

Initial enrollment - active employees

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

You can apply for a benefit level higher than three times your annual salary, in increments of \$10,000, up to a maximum of \$500,000, by completing an electronic *Statement of Health* to provide medical evidence. You will

receive an email from MetLife to complete a *Statement of Health*.

Your coverage begins on the first day of the month you are Actively at Work as a full-time employee. If you become eligible on a day other than the first calendar day or first working day of the month, your coverage starts on the first day of the next month. If you enroll in an amount of coverage that requires medical evidence, your coverage effective date for the amount requiring medical evidence will be the first of the month after approval of medical evidence and receipt of a completed *Notice of Election*.

All effective dates of coverage are subject to the Actively at Work provision (see Page 94).

Late entry

With the Pretax Group Insurance Premium feature

If you participate in the MoneyPlus Pretax Group Insurance Premium feature and do not enroll in Optional Life coverage within 31 days of the date you begin employment, you can enroll only within 31 days of a special eligibility situation (see Page 19) or during the annual open enrollment period each October. In certain special eligibility situations, you can purchase Optional Life coverage, in \$10,000 increments, up to a maximum increase of \$50,000 without providing medical evidence. Coverage elected because of a special eligibility situation that does not require medical evidence will be effective the first of the month after the request. Coverage elected because of a special eligibility situation that requires medical evidence will be effective the first of the month after approval of medical evidence and receipt of a completed *Notice of Election*. Otherwise, you will need to complete a *Notice of Election* and an electronic *Statement of Health* during the open enrollment period. If approved, your coverage will be effective on the first day of January after the enrollment period or, if approved after January 1, coverage will be effective the first of the month after approval of medical evidence and receipt of a completed *Notice of Election*. All effective dates of coverage are subject to the Actively at Work provision (see Page 94).

Without the Pretax Group Insurance Premium feature

If you do not participate in the MoneyPlus Pretax Group Insurance Premium feature and do not enroll in Optional Life coverage within 31 days of the date you begin employment, you can enroll throughout the year as long

as you provide medical evidence, and it is approved by MetLife. To enroll, you will need to complete a *Notice of Election* and an electronic *Statement of Health*. Your coverage will be effective on the first of the month following approval. In certain special eligibility situations, you can purchase Optional Life coverage, in \$10,000 increments, up to a maximum increase of \$50,000, without providing medical evidence. Coverage will be effective on the first of the month after the request.

All effective dates of Optional Life coverage are subject to the Actively at Work requirement (see Page 94).

Premiums

Optional Life premiums are determined by your age as of the preceding December 31 and the amount of coverage you select. Active employees can pay premiums for up to \$50,000 of coverage before taxes through MoneyPlus (see Page 120). Retired employees are not eligible to pay premiums through MoneyPlus.

What if my age category changes?

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

Changing your coverage amount

With Pretax Group Insurance Premium feature

If you participate in the MoneyPlus Pretax Group Insurance Premium feature, you can increase, decrease or drop your Optional Life coverage only during the annual open enrollment period in October or within 31 days of a special eligibility situation (see Page 19).

To increase your coverage during open enrollment, you will need to provide medical evidence and be approved by MetLife. If approved, coverage will be effective on January 1 following the enrollment period or upon MetLife approval, whichever is later. All effective dates of Optional Life coverage are subject to the Actively at Work requirement (see Page 93). If you are increasing your Optional Life coverage due to a special eligibility situation, you can increase, in increments of \$10,000 up to \$50,000 (\$500,000 serves as the maximum coverage amount) without

providing medical evidence.

Without the Pretax Group Insurance Premium feature

If you do not participate in the MoneyPlus Pretax Group Insurance Premium feature, you can apply to increase your amount of Optional Life coverage at any time during the year by providing medical evidence and being approved by MetLife. Your coverage at the new level will be effective on the first day of the month following the date of approval. In certain special eligibility situations, you can purchase Optional Life coverage, in \$10,000 increments, up to a maximum increase of \$50,000, without providing medical evidence. Coverage will be effective the first of the month after you complete and file the *Notice of Election*.

All effective dates of Optional Life coverage are subject to the Actively at Work requirement (see Page 94). You can decrease or cancel your coverage at any time. However, if you want to reenroll or increase coverage at a later date, you must provide medical evidence and be approved by MetLife.

Dependent Life insurance

Eligible dependents

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

Eligible dependents include:

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

Insurance eligibility changes made by the Patient Protection

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

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

For more information about covering an incapacitated child, including your notification requirements, see Page 14.

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

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

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

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

To file a claim for an incapacitated older than age 25, you must give certification of incapacitation to your benefits administrator, who will send it to MetLife.

Excluded dependents

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

Dependent Life-Spouse coverage

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

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

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

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

Spouses enrolled in Dependent Life coverage are also covered for Accidental Death and Dismemberment benefits. They are eligible for the Seat Belt Benefit, Air Bag Benefit, Child Care benefit and Child Education Benefit (see Pages 100-101).

Dependent Life-Child coverage

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

Enrollment

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

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

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

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

can choose to have coverage start on the first day of that month or the first day of the next month. If you become eligible on a day other than the first calendar day or first working day of the month, coverage starts on the first day of the next month.

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

All effective dates are subject to the Actively at Work requirement (see Page 94) and the dependent non-confinement provision, found later in this section.

Adding a new spouse

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

If you divorce, you must drop your spouse from your Dependent Life coverage. You will need to complete a *Notice of Election* within 31 days of the date of your divorce. Coverage ends the last day of the month in which the divorce is final.

Spouse's loss of employment

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

Late entry

If you do not enroll within 31 days of the date you begin employment or are married, you can enroll your spouse throughout the year as long as you provide medical evidence, and it is approved by MetLife. To do so, complete

a *Notice of Election* and an electronic *Statement of Health*.

Coverage will be effective on the first day of the month after approval. All effective dates of coverage are subject to the Actively at Work requirement and the dependent non-confinement provision.

Adding children

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

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

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

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

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

Premiums

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

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

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

Beneficiaries

A beneficiary is the person or people who will receive insurance payments if you die. You can change your

beneficiaries at any time, unless you have given up this right. If you have no eligible beneficiaries named, death benefits will be paid to:

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

Changing your beneficiaries

You can change your beneficiaries online at [MyBenefits](#) or by notifying your benefits administrator and completing a *Notice of Election*. The change will be effective on the date the request is signed. Note that MetLife will allow beneficiary changes by power of attorney only if the documents specifically state an attorney-in-fact has the power to change beneficiary designations.

Assignment

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

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

Accidental Death and Dismemberment

This section does not apply to retirees or dependent children.

Schedule of accidental losses and benefits

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

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

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

The amount of the benefit shall be a percentage of the amount of Basic, Optional and Dependent Life-Spouse insurance. The percentage is determined by the type of loss, as shown in the table on the following page.

Description of loss	Percent of life insurance amount
Life	100%
Both hands, both feet or sight of both eyes	100%
One hand and one foot	100%
Speech and hearing in both ears	100%
Either hand or foot, and sight of one eye	100%
Movement of both upper and lower limbs (quadriplegia)	100%
Movement of both lower limbs (paraplegia)	75%
Movement of both legs and one arm, or both arms and one leg	75%
Movement of the upper and lower limbs of one side of body (hemiplegia)	50%
Either hand or foot	50%
Sight of one eye	50%
Speech or hearing in both ears	50%
Movement of one limb (uniplegia)	25%
Thumb and index finger of same hand	25%

What is not covered?

MetLife will not pay Accidental Death and Dismemberment benefits under this section for any loss caused or contributed to by:

- Intentionally self-inflicted injury.
- Suicide or attempted suicide.
- Committing or attempting to commit a felony.
- Bodily or mental infirmity, illness or disease.
- Alcohol in combination with any drug, medication or sedative.
- The voluntary use of prescription drugs, nonprescription drugs, illegal drugs, medications, poisons, gases, fumes or other substances taken, absorbed, inhaled, ingested or injected unless it is taken upon the advice of a licensed physician in the verifiable prescribed manner and dosage.
- Motor vehicle collision or accident where you are the operator of the motor vehicle and your blood alcohol level meets or exceeds the level at which intoxication is defined in the state where the collision or accident occurred, regardless of any legal proceedings thereto.
- Infection, other than infection occurring simultaneously with, and as a direct and independent result of, the accidental injury.
- Medical or surgical treatment, diagnostic procedures or any resulting complications, including complications from medical misadventure.
- War or any act of war, whether declared or undeclared.
- Service in the military of any nation, except the U.S. National Guard.

Accidental Death and Dismemberment benefits

Seat Belt and Air Bag Benefit (Basic, Optional and Dependent-Life Spouse Accidental Death and Dismemberment only)

The Seat Belt Benefit is an additional 10% of your accidental death benefit. However, the amount MetLife will pay for this benefit will not be less than \$1,000 or more than \$25,000. For example, if your amount of Optional Life insurance is

\$20,000 and you die in an accident, an additional \$20,000 accidental death benefit will be payable. The Seat Belt Benefit increases this accidental death benefit by 10%, or \$2,000. The total accidental death benefit will then be \$22,000, which means the entire death benefit will be \$42,000.

The Air Bag Benefit is an additional 5%. However, the amount paid for this benefit will not be less than \$1,000 or more than \$10,000 of your accidental death benefit. For example, if your amount of life insurance is \$20,000, and you die in an accident, an additional \$20,000 accidental death benefit will be payable. The Seat Belt Benefit increases the accidental death benefit by \$2,000, and the Air Bag Benefit increases the accidental death benefit by \$1,000 (5% of \$20,000), which means the entire death benefit will be \$43,000.

To be eligible for these benefits, the following must apply:

1. The seat in which the insured was seated was equipped with a properly installed air bag at the time of the accident.
2. The private passenger car was equipped with seat belts.
3. The seat belt was in proper use by the insured at the time of the accident as certified in the official accident report or by the investigating officer.
4. At the time of the accident, the driver of the private passenger car was a licensed driver and was not intoxicated, impaired or under the influence of alcohol or drugs.

Childcare Benefit (Optional and Dependent- Life Spouse Accidental Death and Dismemberment only)

A Childcare Benefit will be paid to each dependent who is younger than age 7 (at the time of the insured's death) and who is enrolled in a daycare program. The benefit for each child per year will be the lesser of:

1. Twelve percent of your amount of Accidental Death and Dismemberment insurance; or
2. \$5,000; or
3. Actual incurred childcare expenses.

It will be paid for each dependent who qualifies for no more than two years. If this benefit is in effect on the date that the employee or the spouse dies, and there is no

dependent child who could qualify for this benefit, MetLife will pay \$1,000 to the beneficiary.

Dependent Child Education Benefit (Optional and Dependent-Life Spouse Accidental Death and Dismemberment only)

An Education Benefit is paid for each dependent who qualifies as a student. A qualified dependent must be either a post-high school student who attends a school for higher learning on a full-time basis at the time of the insured's death, or in the 12th grade and will become a full-time post-high school student in a school for higher learning within 365 days after the insured's death. The benefit is a maximum of \$10,000 per academic year, with a maximum overall benefit of 25% of the coverage amount. The benefit will be payable at the beginning of each school year for a maximum of four consecutive years, but not beyond the date the child turns age 25.

If this benefit is in effect on the day you die or your spouse dies, and you do not have a child who could qualify for it, MetLife will pay \$1,000 to your beneficiary.

Felonious Assault Benefit (Optional Accidental Death and Dismemberment, Employee only)

A Felonious Assault Benefit is paid if you are injured in a felonious assault, and the injury results in a loss for which benefits are payable under the Accidental Death and Dismemberment benefit. The benefit is the lesser of your annual earnings, \$25,000 or your amount of Optional Accidental Death and Dismemberment insurance coverage.

A felonious assault is a physical assault by another person resulting in bodily harm to you. The assault must involve the use of force or violence with intent to cause harm, and it must be a felony under the laws of the jurisdiction in which the act was committed.

Repatriation Benefit (Basic Life, Optional Life and Dependent Life- Spouse Accidental Death and Dismemberment)

A Repatriation Benefit will be paid if you or your spouse with Dependent Life-Spouse coverage dies in a way that would be covered under the Accidental Death and Dismemberment benefit and if the death occurs more than 100 miles from your principal residence.

The Repatriation Benefit will be the lesser of:

- The actual expenses incurred for:

- Preparation of the body for burial or cremation, and
- Transportation of the body to the place of burial or cremation;

or

- \$5,000, the maximum amount for this benefit.

Public Transportation (Common Carrier) Benefit (Basic, Optional Accidental Death and Dismemberment, Employee only)

If you die as a result of a covered accident that occurs while you are a fare-paying passenger on a public transportation vehicle, MetLife will pay an additional benefit equal to your full amount of Accidental Death and Dismemberment insurance.

Public transportation vehicle means any air, land or water vehicle operated under a license for the transportation of fare-paying passengers.

MetLife AdvantagesSM

Your Optional Life insurance benefits include access to MetLife AdvantagesSM—a comprehensive suite of valuable services for support, planning and protection when you need it most at no cost to you.

Will Preparation

Having a will prevents unnecessary stress and ensures your final wishes are clear. MetLife offers valuable legal resources through MetLife Legal Plans to assist you with creating or updating a will at no additional cost. Choose to meet with any of more than 18,500 network attorneys in person or by phone for a one-on-one consultation in a private and supportive environment.

For more information, log in to the [MetLife Legal Plans](#) website.

Estate Resolution Services

Estate representatives and beneficiaries can receive unlimited face-to-face legal assistance with probating your and your spouse's estates. Beneficiaries can also consult an attorney from the MetLife Legal Plans' network of more than 18,500 participating attorneys for general questions about the probate process.

For more information, call MetLife Legal Plans at

800.821.6400, 8 a.m. to 7 p.m., Monday-Friday. Advise the Client Service Representative you are with PEBA (group number 200879) and provide the last four digits of your Social Security number.

Digital Estate Planning

With Digital Estate Planning, it's easier than ever to create and execute key estate planning documents online by answering a few simple questions. The best part? You can have your estate planning documents witnessed and notarized from the comfort of your home with real-time ID verification and video notary, where allowed by law.

Visit the [MetLife Legal Plans](#) website and follow the online instructions. You will need to create an account using your email address and a password.

Funeral Discounts and Planning Services

Alleviating the burden of making funeral arrangements from their loved ones, employees get exclusive access to the largest network of funeral homes and cemeteries to preplan with a counselor and receive discounts on funeral services.

For more information, call 866.853.0954 or visit [Dignity Memorial's website](#).

Grief Counseling

Grief Counseling offers professional support in times of need through face-to-face sessions with a licensed counselor to help employees cope with a loss or major life change. Employees can also speak to a licensed counselor from the comfort of their home through the helpline.

Call 888.319.7819, then select Option 2 for grief counseling or visit [Telus Health's website](#). The username is **metlifeassist**, and the password is **support**.

Total Control Account

This benefit reduces the pressure of immediate financial decisions. Beneficiaries can take their time to make the right decision with the flexible settlement option that gives them full access to policy funds while earning a guaranteed minimum interest rate through TCA.

For more information, visit [MetLife's Total Control Account website](#).

Transition Solutions

Employees get help with time-sensitive benefit and financial decisions to help them make the right choices during changes in employment.

Call 877.ASK.MET7 (877.275.6387) to speak with a local financial representative. MetLife has arranged for specially trained third-party financial professionals to answer questions and provide guidance to help you make the right decisions to protect your financial future.

Beneficiary Claims Assistance

MetLife offers a third-party provider, Empathy, which provides beneficiary support services to help beneficiaries and their families cope with and plan for issues that follow the loss of a loved one.

Call 720.828.7238 from 9 a.m. to 9 p.m., Eastern Standard Time.

Claims

To pay benefits, MetLife must be given written proof of loss. This means a claim must be filed as described below.

Your accelerated benefit

If you or your covered dependent is diagnosed by a physician as having a terminal illness, you can request that MetLife pay up to 80% of your life insurance prior to your death. Any remaining benefits will be paid to your beneficiary upon your death. A terminal illness means that you have a life expectancy of 12 months or fewer.

To file a claim, notify your employer. Then you, your employer and the attending physician will each complete a section of MetLife's *Accelerated Benefit Option* form.

How to file a claim

When you or your dependent dies, your employer should be notified. This should be done as soon as reasonably possible. The benefits administrator will notify PEBA and PEBA will submit the information to initiate a life insurance claim to MetLife. PEBA will send the beneficiary a beneficiary statement and a condolence letter, which requests an original certified death certificate. The beneficiary should mail or fax the beneficiary statement and original certified death certificate to MetLife.

When MetLife receives acceptable proof of your covered dependent's death, it will pay the life insurance benefit to you. If you are no longer living, it will be paid to your beneficiary.

When a retiree dies, the beneficiary, or the employer on their behalf, should notify MetLife of the death by calling 800.638.6420.

Suicide provision

No Optional Life, Dependent Life-Spouse or Dependent Life-Child benefit will be payable if death results from suicide within two years of the effective date. If death by suicide occurs within two years of a coverage increase, the death benefit payable is limited to the amount of coverage in force prior to the increase.

How Accidental Death and Dismemberment claims are paid

In the case of accidental death, your employer should be notified. The benefits administrator will notify PEBA, and PEBA will submit some information to initiate a life insurance claim to MetLife. The benefits administrator will complete and submit MetLife's *Life Insurance Claim Form* with information and supporting documentation to validate the accidental death. MetLife will pay the accidental death benefit to your beneficiaries.

If you sustained other losses covered under Accidental Death and Dismemberment, you, your employer and your physician must complete the *Accidental Death and Dismemberment Claim Form* and submit it to MetLife. The benefit for other losses you sustained will be paid to you if you are living. Otherwise, it will be paid to your beneficiary.

A dependent's Accidental Death and Dismemberment benefit will be paid to you if you are living. Otherwise, it will be paid to your beneficiary.

Examinations and autopsies

MetLife retains the right to have you medically examined at its expense when and so often as it may reasonably require whenever a claim is pending and, where not forbidden by law, MetLife reserves the right to have an autopsy performed in case of death.

When your coverage ends

Termination of coverage

Your insurance will end at midnight on the earliest of:

- The last day of the month you terminate your employment;
- The last day of the month you go on unapproved leave of absence;
- The last day of the month you enter a class of employees not eligible for coverage (e.g., a change from full-time to part-time status);
- The date PEBA's policy ends; or
- The last day of the month you do not pay the required premium for that month.

Retiree coverage will end the January 1 after:

- You reach age 70, if you continued coverage and retired before January 1, 1999; or
- You reach age 75, if you continued coverage and retired January 1, 1999, and later.

Claims incurred before the date insurance coverage ends will not be affected by coverage termination.

Termination of Dependent Life insurance coverage

Your dependent's coverage will terminate at midnight on the earliest of:

- The day PEBA's policy ends;
- The day you, the employee, die;
- The last day of the month in which the dependent no longer meets the definition of a dependent; or
- The day any premiums for Dependent Life insurance coverage are due and unpaid for a period of 30 days.

Claims incurred before the date insurance coverage ends will not be affected by coverage termination.

Extension of benefits

An extension of benefits is provided according to the requirements below. MetLife is not required by contract to provide these benefits unless you meet these requirements.

Leave of absence

If you are on an employer-approved leave of absence and you remain eligible for active benefits, you can continue your Optional Life insurance for up to 12 months from the first of the month after the last day worked, as long as you pay the required premiums. MetLife might require written proof of your leave of absence approval before any claims are paid.

Military leave of absence

If you enter active military service and are granted a military leave of absence in writing, your life insurance coverage (including Dependent Life coverage) can be continued for up to 12 months from the first of the month after the last day worked, as long as you pay the required premiums. If the leave ends before the agreed-upon date, this continuation will end immediately. If you return from active military duty after being discharged and you qualify to return to work under applicable federal or state law, you might be eligible for the life insurance coverage you had before the leave of absence began, provided you are rehired by the same employer and request reinstatement within 31 days of returning to work.

Disability

If you become disabled, your life insurance coverage can be continued for up to 12 months from your last day worked as long as you remain eligible for active benefits and:

- You continue to pay the premiums; and
- The Optional Life insurance policy does not end.

When you lose eligibility for active benefits due to disability

- If you are eligible for retiree insurance, you can convert your coverage to an individual whole life policy or continue your Optional Life insurance until age 75. Learn more about your options for life insurance on Page 144.
- If you are not eligible for retiree insurance, you can convert your coverage to an individual whole life

policy. You must apply for conversion within 31 days of termination of your active employee coverage.

- If you are later approved for disability retirement benefits, and therefore are eligible for retiree insurance, you can enroll in up to the same amount of Optional Life coverage you had when your eligibility for active benefits ended. To do so, contact MetLife within 31 days of your disability retirement approval date. Coverage would begin the first of the month after your approval for disability retirement.

For more information about retiree insurance eligibility, see Page 135.

Continuing or converting your life insurance

Note that Accidental Death and Dismemberment coverage cannot be continued or converted.

Continuation at retirement

If you are eligible for retiree insurance, you might be able to continue your Optional Life insurance coverage and pay premiums directly to MetLife. MetLife will mail you a conversion/continuation packet. Packets are sent by U.S. Mail three to five business days after MetLife receives the eligibility file from PEBA. To continue your coverage, complete the form that will be included in your packet from MetLife. Coverage is lost due to approved retirement or approved disability retirement.

If you have questions about your options for continuing your insurance coverage or would like to request continuation forms, call MetLife at 888.507.3767, 8 a.m. to 11 p.m., Monday through Friday. A complete application must be received within 31 days of your benefit termination.

If you continue your coverage, you will receive a bill from MetLife for your premiums. You will pay your premiums directly to MetLife. Call MetLife at 888.507.3767 if you want to make changes to your coverage.

Conversion

If your Basic, Optional or Dependent Life insurance ends because your employment or eligibility for coverage ends, you can apply to convert your coverage to an individual whole life insurance policy, a permanent form of life insurance, without providing medical evidence. MetLife

will mail you a conversion packet. Packets are sent by U.S. mail three to five business days after MetLife receives the eligibility file from PEBA. To convert your coverage, follow the instructions included in your packet from MetLife. The policy will be issued without medical evidence if you apply for and pay the premium within 31 days.

When applying for coverage, remember these rules:

1. You cannot apply for more than the amount of life insurance you had under your terminated group life insurance.
2. Your new premium for the conversion policy will be set at MetLife's standard rate for the amount of coverage you want to convert and your age.

You must contact MetLife within 31 days of the date your insurance coverage ends.

Group policy is terminated

If your group life insurance ends because of termination by the state of the policy or termination as a class, you might be eligible for a conversion policy. For more information, see the MetLife certificate under the Conversion Option section.

Death benefit during conversion period

If you die within 31 days of the date your group insurance was terminated and meet the conversion eligibility requirements, MetLife will pay a death benefit regardless of if an application for coverage under an individual policy has been submitted. The death benefit will be the amount of insurance you would have been eligible to convert under the terms of the Conversion Right section.



Long term disability

Basic Long Term Disability

The Basic Long Term Disability Plan, administered by Standard Insurance Company, is an employer-funded disability plan provided by PEBA. It helps protect a portion of your income if you become disabled as defined by the Plan. This benefit is provided at no cost to you.

If you have questions or need more information, call The Standard at 800.628.9696, or see [The Standard's website](#).

BLTD plan benefits overview

	Benefit
Benefit waiting period	90 days
Monthly BLTD benefit percentage	Up to 62.5% of your predisability earnings, reduced by deductible income.
Maximum benefit	\$800 per month
Maximum benefit period	To age 65 if you become disabled before age 62. If you become disabled at age 62 or older, the maximum benefit period is based on your age at the time of disability. The maximum benefit period for ages 69 and older is one year.

Eligibility

You are eligible for BLTD if you are covered under the State Health Plan or the TRICARE Supplement Plan and are an active, full-time employee as defined by the Plan or a full-time academic employee and you are employed by: a department, agency, board, commission or institution of the state; a public school district; a county government (including county council members); or another group participating in the state's insurance program. Members of the General Assembly and judges in the state courts are also eligible for coverage.

To receive benefits, you must be actively employed when your disability occurs.

If you become disabled, you might be eligible for additional benefits through PEBA that are separate from

the benefits described here. Call 803.737.6800 for more information.

Benefit waiting period

The benefit waiting period is the length of time you must be disabled before benefits are payable. The BLTD Plan has a 90-day benefit waiting period, and benefits are not paid during this period.

Certificate

The BLTD certificate is available on our [Publications webpage](#) under Long term disability. The BLTD plan document is a contract containing the controlling provisions of this insurance plan. Neither the certificate nor any other material, including this publication, can modify the provisions of the Plan document.

When are you considered disabled?

You are considered disabled and eligible for benefits if you cannot fulfill the requirements of your occupation due to a covered injury, physical disease, mental disorder or pregnancy. You also will need to satisfy the benefit waiting period and meet the applicable definitions of disability below during the period to which they apply.

Own occupation disability

You are unable to perform, with reasonable continuity, the material duties¹ of your own occupation during the benefit waiting period and the first 24 months of disability.

"Own occupation" means any employment, business, trade, profession, calling or vocation that involves material duties¹ of the same general character as your regular and ordinary employment with the employer. Your own occupation is not limited to your job with your employer, nor is it limited to when your job is available.

Any occupation disability

You are unable to perform, with reasonable continuity, the material duties¹ of any occupation.

"Any occupation" means any occupation or employment you are able to perform, due to education, training or experience, which is available at one or more locations in

¹ "Material duties" means the essential tasks, functions and operations, and the skills, abilities, knowledge, training and experience generally required by employers from those engaged in a particular occupation.

the national economy and in which you can be expected to earn at least 65% of your indexed predisability earnings (adjusted for inflation) within 12 months following your return to work, regardless of whether you are working in that or any other occupation. The any occupation period begins at the end of the own occupation period and continues to the end of the maximum benefit period.

Partial disability

You are considered partially disabled if, during the benefit waiting period and the own occupation period, you are working while disabled, but you are unable to earn more than 80% of your indexed predisability earnings, adjusted for inflation, while working in your own occupation. Predisability earnings are indexed/adjusted for inflation beginning in year two.

You are considered partially disabled if, during the any occupation period you are working while disabled, but you are unable to earn more than 65% of your indexed predisability earnings, adjusted for inflation, while working in any occupation.

Preexisting conditions

“Preexisting condition” means any injury, illness or symptom (including secondary conditions and complications) that was medically documented as existing, or for which medical treatment, medical service, prescriptions or other medical expense was incurred at any time during the preexisting condition period shown in the Coverage Features of the *Certificate of Coverage*.

Benefits will not be paid for a disability caused or contributed to by a preexisting condition unless on the date you become disabled:

- You have been continuously covered under the Plan for at least 12 months (this is the exclusion period); or
- Your date of disability falls within 12 months after your BLTD coverage became effective, and you served the entire treatment-free period without having received medical treatment, medical services or prescriptions; or having incurred any other medical expense in connection with the preexisting condition.

Claims

Once it appears you will be disabled for 90 days or more, or your employer is modifying your duties due to a health condition, talk to your benefits administrator and review the [Frequently asked questions about LTD coverage provided by The Standard](#) for details about how to file a claim and what to expect once your claim is filed.

To file a claim by phone, call The Standard’s Claim Intake Service Center at 800.628.9696.

To file a claim online, go to [The Standard’s website](#) to begin the claim process. Instructions will be provided throughout the entire claim submission process.

To file a paper claim, download a claim form packet on our [Forms webpage](#). The packet contains:

- *Employee’s Statement*;
- *Authorization to Obtain and Release Information*;
- *Authorization to Obtain Psychotherapy Notes*;
- *Attending Physician’s Statement*; and
- *Employer’s Statement*.

You are responsible for ensuring these forms are completed and returned to The Standard. You can fax the forms to 800.437.0961, or you can mail them to the address on the claim form. If you have questions, call The Standard at 800.628.9696.

You must file your claim with The Standard within 90 days of the end of your benefit waiting period. If you cannot meet this deadline, you must file your claim as soon as reasonably possible, but no later than one year after that 90-day period. If you do not file your claim within this time, barring The Standard’s determination of legal incapacity, The Standard might deny your claim.

Active work requirement

If physical disease, mental disorder, injury or pregnancy prevent you from working the day before the scheduled effective date of your coverage, your coverage will not become effective until the day after you are actively at work for one full day.

Predisability earnings

Predisability earnings are the monthly earnings, including merit and longevity increases, from your covered employer

as of the January 1 preceding your last full day of active work, or on the date you became a member if you were not a member on January 1. It does not include your bonuses, commissions, overtime or incentive pay. If you are a teacher, it does not include your compensation for summer school, but it does include compensation earned during regular summer sessions by university staff.

Deductible income

Your BLTD benefits will be reduced by your deductible income—income you receive or are eligible to receive from other sources. Deductible income includes:

- Sick pay or other salary continuation (including sick-leave pool);
- Primary Social Security benefits;
- Workers' compensation;
- Other group disability benefits (except Supplemental Long Term Disability benefits described on Page 110);
- Maximum plan retirement benefits; and
- Other income sources.

Note vacation pay is excluded from deductible income.

BLTD insurance serves as income replacement insurance.

The BLTD Plan has no minimum benefit, so if you have enough deductible income, your benefit will be reduced to \$0.

Example one - no deductible income

Predisability earnings	\$1,280.00
	× 62.5%
Maximum benefit	\$800.00
Deductible income	- \$0.00
Your BLTD benefit	\$800.00

Example two - all other sources of deductible income

Predisability earnings	\$1,280.00
	× 62.5%
Maximum benefit	\$800.00
Deductible income	- \$800.00
Your BLTD benefit	\$0.00

In another example, assume that 62.5% of your predisability earnings is \$1,200 and you are working part-time. The Standard will pay the \$800 maximum benefit, and your BLTD benefit will be reduced when your work earnings (deductible income) exceed \$400. In other words, your benefit will be reduced when the maximum benefit of \$800 added with your work earnings total an amount that exceeds your predisability earnings. In this example, no benefits would be payable if your work earnings were \$1,200 or more.

You must meet deadlines for applying for all deductible income you are eligible to receive. PEBA has different requirements for disability retirement. Contact PEBA at 803.737.6800 or 888.260.9430 for more information.

When other benefits are awarded, they might include payments due to you while you were receiving BLTD benefits. If the award includes past benefits, or if you receive other income before notifying The Standard, your BLTD claim could be overpaid. This is because you received benefits from the Plan and income from another source for the same period of time. You will need to repay the Plan for this overpayment.

When BLTD coverage ends

Your BLTD coverage ends automatically on the earliest of these:

- The date the Plan ends;
- The date you no longer meet the requirements noted in the Eligibility section of this chapter;
- The date your health coverage as an active employee ends; or
- The date your employment ends.

When benefits end

Your benefits will end automatically on the earliest of these:

- The date you are no longer disabled under the terms of the BLTD Plan;
- The date your maximum benefit period ends (refer to Exclusions and limitations);
- The date benefits become payable under any other group long term disability insurance policy under which you became insured during a period of

temporary recovery; or

- The date of your death.

If you are an employee of an optional employer, your employer becomes responsible for your BLTD benefit payments if your employer stops participating in the state insurance program.

Exclusions and limitations

- Disabilities resulting from war or any act of war are not covered.
- Intentional self-inflicted injuries are not covered.
- Benefits are not payable when you are not under the ongoing care of a physician in the appropriate specialty.
- Benefits are not payable for any period when you are not participating, in good faith, in a course of medical treatment, vocational training or education approved by The Standard, unless your disability prevents you from participating.
- Benefits are not payable for any period of disability when you are confined for any reason in a penal or correctional institution.
- Benefits are not payable after you have been disabled under the terms of the BLTD Plan for 24 months during your entire lifetime, excluding the benefit waiting period, for a disability caused or contributed to by:
 - A mental disorder, unless you are continuously confined to a hospital solely because of a mental disorder at the end of the 24 months;
 - Your use of alcohol, alcoholism, use of any illicit drug, including hallucinogens or drug addiction;
 - Chronic pain, musculoskeletal or connective tissue conditions;
 - Chronic fatigue or related conditions; or
 - Chemical and environmental sensitivities.
- During the first 24 months of disability, after the 90-day benefit waiting period, BLTD benefits will not be paid for any period of disability when you are able to work in your own occupation and you are able to earn at least 20% of your predisability earnings, adjusted

for inflation, but you choose not to work. Predisability earnings are indexed/adjusted for inflation beginning in year two.

- While living outside the United States or Canada, payment of benefits is limited to 12 months for each period of continuous disability.

Appeals

If The Standard denies your claim for Basic Long Term Disability benefits, you can appeal the decision to The Standard by emailing your appeal to your assigned claims analyst or sending written notice within 180 days of receiving the denial letter.

Send the appeal to:

Standard Insurance Company
P.O. Box 5031
White Plains, NY 10602

If The Standard upholds its decision after a review by its Administrative Review Unit, you can appeal that decision by sending an [Appeal Request Form](#) to PEBA within 90 days of the Administrative Review Unit's denial. Include a copy of the previous two denials with your appeal to PEBA. Send the request to:

IAD@peba.sc.gov

or

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

Appeals can be brought only by the covered person at issue, their legal representative (who cannot be, including but not limited to, a provider, medical device manufacturer, pharmaceutical manufacturer, employer, or a representative or agent of any of the foregoing), or a licensed attorney admitted to practice in South Carolina.

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

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

Supplemental Long Term Disability

Supplemental Long Term Disability Insurance, fully-insured by Standard Insurance Company, is designed to provide additional financial assistance beyond the Basic Long Term Disability Plan if you become disabled. Your benefit will be based on a percentage of your predisability earnings. This program is customized for you. The SLTD Plan benefits summary below provides more information about your plan, including:

- Your level of coverage;
- How long benefits payments would continue if you remain disabled;

- The maximum benefit amount;
- Your choice of benefit waiting periods; and
- Your premium schedule.

What SLTD insurance provides

- Competitive group rates;
- A survivor benefit for eligible dependents;
- Coverage for injury, physical disease, mental disorder or pregnancy;
- A return-to-work incentive;
- SLTD conversion insurance;
- A cost-of-living adjustment; and
- Lifetime security benefit.

SLTD Plan benefits summary

	Benefit
Benefit waiting period	Plan 1: 90 days Plan 2: 180 days
Maximum SLTD covered predisability earnings	\$12,307 per month
Monthly SLTD benefit percentage²	Up to 65% of your first \$12,307 of your monthly predisability earnings, reduced by deductible income.
Minimum benefit	\$100 per month
Maximum benefit	\$8,000 per month
Cost-of-living adjustment	After 12 consecutive months of receiving SLTD benefits, effective on April 1 of each year thereafter; based on the prior year's Consumer Price Index up to 4%. This cost-of-living adjustment does not apply when you are receiving the minimum monthly benefit or a monthly benefit of \$25,000 as a result of these adjustments.
Maximum benefit period	To age 65 if you become disabled before age 62. If you become disabled at age 62 or older, the maximum benefit period is based on your age at the time of disability. The maximum benefit period for age 69 and older is one year. In certain circumstances, benefits can continue after the maximum benefit period. See Lifetime security benefit on Page 114 for more information.
Monthly premium rate³	Multiply the premium factor for your age and plan selection by your covered monthly earnings.

² These benefits are not taxable provided you pay the premium on an after-tax basis.

³ Premium must be an even amount (amount is rounded up to next even number). Visit our [Premiums webpage](#).

Eligibility

You are eligible for SLTD insurance if you are:

- An active, full-time, compensated employee as defined by the Plan;
- A full-time, compensated academic employee; or
- A member of the General Assembly, or a judge in the state courts.

You are not eligible for this coverage if you are an employee of an employer covered under any other group long term disability plan that insures any portion of your predisability earnings (other than the BLTD Plan); if you are receiving retirement benefits from PEBA and did not enroll in active employee coverage; if you are a temporary or seasonal employee; if you are a part-time teacher; or if you are a full-time member of the armed forces of any country.

Enrollment

You can enroll in the SLTD program within 31 days of eligibility. You can choose from one of two benefit waiting periods described below. If you fail to enroll within 31 days of your hire date, you must complete a medical history statement. The Standard might require you to undergo a physical examination and blood test. You also might be required to provide any additional information about your insurability that The Standard might reasonably require at your expense. Throughout the year, you can enroll with medical evidence of good health.

Benefit waiting period

The benefit waiting period is the length of time you must be disabled before benefits are payable. You can choose a 90-day or a 180-day benefit waiting period, and you can change from a 90-day to a 180-day benefit waiting period at any time by completing a *Notice of Election* and returning it to your benefits administrator.

To change from a 180-day to a 90-day benefit waiting period, you must complete a *Notice of Election* and provide medical evidence of good health, which The Standard will consider in determining whether to approve your application.

Certificate

The SLTD certificate is available on our [Publications webpage](#) under Long term disability. The group policy contains the controlling provisions of this insurance plan. Neither the certificate nor any other material, including this publication, can modify those provisions.

When are you considered disabled?

You are considered disabled and eligible for benefits if you cannot work due to a covered injury, physical disease, mental disorder or pregnancy. You will also need to satisfy your appropriate benefit waiting period and meet the following definitions of disability during the period to which they apply.

Own occupation disability

You are unable to perform, with reasonable continuity, the material duties⁴ of your own occupation during the benefit waiting period and the first 24 months SLTD benefits are payable.

“Own occupation” means any employment, business, trade, profession, calling or vocation that involves material duties⁴ of the same general character as your regular and ordinary employment with the employer. Your own occupation is not limited to your job with your employer, nor is it limited to when your job is available.

Any occupation disability

You are unable to perform, with reasonable continuity, the material duties⁴ of any occupation.

“Any occupation” means any occupation or employment you are able to perform, due to education, training or experience, that is available at one or more locations in the national economy and in which you can be expected to earn at least 65% of your indexed predisability earnings (adjusted for inflation) within 12 months following your return to work, regardless of if you are working in that or any other occupation. The any occupation period begins at the end of the own occupation period and continues to the end of the maximum benefit period.

⁴ “Material duties” means the essential tasks, functions and operations, and the skills, abilities, knowledge, training and experience generally required by employers from those engaged in a particular occupation.

Partial disability

You are considered partially disabled if, during the benefit waiting period and the own occupation period, you are working while disabled, but you are unable to earn more than 80% of your indexed predisability earnings, adjusted for inflation, while working in your own occupation. Predisability earnings are indexed/adjusted for inflation beginning in year two.

You are considered to be partially disabled if, during the any occupation period, you are working while disabled but you are unable to earn more than 65% of your indexed predisability earnings, adjusted for inflation, while working in any occupation.

Preexisting conditions

Preexisting condition means any injury, illness or symptom (including secondary conditions and complications) that was medically documented as existing, or for which medical treatment, medical service, prescriptions or other medical expenses were incurred, at any time during the preexisting condition period shown in the Coverage Features of the *Certificate of Coverage*.

No benefits will be paid for a disability caused or contributed to by a preexisting condition unless on the date you become disabled:

- You have been continuously covered under the Plan for at least 12 months (this is the exclusion period); or
- Your date of disability falls within 12 months after your SLTD coverage became effective, and you have served the entire treatment-free period without having received medical treatment, medical service or prescriptions; or having incurred any other medical expense in connection with the preexisting condition.

The preexisting condition exclusion also applies when you change from the Plan with the 180-day benefit waiting period to the Plan with the 90-day benefit waiting period. The preexisting condition period, treatment free period and exclusion period for the new Plan will be based on the effective date of your coverage under the 90-day Plan. However, if benefits do not become payable under the 90-day Plan because of the preexisting condition exclusion, your claim will be processed under the 180-day Plan as if you had not changed plans.

Claims

Once it appears you will be disabled for 90 days or more, or your employer is modifying your duties due to a health condition, talk to your benefits administrator and review the [Frequently asked questions about LTD coverage provided by The Standard](#) for details about how to file a claim and what to expect once your claim is filed.

To file a claim by phone, call The Standard's Claim Intake Service Center at 800.628.9696.

To file a claim online, go to [The Standard's website](#) to begin the process. Instructions will be provided through the entire claim submission process.

To file a paper claim, download a claim form packet on our [Forms webpage](#). The packet contains:

- *Employee's Statement*;
- *Authorization to Obtain and Release Information*;
- *Authorization to Obtain Psychotherapy Notes*;
- *Attending Physician's Statement*; and
- *Employer's Statement*.

You are responsible for ensuring these forms are completed and returned to The Standard. You can fax the forms to 800.437.0961, or you can mail them to the address on the claim form. If you have questions, call The Standard at 800.628.9696.

You must file your claim with The Standard within 90 days of the end of your benefit waiting period. If you cannot meet this deadline, you must file your claim as soon as reasonably possible, but no later than one year after that 90-day period. If you do not file your claim within this time, barring The Standard's determination of legal incapacity, The Standard might deny your claim.

Active work requirement

If physical disease, mental disorder, injury or pregnancy prevents you from working the day before the scheduled effective date of your insurance coverage, your coverage will not become effective until the day after you are actively at work for one full day.

Salary change

Your SLTD premium is recalculated based on your age as of the preceding January 1. Any change in your predisability

earnings after you become disabled will have no effect on the amount of your SLTD benefit.

Predisability earnings

Predisability earnings are the monthly earnings, including merit and longevity increases, from your covered employer as of the January 1 before your last full day of active work, or on the date you became a member if you were not a member on January 1. It does not include your bonuses, commissions, overtime pay or incentive pay.

If you are a teacher, it does not include your compensation for summer school, but it does include compensation earned during regular summer sessions by university staff.

Deductible income

Your SLTD benefits will be reduced by your deductible income—income you receive or are eligible to receive from other sources. Deductible income includes:

- Sick pay or other salary continuation (including sick-leave pool);
- Primary and dependent Social Security benefits;
- Workers' compensation;
- BLTD benefits;
- Other group disability benefits;
- Maximum plan retirement benefit; and
- Other income sources.

Note that vacation pay is excluded from deductible income.

For example, your SLTD benefit before being reduced by deductible income is 65% of your covered predisability salary. The benefit will then be reduced by the amount of any deductible income you receive or are eligible to receive. The total of the reduced SLTD benefit plus the deductible income will provide at least 65% of your covered predisability salary. The guaranteed minimum SLTD benefit is \$100, regardless of the amount of deductible income.

You are required to meet deadlines for applying for all deductible income you are eligible to receive. PEBA has different requirements for disability retirement. Call PEBA at 803.737.6800 or 888.260.9430 for more information.

When other benefits are awarded, they might include payments due to you while you were receiving SLTD

benefits. If the award includes past benefits, or if you receive other income before notifying The Standard, your SLTD claim might be overpaid. This is because you received benefits from The Standard and income from another source for the same period of time. You will need to repay The Standard for this overpayment.

Lifetime security benefit

SLTD coverage provides lifetime long term disability benefits if, on the last day of the regular maximum benefit period, you are unable to perform two or more activities of daily living or suffer from a severe cognitive impairment that is expected to last 90 days or more, as certified by a physician in the appropriate specialty as determined by The Standard. The lifetime benefit will be equal to the benefit that was being paid on the last day of the regular long term disability period.

Death benefits

If you die while SLTD benefits are payable, The Standard will pay a lump-sum benefit to your eligible survivor. This benefit will be equal to three months of your SLTD benefit, not reduced by deductible income. Eligible survivors include:

- Your surviving spouse;
- Surviving, unmarried children younger than age 25; and
- Any person providing care and support for any eligible children.

This benefit is not available to any eligible survivors if your SLTD benefits and claim have reached the maximum benefit period before your death. Also, this benefit is not available if you have been approved for or you are receiving the lifetime security benefit.

When SLTD coverage ends

Your SLTD coverage ends automatically on the earliest of:

- The last day of the month for which you paid a premium;
- The date the group policy ends; or
- The date you no longer meet the requirements noted in the Eligibility section of this chapter.

When benefits end

Your benefits will end automatically on the earliest of these dates:

- The date you are no longer disabled;
- The date your maximum benefit period ends, unless SLTD benefits are continued by the lifetime security benefit;
- The date benefits become payable under any other group long term disability insurance policy for which you become insured during a period of temporary recovery; or
- The date of your death.

Conversion

When your SLTD insurance ends, you can buy SLTD conversion insurance if you meet all these criteria:

- Your insurance ends for a reason other than:
 - Termination or amendment of the group policy;
 - Your failure to pay a required premium; or
 - Your retirement.
- You were insured under your employer's long term disability insurance plan for at least one year as of the date your insurance ended.
- You are not disabled on the date your insurance ends.
- You are a citizen or resident of the United States or Canada.
- You complete and return to The Standard a *Request for Long Term Disability Conversion Materials* packet and pay the first premium for SLTD conversion insurance within 31 days after your insurance ends.

If you have questions about converting your SLTD policy, call The Standard at 800.378.4668. You will need to reference the state of South Carolina's group number, 621144.

Exclusions and limitations

- Disabilities resulting from war or any act of war are not covered.
- Intentional self-inflicted injuries are not covered.
- Benefits are not payable when you are not under

the ongoing care of a physician in the appropriate specialty.

- Benefits are not payable for any period when you are not participating, in good faith, in a course of medical treatment, vocational training or education approved by The Standard, unless your disability prevents you from participating.
- Benefits are not payable for any period of disability when you are confined for any reason in a penal or correctional institution.
- Benefits are not payable after you have been disabled under the terms of the SLTD Plan for 24 months during your entire lifetime, excluding the benefit waiting period, for a disability caused or contributed to by:
 - A mental disorder, unless you are continuously confined to a hospital solely because of a mental disorder at the end of the 24 months;
 - Your use of alcohol, alcoholism, use of any illicit drug, including hallucinogens or drug addiction;
 - Chronic pain, musculoskeletal or connective tissue conditions;
 - Chronic fatigue or related conditions; or
 - Chemical and environmental sensitivities.
- During the first 24 months of disability, after the benefit waiting period, SLTD benefits will not be paid for any period of disability when you are able to work in your own occupation, and you are able to earn at least 20% of your indexed predisability earnings, adjusted for inflation, but you choose not to work. Predisability earnings are indexed/adjusted for inflation beginning in year two. After this time, no SLTD benefits will be paid for any period of disability when you can work in any occupation and are able to earn at least 20% of your indexed predisability earnings adjusted for inflation, but you choose not to work.
- Generally, benefits are not payable for any period of disability when you are not receiving disability benefits under the BLTD Plan. However, this might not apply if:
 - You receive or are eligible to receive other income that is deductible under the BLTD Plan, and the

amount of that income equals or exceeds the amount of the benefits that would otherwise be payable to you under that plan;

- Benefits that would otherwise be payable to you under the BLTD Plan are being used to repay an overpayment of any claim; or
- You were not insured under the BLTD Plan when you became disabled.
- While living outside the United States or Canada, payment of benefits is limited to 12 months for each period of continuous disability.

Appeals

If The Standard denies your claim for Supplemental Long Term Disability benefits, you can appeal the decision by written notice within 180 days of receiving the denial letter. Written notice can be sent via email to your assigned claims analyst or by U.S. Mail to:

Standard Insurance Company
P.O. Box 5031
White Plains, NY 10602

Your claim will receive an independent review by The Standard's Administrative Review Unit.

Because Supplemental Long Term Disability is fully insured by The Standard, you cannot appeal SLTD decisions to PEBA.



MoneyPlus

MoneyPlus allows you to save money on eligible medical and dependent care costs. With MoneyPlus, you elect to contribute an annual amount to an IRS-approved flexible spending account. Your contributions are deducted from your paycheck, before taxes. You can use these funds to pay your eligible medical and dependent care expenses. As you incur eligible expenses during the plan year, you request reimbursement. ASIFlex administers the MoneyPlus program. Learn more on our [MoneyPlus webpage](#).

How MoneyPlus can save you money

With MoneyPlus, you benefit from having less taxable income in each of your paychecks, which means more spendable income to use toward your eligible medical and dependent care expenses. The monthly savings example on this page shows how paying eligible expenses with a pretax payroll deduction can increase your spendable income. The scenario is for a married person who covers two children enrolled in the Standard Plan and who is also a member of the South Carolina Retirement System, or SCRS.

	With MoneyPlus	Without MoneyPlus	MoneyPlus advantage
Gross monthly pay¹	\$3,750.00	\$3,750.00	
State retirement contribution (9%)	- \$337.50	-\$337.50	
Medical Spending Account fee	- \$1.10	- \$0.00	
Dependent Care Spending Account fee	- \$1.10	- \$0.00	
MoneyPlus pretax payroll deductions			
Medical Spending Account	- \$56.00	- \$0.00	
Dependent Care Spending Account	- \$400.00	- \$0.00	
Standard Plan, Basic Dental premiums Paid with Pretax feature with employee/children coverage level	- <u>\$157.58</u>	- <u>\$0.00</u>	
Taxable gross income	\$2,796.72	\$3,412.50	\$615.78
Estimated payroll taxes (27%)²	- \$755.11	- \$921.38	\$166.27
Expenses			
Medical expenses	- \$0.00	- \$56.00	
Dependent care expenses	- \$0.00	- \$400.00	
Standard Plan, Basic Dental premiums Employee/children coverage level	\$0.00	\$157.58	
Your take-home pay	\$2,041.61	\$1,877.54	\$164.07

¹ Assumes annual salary of \$45,000.

² Includes state and federal taxes; married, filing jointly.

Administrative fees

MoneyPlus accounts have an administrative fee, which is set up to have a minimal impact relative to the tax savings the accounts provide. You will pay an administrative fee for every account in which you enroll. Because MoneyPlus is governed by the Internal Revenue Code, Internal Revenue Service requirements and restrictions exist for program participants.

2027 Monthly administrative fees

Account	Fee
Medical Spending Account	\$1.10
Limited-use Medical Spending Account	\$1.10
Dependent Care Spending Account	\$1.10

The Pretax Group Insurance Premium feature allows you to pay your premiums with pretax money, and there is no administrative fee.

Member resources

ASIFlex website

The [ASIFlex website](#) allows you to:

- Review your account, online statement, claims information and card transactions;
- Submit claims;
- Set up direct deposit;
- Set up email and/or text alert notifications for your account;
- Learn about the specific tax benefits available to you; and
- Access resources, including eligible expenses, program descriptions, debit card information, online claim and administrative forms, and an expense estimator and cost savings tool.

ASIFlex mobile app

The ASIFlex mobile app allows participants to file claims and view their MoneyPlus accounts from their phone or tablet. The claim filing feature allows you to capture documentation using the mobile device's camera and

submit that documentation with your claim. The mobile app also allows you to use the microphone feature to enter a claim. This means you can choose to speak, rather than type, some of the claim information. In addition to filing claims, you can view your annual election amount, account balance, contributions, reimbursements and previously submitted claims. The app is free and available on the [ASIFlex website](#) or through Google Play or the App Store.

Responsibilities for using an account

When you enroll in any MoneyPlus spending account, you certify you will:

- Ask for and keep copies of the documentation you will need for your reimbursement claims, including itemized statements of service and insurance plan explanation of benefits (EOBs);
- Use the account to pay only for IRS-qualified expenses for yourself and your IRS-eligible dependents;
- First use all other sources of reimbursement, including those provided by your insurance plan or plans, before seeking reimbursement from your spending account; and
- Not seek reimbursement through any additional source after seeking it from your account.

Earned income tax credit

Contributions made before taxes to a Dependent Care Spending Account or a Medical Spending Account lower your taxable earned income. The lower your earned income, the higher the earned income tax credit. See *IRS Publication 596* or talk to a tax professional for more information.

IRS rules for spending accounts

- You can enroll each year during open enrollment to make a new election, because elections for Medical Spending Accounts (MSAs), Limited-use MSAs and Dependent Care Spending Accounts (DCSAs) do not automatically renew.
- You might be able to change your election if you experience a qualifying change in status event, as stated in the Plan.
- You do not have to be enrolled in PEBA's medical,

dental or vision plans to participate. For example, you might have insurance through a spouse's employer, and you can still sign up for spending accounts through PEBA (subject to Plan and IRS limits).

- You have access to your entire MSA election amount on the effective date of your election. Therefore, you can be reimbursed up to this amount, minus previous reimbursements, any time during the year regardless of your balance.
- You cannot pay any insurance premiums through any type of flexible spending account. These accounts are separate from the Pretax Group Insurance Premium feature.
- You cannot pay a dependent care expense from your MSA, or a medical expense from your DCSA.
- The MSA includes a carryover provision. You can carry over up to \$680 of unused funds into the new plan year in your Medical Spending Account. You will forfeit any unused funds over \$680.
- The DCSA includes a grace period. This means you can continue to spend 2027 funds through March 15, 2028. Expenses incurred from January 1, 2027, through March 15, 2028, can be considered for reimbursement from your 2027 account.
- You cannot be reimbursed through your MoneyPlus accounts for expenses paid by insurance or any other source.
- You cannot deduct reimbursed expenses from your income tax.
- You can be reimbursed only for services received. You cannot be reimbursed for a future service, nor can you make an advance payment for a future service.

Pretax Group Insurance Premium feature

The Pretax feature allows you to pay your health premiums, including the tobacco-use premium, with money from your paycheck before taxes are withheld. You can also use your pretax income to pay premiums for Dental Plus, Basic Dental, the State Vision Plan, Optional Life coverage up to \$50,000 and the TRICARE Supplement Plan.

Eligibility and enrollment

Active employees who pay health, dental, vision care, Optional Life or TRICARE Supplement Plan premiums are automatically enrolled in the Pretax Group Insurance Premium feature; however, you can decline it when you first enroll.

If you decline the feature, you can enroll in it during open enrollment, which takes place in October, or within 31 days of a special eligibility situation. To do this, see Making changes to your MoneyPlus coverage on Page 126. To learn about special eligibility situations, see Page 19.

Medical Spending Account

A Medical Spending Account allows you to pay eligible medical expenses not covered by insurance, including copayments and coinsurance, with pretax income. MSAs offer the ASIFlex Card, which functions like a debit card. You can use this card to spend funds as an alternative to submitting claims for reimbursement. You can carry over up to \$680 of funds placed in your MSA that you did not use during the plan year into the next plan year. You will forfeit funds over \$680 left in your account after the reimbursement deadline.

Eligibility

You must be eligible for state group insurance benefits to participate in an MSA. However, you are not required to be covered by an insurance program to participate. Members enrolled in the Standard Plan are encouraged to participate in an MSA.

If you are enrolled in the Savings Plan, you are not eligible for an MSA and can instead enroll in a Health Savings Account and Limited-Use Medical Spending Account. See Page 130 to learn about HSAs.

Enrollment

You can enroll in an MSA within 31 days of your hire date through your employer. If you do not enroll then, you can enroll during the next open enrollment period in October through [MyBenefits](#).

You also can enroll in or make changes to this account within 31 days of a special eligibility situation. To do this, see Making changes to your MoneyPlus coverage on Page 127. To learn about special eligibility situations, see Page 19.

You must reenroll each year during open enrollment to continue your account the following year.

Deciding how much to set aside

Estimate the amount you and your family will spend on routine, recurring and predictable medical expenses throughout the year. You are allowed to carry over \$680 of funds each year into the next plan year. You have until March 31, 2028, to file claims for reimbursement and submit documentation for eligible expenses incurred during 2027. You will forfeit funds over \$680 left in your account after the reimbursement deadline.

The annual amount you elect to contribute to your account will be divided into equal installments and deducted from each paycheck before taxes.

Once you sign up for an MSA and decide how much to contribute, the entire amount will be available on your effective date. You do not have to wait for the funds to accumulate in your account before being reimbursed for eligible medical expenses.

Contribution limits

The contribution limit for 2027 is \$3,400. If you are married, and your spouse is eligible for PEBA-sponsored insurance coverage as an employee, you can each contribute up to \$3,400 annually.

People who can be covered by an MSA

An MSA can be used to reimburse eligible expenses for:

- You;
- Your spouse (even if they have a separate MSA);
- Your qualifying child; and
- Your qualifying relative.

An individual is a qualifying child if they are not someone else's qualifying child, although an eligible child of divorced parents is treated as a dependent of both, so either or both parents can establish an MSA. Additionally, a child qualifies if they:

- Do not reach age 27 during the taxable year (if a qualifying child is physically or mentally incapable of self-care, there is no age limitation);
- Have a specified family-type relationship to you: son/daughter, stepson/stepdaughter, eligible foster child,

legally adopted child or child placed for legal adoption; and

- Are a U.S. citizen, a U.S. national or a resident of the U.S., Mexico or Canada.

An individual is a qualifying relative if they are a U.S. citizen, a U.S. national or a resident of the U.S., Mexico or Canada and:

- Has a specified family-type relationship to you, is not someone else's qualifying child and receives more than half of their support from you during the tax year; or
- If no specified family-type relationship to you exists, is a member of and lives in your household (without violating local law) for the entire tax year and receives more than half of their support from you during the tax year.

For more information, contact your employer or tax professional. You can also contact the [IRS](#) online or 800.829.1040, or view IRS Publications 501 and 502.

Eligible expenses

Expenses eligible for reimbursement include your copayments, deductibles and coinsurance. You can also use your MSA to pay for:

- Doctor office visits;
- Out-of-pocket dental fees, such as deductibles or coinsurance, including fillings, crowns, bridges, dentures and adhesives, occlusal guards, implants and orthodontics;
- Vision care, including prescription eyeglasses/sunglasses, contact lenses, cleaning solutions, eye drops for contact lens wearers, over-the-counter reading glasses and vision correction surgery;
- Hearing exams, hearing aids and batteries;
- Mileage expenses incurred traveling to obtain healthcare (subject to IRS limit);
- Over-the-counter healthcare items such as adhesive bandages, birth control, feminine hygiene products, pregnancy and fertility kits, prenatal vitamins, breast pumps, sunscreen or lip balm (SPF 15 and broad spectrum), first aid supplies/kits, joint braces and supports, blood pressure monitors, diabetic supplies,

thermometers, canes, crutches, pill holders/ splitters and thousands of other items;

- Over-the-counter medicines or drugs (pain relief, allergy medicines, cold/cough/flu medicines, stomach/ digestive aids, etc.); and
- Any other out-of-pocket medical expenses deductible under current tax laws, including travel to and from medical facilities (subject to IRS limits).

Ineligible expenses

- Insurance premiums;
- Vision warranties and service contracts;
- Expenses for a service not yet provided or for pretreatment estimates;
- Expenses for general good health and well-being;
- Illegal operations;
- Expenses paid by insurance or any other source;
- Health or fitness club membership fees; and
- Cosmetic surgery, treatments or medications not deemed medically necessary to alleviate, mitigate or prevent a medical condition.

Using your MSA funds

You have several ways to access your MSA funds. You can use a special debit card, known as the ASIFlex Card, to pay for expenses directly, or you can have expenses reimbursed to you through direct deposit by submitting a claim online at the [ASIFlex website](#), or via the ASIFlex mobile app, toll-free fax or mail.

ASIFlex Card

The ASIFlex Card, a debit card issued at no cost to MSA participants, can be used to pay eligible, uninsured medical expenses for you and your covered family members. When signing up for an MSA, you will receive two cards so you can give one to your spouse or child.

Activating your card

To activate your ASIFlex Card so you can begin using it, call the toll-free number on the card sticker. You can set up a PIN known only to you.

Using your card

You can sign for credit transactions or enter your PIN for debit transactions.

The card is a limited-use card and can be used at healthcare providers and merchants who accept VISA®. It can also be used at retail merchants who use the Inventory Information Approval System, known as IIAS, and identify which products are MSA-eligible. To find a current list of available IIAS merchants, go to www.ASIFlex.com/SCMoneyPlus.

Use of the card is not paperless. Each time you swipe the card, ask the provider for an itemized statement of service that includes the provider name, patient name, date of service, description of service and dollar amount. ASIFlex will automatically accept and process as many transactions as possible; however, IRS regulations do require that you provide backup documentation to substantiate certain transactions.

You can request the documentation and keep the paper copy; or simply snap a picture of the documentation and store in your device gallery. See the Auto-validation of transactions section below for more information.

Documenting ASIFlex Card transactions

According to the IRS, it is not necessary to submit documentation for:

- Known copayments for services provided through the State Health Plan in which you are enrolled;
- Eligible prescriptions purchased through your health plan's mail-order pharmacy;
- Recurring expenses at the same provider for the same dollar amount (such as monthly orthodontia payments); or
- IRS-approved over-the-counter healthcare products.

Auto-validation of transactions

For other healthcare expenses, documentation is needed. ASIFlex will receive claims data from BlueCross BlueShield of South Carolina and EyeMed. ASIFlex will auto-validate debit card transactions it can match to claims received from other vendors. If ASIFlex cannot validate a claim, you will need to provide documentation for that transaction.

Requests for documentation are emailed and posted online to your account. You have 52 days to respond, or your card will be deactivated.

- Initial notice - sent approximately 10 days after ASIFlex receives notice of the card transaction.
- Reminder notice - sent 21 days after initial notice.
- Deactivation notice - sent 21 days after reminder notice. Your card will be deactivated, and future claim submissions will be offset by the outstanding amount.

When documentation is submitted, your card will be automatically reinstated. Any amounts from the plan year not documented by March 31, 2028, will not meet IRS guidelines and will be taxed as income.

You should keep all documents substantiating your claims for at least one year and submit them to ASIFlex on request.

Lost cards

If your ASIFlex Card is lost or stolen, call ASIFlex at 833.726.7587 immediately.

Requesting reimbursement of eligible expenses

Before you file claims for reimbursement, you must first file insurance claims for the benefits you have received. Out-of-pocket expenses remaining after that can then be submitted to ASIFlex for reimbursement from your MSA. The minimum check reimbursement is \$25, except for the last reimbursement, which brings your account balance to zero. Be sure to sign up for direct deposit, as there is no minimum for electronic transactions.

If you do not use your ASIFlex Card, you can submit a *MoneyPlus Claim Form* at the [ASIFlex website](#) or through the ASIFlex mobile app. You can also submit a paper claim form, along with a copy of your expense documentation or the *Explanation of Benefits*. In addition, you should note the deadlines described in the IRS restrictions section on Page 118.

When gathering documentation, consider these requirements:

- Documentation can be an invoice or bill from your healthcare provider listing the date of service, the cost of the service, the type of service, the service provider and the person for whom the service was provided. Note: copayment receipts must show a description, such as "office visit copayment."
- Documentation can also be an *Explanation of Benefits*

from your insurance plan showing the insurance plan payment and the amount you are responsible to pay.

- For over-the-counter health care products, drugs or medications, provide the itemized merchant receipt.
- For prescriptions, provide the pharmacy receipt showing the prescription number and the name of the drug. You can also request a printout from the pharmacy that itemizes your prescriptions; or otherwise obtain this information from the pharmacy website. For mail-order prescriptions, simply provide the itemized mail-order receipt.
- In some circumstances, a written statement from your healthcare provider that the service was medically necessary might be needed. A sample Letter of Medical Necessity can be found on [ASIFlex's website](#) under the Resources tab.

ASIFlex will process your claim within three business days of receiving it. Your reimbursement can be deposited directly into your bank account within one day of processing your claims. This service has no extra fee and includes notifications of when your funds are processed. To set up direct deposit, log in to your online account and update your personal account settings. You should also sign up for email and/or text alerts.

Comparing the MSA to claiming expenses on IRS Form 1040

You can claim itemized medical and dental expenses on your IRS Form 1040 only if they exceed 10% of your adjusted gross income. If you file a joint tax return, your adjusted gross income includes both your income and your spouse's. The tax-free MSA gives you an alternate way to save taxes on your uninsured, out-of-pocket medical expenses. Refer to the chart on Page 117 for an example.

To learn more about the tax credit, see *IRS Publication 502* or use the services of a tax professional.

What happens to your MSA when you leave your job?

When you have an MSA and leave your job, you might be eligible to continue to contribute to your MSA through the end of the plan year.

COBRA coverage will consist of the amount you have in

your MSA at the time of the qualifying event, plus additional contributions up to the annual amount you elected to contribute. You will pay 102% of your normal cost, which is your contribution amount plus the \$1.10 administrative fee, for COBRA coverage. If you have funds remaining at the end of the plan year, up to \$680 will carry over and be available to you until the end of your COBRA period of coverage. ASIFlex will contact you about continuation of coverage.

If you do not continue your MSA as permitted under COBRA, you have until March 31 of the following year or until you exhaust your account, whichever is sooner, to submit eligible MSA expenses incurred before the first of the month following the last day worked. Any funds still in your account will not be returned to you.

If you return to employment with an employer who participates in PEBA-administered insurance within 30 days, your original MSA elections will automatically be reinstated. If you return to employment with an employer who participates in PEBA-administered insurance after 30 days, you cannot participate in an MSA for the remainder of the plan year. You can, however, reenroll during open enrollment for the next plan year.

The Family and Medical Leave Act might affect your rights to continue coverage while on leave. Contact your employer for further information.

What happens to your MSA after you die?

Your MSA ends on the date you die, and the balance is not refunded to your survivors. An IRS-qualified dependent or beneficiary can continue an MSA through the end of the plan year under COBRA. Contact ASIFlex for more information. If the MSA is not continued through COBRA, your beneficiary has 90 days from the date of your death or the end of the run-out period, whichever is sooner, to submit claims for eligible expenses incurred through your date of death.

The death of a spouse or child creates a change in status. You can stop, start or change the amount contributed to your MSA at that time. You have 31 days from the date of their death to make the change. See Page 127 for information about changing your contribution.

Dependent Care Spending Account

A Dependent Care Spending Account, or DCSA, allows you to pay work-related dependent care expenses with pretax income. This account is only for daycare costs for children and dependent adults, and it cannot be used to pay for dependent medical care. The funds can be used only for expenses incurred during the 2027 plan year. If you have money left in your account on December 31, you have until March 15, 2028, to spend funds contributed during 2027. You will have until March 31, 2028, to request reimbursement from your 2027 funds for expenses incurred on or before March 15, 2028. You will forfeit any funds left in your account after the reimbursement deadline.

Eligibility

You must be eligible for state group insurance benefits to participate in a DCSA. However, you are not required to be covered by an insurance program to participate.

Enrollment

You can enroll in a DCSA within 31 days of your hire date through your employer. If you do not enroll then, you can enroll during the next open enrollment period in October through [MyBenefits](#).

You also can enroll in or make changes to this account within 31 days of a special eligibility situation. To do this, see Making changes to your MoneyPlus coverage on Page 127. To learn about special eligibility situations, see Page 19.

You must reenroll each year during open enrollment to continue your account the following year.

Deciding how much to set aside

Estimate the amount you will spend on dependent care throughout the year. Consider vacation and holiday time, when you might not have to pay for dependent care. The yearly amount you elect to contribute to your account will be divided into equal installments and deducted from each paycheck before taxes.

The IRS will not allow any money still in your account after you have claimed all of your expenses at the end of the year to be returned to you, or be carried over into the next plan year. If you have money left in your account on

December 31, you have until March 15, 2028, to spend funds contributed during 2027. You will have until March 31, 2028, to request reimbursement for expenses incurred on or before March 15, 2028. You will forfeit any funds left in your account after the reimbursement deadline.

Once you sign up for a DCSA and decide how much to contribute, you have to wait for the funds to accumulate in your account before being reimbursed for eligible expenses.

Contribution limits

The contribution limit for a DCSA is based on your tax filing status. Below are the 2027 limits.

- Married, filing separately: \$3,750
- Single, head of household: \$7,500
- Married, filing jointly: \$7,500

If you or your spouse earns less than \$5,000 a year, your maximum is equal to the lower of the two incomes.

In 2027, the DCSA is capped at \$1,600 for highly compensated employees. For 2027, the IRC defines highly compensated employees as those who earned \$160,000 or more in calendar year 2026. The cap is subject to adjustment during the year if PEBA's DCSA does not meet the federal average benefit test. The test is designed to ensure that highly compensated employees do not receive a benefit that is out of proportion with the benefit received by other employees.

For more information, talk with a tax professional or contact the [IRS](#) online or at 800.829.1040.

People who can be covered by a DCSA

Your child and dependent care expenses must be for the care of one or more qualifying people. A qualifying person is:

1. Your qualifying child who is your dependent and was younger than age 13 when the care was provided;
2. Your spouse who was not physically or mentally able to care for themselves and lived with you for more than half the year; or
3. A person who was not physically or mentally able to care for themselves, lived with you for more than half the year, and either:

- a. Was your dependent; or
- b. Would have been your dependent except that:
 - i. They received gross income of \$4,050 or more;
 - ii. They filed a joint return; or
 - iii. You or your spouse, if filing jointly, could be claimed as a dependent on someone else's tax return.

Eligible expenses

Generally, child, adult and elder care costs that allow you and your spouse to work or actively look for work are eligible for reimbursement. If you are married, your spouse must work, be a full-time student or be mentally or physically incapable of self-care. Examples include:

- Daycare facility fees;
- Local day camp fees;
- Before or after school care;
- Preschool or nursery school; and
- Babysitting fees for at-home care while you and your spouse are working. You, your spouse or another tax dependent cannot provide the care.

Ineligible expenses

- Child support payments or childcare if you are a non-custodial parent.
- Payments for dependent care services provided by your dependent, your spouse's dependent or your child who is younger than age 19.
- Healthcare costs.
- Educational tuition.
- Overnight camps.
- Overnight care for your dependents, unless it allows you and your spouse to work during that time.
- Nursing home fees.
- Diaper services.
- Books and supplies.
- Activity fees.
- Tuition.

Requesting reimbursement of eligible expenses

When you have a dependent care expense, you request reimbursement from your [ASIFlex account](#). You will also need to submit documentation for your expense. A paper claim form is available on our [Forms webpage](#).

Your claim and the expense documentation should show the following:

- The dates your dependent received the care, not the date you paid for the service;
- The name and address of the facility; and
- The name, address and signature of the individual who provided the dependent care.

This information is required with each reimbursement request. The claim form can serve as documentation if it includes the provider's signature. Although the form does not request the provider's Tax ID Number or Social Security number, you should be prepared to provide it to the IRS, if asked.

ASIFlex will process your claim within three business days of receiving it. Your reimbursement can be deposited directly into your bank account within one day of processing your claims. This service has no extra fee and includes notifications of when your funds are processed. To set up direct deposit, log in to your online account and update your personal account settings. You should also sign up for email and/or text alerts on [ASIFlex's website](#).

An approved expense also will not be reimbursed until after the last date of service for which you are requesting reimbursement. For example, if you pay your dependent care provider on October 1 for the month of October, you can submit your reimbursement request for the entire month. Payment will not be made, though, until you receive the last day of care for October.

An approved expense also will not be reimbursed until enough funds are in the DCSA to cover it. On your claim, you can divide the dates of service into periods that correspond with your payroll cycle. This will allow you to be reimbursed for part of the amount on the documentation when there are enough funds in your account.

Reporting your DCSA to the IRS

If you participate in a DCSA, you must attach IRS Form 2441 to your 1040 income tax return. Otherwise, the IRS might not allow your pretax exclusion. To claim the income exclusion for dependent care expenses on Form 2441, you must list each dependent care provider's Social Security number or Employer Identification Number. If you are unable to obtain one of these numbers, you will need to provide a written statement with your Form 2441 explaining the situation and stating that you made a serious effort to get the information.

Comparing the DCSA to the child and dependent care credit

If you pay for dependent care so you can work, you might be able to reduce your taxes by claiming those expenses on your federal income tax return through the child and dependent care credit instead of using a DCSA. Depending on your circumstances, participating in a DCSA on a salary-reduction basis might produce a greater tax benefit. For more information, see IRS Publication 503 or speak with a qualified tax professional.

What happens to your DCSA if you leave your job?

If you leave your job permanently or take an unpaid leave of absence, you cannot continue contributing to your DCSA. You can, however, continue to incur expenses through March 15 of the following year, and request reimbursement for eligible expenses until March 31 of the following year, or until you exhaust your account, whichever is sooner.

If you return to employment with an employer who participates in PEBA-administered insurance within 30 days, your original DCSA elections will automatically be reinstated. If you return to employment with an employer who participates in PEBA-administered insurance after 30 days, you cannot participate in a DCSA for the remainder of the plan year. You can, however, reenroll during open enrollment for the next plan year.

What happens to your DCSA after you die?

Your DCSA ends on the date you die and is not refunded to your survivors. DCSA claims for expenses that occurred up through your date of death can be submitted until the account is exhausted or through the end of the plan year.

The death of a spouse or child creates a change in status. You can stop, start or change the amount contributed to your DCSA at that time. You have 31 days from the date of their death to make the change. See Page 127 for information about changing your contribution.

Limited-use Medical Spending Account

If you enrolled in the Savings Plan, you also might be eligible for a Limited-use Medical Spending Account. This account can be used for dental and vision care expenses only. Except for the restriction on what kinds of expenses are reimbursable, a Limited-use MSA works the same as a Medical Spending Account. Enrolling in a Limited-use MSA allows you to save any HSA funds for future medical expenses. More information about HSAs is available on Page 130.

Eligible expenses

You can use your HSA, but not your Limited-use MSA, for medical deductibles and coinsurance. You can use your Limited-use MSA for dental and vision care expenses.

Ineligible expenses (Limited-use MSA only)

- Insurance premiums;
- Vision warranties and service contracts;
- Expenses for a service not yet provided or for pretreatment estimates;
- Expenses for general good health and well-being;
- Illegal operations;
- Expenses paid by insurance or any other source;
- Health or fitness club membership fees;
- Cosmetic surgery, treatments or medications not deemed medically necessary to alleviate, mitigate or prevent a medical condition;

- Medical plan deductibles and coinsurance; and
- Over-the-counter healthcare products that are not for dental or vision care.

Making changes to your MoneyPlus coverage

You have limited circumstances for starting or stopping your DCSA, MSA and Limited-use MSA, or varying the amounts you contribute. Any changes you make to your DCSA, MSA or Limited-use MSA must be consistent with the event that initiates the change.

For example, you might want to start a DCSA if you have a baby or adopt a child. You might want to decrease your MSA contribution if you get a divorce and will no longer be paying for your former spouse's out-of-pocket medical expenses.

Within 31 days of one of the events listed below, contact your employer if you want to make changes.

Any related claims you submit while ASIFlex is processing your change in status will be held until the processing is complete. Birth, adoption and placement for adoption are effective on the date of the event. All other changes are effective on the first of the month following the request.

Some special eligibility situations that might permit changes to your MoneyPlus account are:

- Marriage or divorce (you cannot make changes because you are in the process of divorce, but you can after it is final);
- Birth, placement for adoption or adoption;
- Placement for custody;
- Dependent loses eligibility;
- Death of spouse or child;
- Gain or loss of employment;
- Beginning or end unpaid leave of absence;
- Change from full-time to part-time employment or vice versa;
- Beginning and/or ending daycare throughout the year (for DCSA only); and
- Change in daycare provider (for DCSA only).

How changes affect your period of coverage

Your MoneyPlus flexible spending account is set up for the entire calendar year, which is your period of coverage. If you make an approved, mid-Plan-year election change and increase your contributions, expenses you had before the mid-year change cannot be reimbursed for more money than was in the account at the time of the change.

Appeals

Reimbursement or claim for benefits

If your request for reimbursement or claim for benefits is denied in full or in part, you have the right to appeal the decision. Appeals are approved only if the extenuating circumstances and supporting documentation are within your employer's, your insurance provider's and IRS' regulations governing the Plan.

Send a written request within 31 days of the denial for review to:

ASIFlex Appeals
Attn: S.C. MoneyPlus
P.O. Box 6044
Columbia, MO 65205-6044

Retain copies of claims and receipts for your records.

Your appeal must include the completed *Appeal Form* found on [ASIFlex's website](#) and:

- The name of your employer;
- The date of the services for which your request was denied;
- A copy of the denied request;
- A copy of the denial letter you received;
- Why you think your request should not have been denied; and
- Any additional documents, information or comments you think might have a bearing on your appeal.

You will be notified of the results of this review within 31 business days from receipt of your appeal. In unusual cases, such as when an appeal requires additional documentation, the review could take longer. If your appeal is approved, additional processing time is required to modify your

benefit elections.

If you are still dissatisfied after the decision is reexamined, you can ask PEBA to review the matter by sending an [Appeal Request Form](#) to PEBA within 90 days of notice of ASIFlex's denial of your appeal. Send the request to:

IAD@peba.sc.gov

or

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

Appeals can be brought only by the covered person at issue, their legal representative (who cannot be, including but not limited to, a provider, medical device manufacturer, pharmaceutical manufacturer, employer, or a representative or agent of any of the foregoing), or a licensed attorney admitted to practice in South Carolina.

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

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

Enrollment

You have the right to appeal enrollment decisions, as well, by submitting a request for review through your benefits administrator. Benefits administrators can submit a request for review online.

If the request for review is denied, you can then appeal by sending an [Appeal Request Form](#) to PEBA within 90 days of notice of the decision. Include a copy of the denial with your appeal. Send the request to:

IAD@peba.sc.gov

or

S.C. PEBA

Attn: Insurance Appeals Division

202 Arbor Lake Drive

Columbia, SC 29223

Appeals can be brought only by the covered person at issue, their legal representative (who cannot be, including but not limited to, a provider, medical device manufacturer, pharmaceutical manufacturer, employer, or a representative or agent of any of the foregoing), or a licensed attorney admitted to practice in South Carolina.

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

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

Contacting ASIFlex

www.ASIFlex.com/SCMoneyPlus

Customer Care Center

8 a.m.-8 p.m., Monday through Friday

10 a.m.-2 p.m., Saturday

833.SCM.PLUS (833.726.7587)

Toll-free claims fax: 877.879.9038

asi@asiflex.com



Health Savings Account

State Health Plan Savings Plan members are encouraged to participate in a Health Savings Account, or HSA. An HSA is a tax-favored account that offers several advantages for saving for future healthcare expenses and even retirement. HSAs carry over from year to year, and you do not have to spend the funds in the year they are deposited.

You can even take your account with you if you leave your job. Because of this, you can use your HSA to save up over time for future medical expenses, and in doing so, you can offset the higher deductible of your insurance plan. You can also use the debit card issued by HSA Central for all your qualified medical expenses. Learn more about the State Health Plan's Savings Plan on Page 37.

Also, once you have accumulated a balance of \$1,000 in your HSA, you can invest the funds among a variety of investment options. The investment earnings are tax-free as long as the funds are spent for qualified medical expenses (see Eligibility section). Learn more about investment options at [HSA Central's website](#).

Eligibility

You must be enrolled in the Savings Plan to be eligible for an HSA. You cannot be covered by any other health plan that is not a high-deductible health plan, including Medicare. You can, however, still be covered for specific injuries, accidents, disability, dental care, vision care and long-term care. You are not eligible if you have received Veterans Affairs benefits within the past three months; exceptions include preventive care. This exclusion does not apply if you have a disability rating from the VA. Additionally, you cannot be claimed as a dependent on another person's income tax return.

A Medical Spending Account, even a spouse's MSA, is considered another health plan under HSA regulations, and as such, prevents you from contributing to an HSA. If you have no funds in your MSA on December 31, you can begin contributing to an HSA on January 1.

When an active subscriber who is enrolled in the Savings Plan turns age 65, they remain eligible to contribute to an HSA if they delay enrollment in Medicare Part A by delaying Social Security benefits. They can delay enrolling in Social Security until they turn age 70½. Once they enroll in Social Security, and therefore Medicare Part A, they can no longer make contributions to an HSA. The funds already

in the HSA, however, can be withdrawn to pay Medicare premiums and out-of-pocket expenses, such as deductible and coinsurance, but cannot be used to pay Medicare Supplement (Medigap) premiums.

Enrollment

You can enroll in, change or stop your pretax payroll contributions to an HSA at any time, but changes are limited to once per month. You do not have to wait to enroll or make changes during open enrollment or a special eligibility situation. You can enroll by submitting a *Notice of Election* to your benefits administrator. Once you enroll in an HSA, you do not need to reenroll as long as you remain eligible.

ASIFlex administers HSAs, and HSA Central serves as the custodian for HSAs. To participate, you must enroll in the Savings Plan and elect to contribute to an HSA. HSA Central will automatically set up your bank account based on enrollment information from PEBA. You will receive a welcome email from HSA Central once it is set up, and you will receive a debit card within seven to 10 business days. To fully open the account, you must log in to your online [HSA Central account](#), accept the terms and conditions, and activate your debit card. Once you activate the card and select a PIN, you can use it to access your funds. Your payroll contributions will automatically post to your bank account within one business day of ASIFlex receiving the funds from your employer.

Contribution limits

The contribution limit, set by the IRS, for an HSA is based upon your health plan coverage level. Below are limits for 2027.

- Single coverage: \$4,500
- Family coverage: \$9,000
- Additional catch-up contributions for a subscriber who is age 55 or older: \$1,000

When you enroll in an HSA, you can begin contributing your maximum beginning on the first of the month in which it goes into effect, but only so long as you remain eligible for the following 12 months. You can contribute up to the maximum in a lump sum payment or in equal amounts through payroll deduction.

ASIFlex will monitor your HSA contributions and send

an alert to your employer if you are exceeding your contribution limit through payroll deductions. The best way to avoid over contributing is to divide your desired annual contribution among the number of paychecks you receive, or expect to receive through the remainder of the year if a mid-plan-year enrollment. For example, if you have single coverage, you can contribute a maximum of \$4,500 for 2027. If you receive 24 paychecks each year, you can contribute \$187.50 each pay period.

Subscribers who are transitioning from an MSA to an HSA might face a restriction on when they can begin making HSA contributions. IRS regulations do not allow you to use your MSA in conjunction with an HSA; however, regulations allow you to use a Limited-use MSA in conjunction with an HSA.

You can use a Limited-use MSA to pay for dental and vision care expenses. Doing so allows you to save your HSA funds for future medical expenses. If you enroll in an HSA and have any carryover funds in your traditional MSA, ASIFlex will automatically convert those funds to a Limited-use MSA because of your new plan year HSA election. Learn more about Limited-use MSAs on Page 127.

Administrative fees

There is no monthly administrative fee charged to participants who are actively contributing to their HSA. Standard retail fees could apply to terminated HSA accounts and accounts no longer associated with a qualified high deductible health plan.

When your funds become available

Each contribution to your HSA will be available after your employer's payroll is received, processed and deposited to your HSA. Funds will be available in your HSA Central bank account no later than one business day after ASIFlex receives the money from your employer.

Using your funds

After you enroll in an HSA, you will receive a Mastercard® debit card from HSA Central to use for all your qualified medical expenses. You can reimburse yourself with a direct deposit to a checking or savings account of your choice or through Bill Pay at no additional charge. If you use your debit card for a transaction and do not have enough money in your account, the transaction will not go through or could

overdraw your account.

You can log in to your HSA Central account to check your balance, make online, after-tax contributions, review monthly statements and annual tax reporting, transfer funds, set up your HSA investment account and more.

HSA Central will provide monthly electronic statements at no cost, but you can opt to receive paper statements for a \$3 monthly fee.

Eligible expenses and documentation

You can use your HSA funds, tax free, to pay for unreimbursed eligible medical expenses for you, your spouse and your tax dependents. Medical expenses include the costs of diagnosis, cure, treatment or prevention of physical or mental defects or illnesses, including dental and vision expenses.

You should keep receipts for expenses paid from your HSA with your tax returns in case the IRS audits your tax return and requests copies. You can also upload scanned copies or pictures of your eligible receipts by logging in to your HSA Central account for easy tracking.

If you use HSA funds for ineligible expenses, you will be subject to taxes on the amount you took from your HSA, as well as a 20% penalty, if you are younger than age 65.

Investing HSA funds

Your HSA funds will be held in an interest-bearing account with HSA Central. As the account grows, you might be eligible to invest your funds more than \$1,000. Investments are not FDIC insured; are not a deposit or other obligation of or guaranteed by any bank; might lose value, including possible loss of principal invested; and are not insured by any federal agency. You should review investments in detail before making your investment selections.

Investment risk is the uncertainty of how a given investment will perform. When you choose to invest your funds, your account balance is affected by investment gains or losses as a result of those choices. You bear all investment risk related to your HSA. If you choose to invest your HSA funds in excess of \$1,000, the annual investment account fee is 0.35% deducted quarterly from your investment account with a monthly \$1 HSA Investment Service Fee. Additional fees might be charged based on the investment options you select.

Learn more about investment options available to you on [HSA Central's website](#).

Reporting your HSA to the IRS

After year-end, HSA Central will provide participants with information to use in reporting HSA contributions and withdrawals when you file your taxes. You should save documentation, including receipts, invoices and explanations of benefits from your health insurance claims processor, in case you are asked to show the IRS proof that your HSA funds were used for qualified expenses.

Pretax HSA contributions will appear on your W-2 as employer-paid contributions because the money was deducted from your salary before it was taxed. You should not deduct this amount on your tax return. Only after-tax contributions can be deducted. Consult with a tax professional for more information.

What happens to your HSA after you die?

If your spouse is the beneficiary of your HSA, the account can be transferred to an HSA in your spouse's name. If your beneficiary is someone other than your spouse, the account will cease to be an HSA on your date of death. If the beneficiary is your estate, the fair market value of the account on your date of death will be taxable on your final return. For beneficiaries other than your spouse or estate, the fair market value of the account is taxable to the beneficiary for the tax year in which you died. For questions about what happens to your HSA after you die, call HSA Central at 833.571.0503.

Closing your HSA

If you are no longer eligible to contribute to an HSA through PEBA or would like to stop contributing pretax through payroll deduction, you must complete a *Notice of Election* form and return it to your benefits administrator. You can continue to use any remaining funds in your HSA for qualified, unreimbursed medical expenses. If you want to close your HSA bank account altogether, you must call HSA Central at 833.571.0503.

Limited-use Medical Spending Account

If you are making contributions to an HSA, you also might be eligible for a Limited-use Medical Spending Account. This account can be used for eligible expenses not covered by the Savings Plan. Eligible expenses include dental and vision care. Using a Limited-use MSA allows you to save your HSA funds for future medical expenses. Plus, you have access to your entire Limited-use MSA contribution amount on January 1 or your coverage effective date, whichever is later. Except for the restriction on what kinds of expenses are reimbursable, a Limited-use MSA works the same as a Medical Spending Account. Learn more on Page 127.

Enrollment appeals

You have the right to appeal enrollment decisions by submitting a request for review through your benefits administrator. Benefits administrators can submit a request for review online.

If the request for review is denied, you can then appeal by sending an [Appeal Request Form](#) to PEBA within 90 days of notice of the decision. Include a copy of the denial with your appeal. Send the request to:

IAD@peba.sc.gov

or

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

Appeals can be brought only by the covered person at issue, their legal representative (who cannot be, including but not limited to, a provider, medical device manufacturer, pharmaceutical manufacturer, employer, or a representative or agent of any of the foregoing), or a licensed attorney admitted to practice in South Carolina.

PEBA will make every effort to process your appeal within 180 days of the date it receives your information, as outlined in the Plan. However, this time might be extended if additional material is requested or you ask for an extension. PEBA will send you status updates. When PEBA's review of your appeal is complete, you will receive a written determination. If the denial is upheld by PEBA, you have 30 days to seek judicial review at the Administrative Law Court, as provided by Sections 1-11-710 and 1-23-380 of the S.C.

Code of Laws, as amended.

Contacting HSA Central

schsa.centralbank.net

Consumer Services

833.571.0503

8 a.m. to 8 p.m., Monday through Friday

Retiree group insurance

Some of the insurance benefits you enjoy as an active employee might be available to you as a retiree through the group insurance programs PEBA administers. This chapter covers retiree group insurance eligibility, and whether your employer might pay a portion of your retiree insurance premiums, your coverage options and how to enroll as a retiree.

Only PEBA can confirm your eligibility

Eligibility for retiree group insurance is not the same as eligibility for retirement. Determining retiree insurance eligibility is complicated, and only PEBA can make that determination. It is extremely important to contact PEBA before making final arrangements for retirement to confirm your eligibility.

If you applied for retirement, you do not need to submit an *Employment Verification Record* because your retirement application initiates the process to determine your eligibility for retiree insurance. You will receive a letter from PEBA notifying you of your eligibility for retiree insurance.

If you plan to retire in three to six months, submit an *Employment Verification Record* to PEBA. If you plan to retire within 90 days, complete and submit to PEBA an *Employment Verification Record*, a *Retiree Notice of Election* and a *Certification Regarding Tobacco and E-cigarette Use* form. The *Employment Verification Record*, *Retiree Notice of Election* and retiree packet are available on our [Forms webpage](#). You can also get copies from your employer or call PEBA at 803.737.6800 or 888.260.9430.

In some situations, eligibility determinations are available in Member Access, the member portal for retirement benefits and/or MyBenefits. PEBA will also send you written confirmation of your eligibility. PEBA does not confirm eligibility for retirement dates further out than six months. PEBA cannot confirm eligibility for retiree group insurance or funding of your retiree insurance premiums by phone or email.

After confirmation of eligibility, you must submit the necessary forms to enroll in retiree coverage. Coverage does not automatically continue at retirement.

Are you eligible for retiree group insurance?

Your eligibility for retiree group insurance coverage and funding depends on several factors, including your eligibility for a retirement benefit, the date you were hired into an insurance-eligible position with an employer that participates in the State Health Plan, your retirement service credit earned while working for an employer that participates in the State Health Plan and the nature of your last five years of employment with an employer that participates in the State Health Plan.

Earned service credit for the purposes of determining retiree insurance eligibility is time earned and established in one of the defined benefit retirement plans PEBA administers; time worked while participating in the State Optional Retirement Program; or time worked for an employer that participates in the State Health Plan, but not the retirement plans PEBA administers.

Earned service credit does not include any purchased service credit not considered earned service in the retirement plans (e.g., non-qualified service or employer-approved sabbatical leave) or service accrued with an employer that does not participate in the State Health Plan.

An employee has retired and established a date of retirement for the purpose of the retiree group insurance eligibility if they:

1. Have terminated from all employment with a participating employer;
2. Have terminated from all employment covered by a PEBA-administered retirement plan; and
3. Are eligible to receive a service or disability retirement benefit from a PEBA-administered retirement plan.

If you return to an insurance-eligible position after retiring, you will not earn additional service credit towards retiree insurance eligibility. So, if you were not eligible for retiree health insurance or funded premiums when you retired, you cannot gain eligibility by returning to work.

Defined benefit plan members

If you are a member of one of the defined benefit retirement plans PEBA administers, your eligibility for retiree group insurance will depend on whether you have met the minimum statutory requirements for retirement eligibility established for the plan in which you are a member when you leave employment.

PEBA's defined benefit plans include the South Carolina Retirement System, the Police Officers Retirement System, the General Assembly Retirement System and the Judges and Solicitors Retirement System.

State Optional Retirement Program participants

PEBA also administers a defined contribution plan, the State Optional Retirement Program. Being eligible to receive State ORP distributions does not mean you are eligible for retiree group insurance.

Because State ORP participants do not earn service credit, their eligibility for retiree insurance is determined as if they had been a member of the South Carolina Retirement System. This means one year of employment with an insurance-participating employer while participating in State ORP is treated like one year of earned service credit in SCRS for purposes of determining your eligibility for retiree insurance.

To be considered State ORP retirement-eligible for retiree insurance purposes, you must meet the following minimum statutory requirements for SCRS retirement eligibility:

Class Two Members (membership effective prior to July 1, 2012)

- Have 28 years of participation in a state retirement system, or
- Be age 60 or older; and
- Have at least five years of earned service credit.

Class Three members (membership effective on or after July 1, 2012)

- Your age and years of participation total at least 90, or
- Be age 60 or older; and
- Have at least eight years of earned service credit.

Learn more about SCRS retirement eligibility requirements

in the [*South Carolina Retirement System Member Handbook*](#).

In addition to being State ORP retirement-eligible, your last five years of employment must have been served consecutively in a full-time permanent position with an employer participating in the State Health Plan. If you do not meet these threshold requirements, then you are ineligible for retiree insurance coverage.

Will your employer pay part of your retiree insurance premiums?

As an active employee, your employer pays part of the cost of your health and dental insurance. When you retire, several factors determine if you pay all or part of your insurance premiums. These factors include your years of earned service credit, the type of employer from which you retire and the date you were hired into an insurance-eligible position.

Employees of state agencies, public higher education institutions, public school districts, as well as charter schools that participate in retirement, that participate in the state insurance program might be eligible for a state contribution to their retiree insurance premiums based on when they began employment and on their number of years of earned service credit.

Retiree insurance eligibility rules are the same for retirees of optional employers and charter schools that participate in insurance only as they are for retirees of state agencies, public higher education institutions, public school districts and charter schools that participate in retirement. However, the funding is different. Participating optional employers and charter schools that participate in insurance only might pay a portion of the cost of their retirees' insurance premiums. Each participating optional employer or charter school develops its own policy for funding retiree insurance premiums for its eligible retirees. If you are an employee of a participating optional employer or charter school that participates in insurance only, contact your benefits office for information about retiree insurance premiums.

Early retirement: SCRS Class Two members

A Class Two member of SCRS who retires under the 55/25 early retirement provision and who is otherwise eligible for funding toward retiree insurance premiums from the South Carolina Retiree Health Insurance Trust Fund must pay the full premium (employee and employer share) until they reach age 60 or the date they would have reached 28 years of service credit had they not retired, whichever occurs first. Contact your employer if you are unsure whether it participates in the Retiree Health Insurance Trust Fund. Premiums for optional employers can vary.

Retirees can also delay or refuse enrollment until age 60 or the date they would have reached 28 years of service credit had they not retired.

Certain elected officials

Special retiree insurance rules apply to members of the General Assembly and members of a municipal or county council who began employment eligible for coverage under the State Health Plan before May 2, 2008. Contact PEBA for more detailed information.

Retiree insurance eligibility, funding

For members who work for a state agency, public higher education institution, public school district or charter school that participates in both insurance and retirement

The charts beginning on Page 139 illustrate eligibility and funding guidelines for retiree group insurance. Refer to the *Plan of Benefits* for more detailed information on these and other eligibility and funding rules. When reviewing the charts, keep these things in mind:

- For any retiree coverage, your last five years of employment must have been served consecutively in a full-time, insurance-eligible permanent position with an employer that participates in the State Health Plan.
- Changing jobs could affect your eligibility for funding. The information on Page 139 applies only if your last employer prior to retirement is a state agency, public higher education institution, public school district or

other employer that participates in the state's Retiree Health Insurance Trust Fund. Contact your employer if you are unsure whether it participates in the Retiree Health Insurance Trust Fund.

- To receive state funding toward your premiums, your last five years of employment must have been in service with a state agency, public higher education institution, public school district or other employer, such as a charter school, that participates in the state's Retiree Health Insurance Trust Fund. Early retirement from the South Carolina Retirement System under the 55/25 provision will delay your eligibility for funding.
- If the charter school for which you work does not participate in a PEBA-administered retirement plan, and you meet the eligibility requirements for retiree group insurance, employer funding, if any, is at the discretion of your charter school.
- Earned service credit for the purposes of determining retiree insurance eligibility is time earned and established in one of the defined benefit retirement plans PEBA administers; time worked while participating in the State Optional Retirement Program; or time worked for an employer that participates in the State Health Plan, but not the retirement plans PEBA administers.
- For State ORP participants and members whose employer does not participate in a PEBA-administered retirement plan, eligibility is determined as if the participant were a member of the South Carolina Retirement System, including reaching retirement eligibility. This means one year of employment with an insurance-participating employer is equated to one year of earned service credit in SCRS for purposes of determining eligibility for retiree insurance. Learn more about SCRS retirement eligibility requirements in the [South Carolina Retirement System Member Handbook](#).

Employees hired into an insurance-eligible position before May 2, 2008

Retirement status	Earned service credit with an employer participating in the State Health Plan	Responsibility for paying premiums
Left employment after reaching service or disability retirement eligibility Learn more about retirement eligibility on PEBA's website .	Five years, but less than 10 years	You pay the full premium (employee and employer share).
	10 years or more	You pay only the employee share of the premium.
Left employment before reaching retirement eligibility	Less than 20 years	You are not eligible for retiree insurance coverage.
	20 years or more	You are eligible for coverage upon reaching retirement eligibility. ¹ You pay only the employee share of the premium.

¹ Retirement eligibility means you have met the minimum statutory requirements for retirement eligibility established for the plan in which you are a member. For State ORP participants and members whose employer does not participate in a PEBA-administered retirement plan, eligibility is determined as if the participant were a member of the South Carolina Retirement System, including reaching retirement eligibility.

Employees hired into an insurance-eligible position on or after May 2, 2008

Retirement status	Earned service credit with an employer participating in the State Health Plan	Responsibility for paying premiums
Left employment after reaching service or disability retirement eligibility Learn more about retirement eligibility on PEBA's website .	Five years, but less than 15 years	You pay the full premium (employee and employer share).
	15 years, but less than 25 years	You pay the employee share of the premium and 50% of the employer share of the premium.
	25 years or more	You pay only the employee share of the premium.
Left employment before reaching retirement eligibility	Less than 20 years	You are not eligible for retiree insurance coverage.
	20 years, but less than 25 years	You are eligible for coverage upon reaching retirement eligibility. ² You pay the employee share of the premium and 50% of the employer share of the premium.
	25 years or more	You are eligible for coverage upon reaching retirement eligibility. ² You pay only the employee share of the premium.

² Retirement eligibility means you have met the minimum statutory requirements for retirement eligibility established for the plan in which you are a member. For State ORP participants and members whose employer does not participate in a PEBA-administered retirement plan, eligibility is determined as if the participant were a member of the South Carolina Retirement System, including reaching retirement eligibility.

For members who work for participating optional employers, such as county governments and municipalities, and charter schools that participate in insurance only

The chart on below illustrates eligibility and funding guidelines for retiree group insurance. Refer to the Plan of Benefits for more detailed information on these and other eligibility and funding rules. When reviewing the charts, keep in mind:

- Your last five years of employment must have been served consecutively in a full-time, insurance-eligible permanent position with an employer that participates in the State Health Plan.
- Changing jobs could affect your eligibility for funding. The information below applies only if your last employer prior to retirement is an optional employer or other employer that does not participate in the state’s Retiree Health Insurance Trust Fund. Contact your employer if you are unsure whether

it participates in the Retiree Health Insurance Trust Fund.

- Earned service credit for the purposes of determining retiree insurance eligibility is time earned and established in one of the defined benefit retirement plans PEBA administers; time worked while participating in the State Optional Retirement Program; or time worked for an employer that participates in the State Health Plan, but not the retirement plans PEBA administers.
- If your employer does not participate in a PEBA-administered retirement plan, your eligibility is determined as if you were a member of the South Carolina Retirement System, including reaching retirement eligibility. This means one year of employment with an insurance-participating employer is equated to one year of earned service credit in SCRS for purposes of determining eligibility for retiree insurance. Learn more about SCRS retirement eligibility requirements in the [South Carolina Retirement System Member Handbook](#).

Employees hired into an insurance-eligible position

Retirement status	Earned service credit with an employer participating in the State Health Plan	Responsibility for paying premiums
Left employment after reaching service or disability retirement eligibility Learn more about retirement eligibility at peba.sc.gov .	At least five years	Your portion of the premium, up to the full amount of the employee and employer share, is at your employer’s discretion.
Left employment before reaching retirement eligibility	Less than 20 years	You are not eligible for retiree insurance coverage.
	20 years or more	You are eligible for coverage upon reaching retirement eligibility. ³ Your portion of the premium, up to the full amount of the employee and employer share, is at your employer’s discretion.

3 Retirement eligibility means you have met the minimum statutory requirements for retirement eligibility established for the plan in which you are a member. For State ORP participants and members whose employer does not participate in a PEBA-administered retirement plan, eligibility is determined as if the participant were a member of the South Carolina Retirement System, including reaching retirement eligibility.

Your retiree insurance coverage choices

If you are not eligible for Medicare

If you, your covered spouse and your covered children are not eligible for Medicare, you might be covered under one of these plans:

- State Health Plan Standard Plan; or
- State Health Plan Savings Plan; or
- TRICARE Supplement Plan (for eligible members of the retired military community).

Your health insurance benefits, which are described in the **Health insurance** chapter (see Page 30), will be the same as if you were an active employee. Your premiums can change depending on whether you are a funded, partially funded or non-funded retiree (see Retiree insurance eligibility, funding on Page 138).

If you are considering the Savings Plan

If you are a retiree who is not eligible for Medicare, you can enroll in the Savings Plan, but contributions to a Health Savings Account cannot be deducted pretax from your retirement benefit payment. You can deduct your contributions to an HSA on your income tax return.

If you are age 65 or older and not eligible for Medicare

If, when you retire, you are age 65 or older and not eligible for Medicare, contact the Social Security Administration. The SSA will send you a letter of denial of Medicare coverage. Give a copy of the letter to your benefits administrator. You can enroll in health insurance as a retiree within 31 days of loss of active coverage, within 31 days of a special eligibility situation, or during an annual open enrollment period. You also can enroll your eligible family members.

If you are eligible for Medicare

If you, your covered spouse or your covered children are eligible for Medicare, you can be covered under one of these plans:

- Medicare Supplemental Plan; or
- Carve-out Plan.

You and your Medicare-eligible dependents will automatically be enrolled in SilverScript Employer PDP,

the State Health Plan's Medicare Part D prescription drug program. For more information about the program, including how to opt out of the program, see PEBA's *Insurance Coverage for the Medicare-eligible Member* handbook on our [Publications webpage](#).

To learn more about how health insurance offered through PEBA works with Medicare:

- Read PEBA's *Insurance Coverage for the Medicare-eligible Member* handbook; or
- Call PEBA at 803.737.6800 or 888.260.9430.

To learn more about Medicare:

- Read Medicare and You;
- Visit the [Medicare website](#); or
- Call Medicare at 800.633.4227 or 877.486.2048 (TTY).

Dental benefits

If you retire from a participating employer, you can continue your Dental Plus or Basic Dental coverage if you meet the eligibility requirements listed on Pages 139-140. Information about dental benefits is on Page 77.

Vision care

If you retire from a participating employer, you can continue your State Vision Plan coverage if you meet the eligibility requirements listed on Pages 139-140. Information about vision care benefits is on Page 86.

When to enroll in retiree insurance coverage

Your insurance does not automatically continue when you retire. Before enrolling in retiree insurance, you will need to confirm eligibility for retiree group insurance. You can confirm your eligibility up to six months prior to your date of retirement by completing an *Employment Verification Record*. If you do not submit an EVR, PEBA will automatically determine your eligibility when you apply for retirement from an employer who participates in PEBA-administered retirement benefits.

If eligible, submit the required forms to PEBA (See Page 135) at least 31 days but not more than six months before your retirement date, or the date of your approval for disability benefits. This will provide PEBA with enough time to process

your enrollment so your insurance coverage as a retiree starts the day your coverage as an active employee ends.

If you do not submit the required forms to enroll within 31 days of your retirement date, you can enroll during the next open enrollment period, which occurs yearly in October. Coverage will be effective the following January 1. You also can enroll within 31 days of a special eligibility situation. Dental enrollment is available only during open enrollment periods in odd-numbered years (e.g., October 2027), or within 31 days of a special eligibility situation.

Service retirement

If you are eligible, you can enroll in retiree insurance within 31 days of your retirement. If you do not enroll within 31 days of your retirement, you can enroll within 31 days of a special eligibility situation (defined on Page 19) or during an annual open enrollment period.

Disability retirement

If you are approved for disability retirement benefits through one of the defined benefit retirement plans PEBA administers (SCRS, PORS, GARS or JSRS), and you meet the eligibility rules for retiree group insurance (see Pages 139-140), you can apply for retiree group insurance within 31 days of the date on the letter from PEBA approving your disability benefits.

If you are approved for disability by the Social Security Administration but are not otherwise eligible for insurance coverage as a retiree through PEBA, your coverage under PEBA cannot begin earlier than the first day of the month that occurs after your Social Security disability approval.

State ORP participants and employees of optional employers or charter schools who do not participate in a PEBA-administered retirement plan are considered retired due to disability if they meet the requirements for a disability retirement benefit from SCRS. For retirements after December 31, 2013, approval for SCRS disability retirement benefits requires approval for disability benefits from the Social Security Administration. You can apply for retiree group insurance within 31 days of the date on the letter from the Social Security Administration approving your disability benefits. Your retiree insurance coverage will be effective the first of the month after PEBA receives documentation establishing your eligibility for disability

retirement benefits.

Within 31 days of a special eligibility situation

A special eligibility situation is created by certain events, such as marriage, birth of a child or loss of other insurance coverage. A special eligibility situation allows you to enroll in an insurance plan or make enrollment changes. You have 31 days from the date of the event to enroll or make changes. More information about special eligibility situations is on Page 19.

During an open enrollment period

If you, your spouse and children do not enroll within 31 days of your retirement, 31 days of approval for disability benefits or 31 days of a special eligibility situation, you can enroll during an open enrollment period, which is held in October. Dental coverage can be added or dropped during an open enrollment period in an odd-numbered year only. Your coverage will take effect the following January 1. You can use PEBA's secure, online insurance benefits enrollment website, [MyBenefits](#), to make open enrollment changes, but not to enroll in coverage.

How to enroll in retiree insurance coverage

If you are eligible to continue PEBA-administered insurance coverage at retirement, complete a *Retiree Notice of Election* and a *Certification Regarding Tobacco and E-cigarette Use* form and submit to PEBA. This is in addition to your previously submitted *Employment Verification Record*. The forms are available on our [Forms webpage](#). You can also get copies from your employer or call PEBA at 803.737.6800 or 888.260.9430. You can ask your benefits administrator for help in completing the forms.

You can enroll yourself and any eligible family members. As a retiree you will make new elections; you do not have to keep the same coverage or cover the same eligible family members you covered as an active employee.

You might be required to submit the appropriate documents to show that the family members you want to cover are eligible for coverage. More information about documents needed at enrollment is on Page 16.

After PEBA processes your retiree insurance enrollment,

you will receive a letter confirming the coverage selected and the premiums due each month. You have 31 days from the date your retiree insurance becomes effective to make any corrections or changes to your coverage. Otherwise, you will have to wait until the next open enrollment period, which occurs every year in October, or until a special eligibility situation to make changes. If you do not enroll in dental coverage within 31 days of eligibility, your next opportunity to add, drop or change dental coverage will be during open enrollment in October of an odd-numbered year.

Retiree premiums and premium payment

State agency, public higher education institution and public school district retirees

If you receive a monthly benefit from a PEBA-administered defined benefit retirement plan, PEBA deducts your health, dental and vision premiums from the monthly benefit payment. If you do not receive a monthly benefit from a PEBA-administered retirement plan, PEBA will send you a monthly bill for your retiree insurance premium.

When you retire, your insurance premiums could be due before your retirement benefit begins. If this happens, PEBA will send you a monthly bill for your insurance premiums until you receive your first benefit payment.

Your retirement benefit is paid on the last business day of each month, and your insurance premiums are paid at the beginning of the month. For example, your insurance premiums for April are deducted from your March benefit payment. Depending on when your retirement paperwork is processed, you might owe more than one month's premium. However, as a new retiree, PEBA will deduct only one month from your first benefit payment. You will receive a letter that provides two options to remit the remaining balance. If at any time the total premiums due add up to an amount greater than the amount of your benefit payment, PEBA will bill you for the full amount. We recommend you enroll in our no-cost Electronic Funds Transfer program. This is the most efficient, safe and accurate way to pay your insurance premiums. To enroll in the EFT program, download and complete the [Authorization Agreement for Electronic Funds Transfer](#).

Participating optional employer retirees

You pay your health, dental and vision premiums to your former employer. Your employer sends them to PEBA. Contact your benefits office for information about your insurance premiums in retirement.

Charter school retirees

If your charter school participates in a PEBA-administered retirement plan, PEBA deducts your health, dental and vision premiums from the monthly benefit payment you receive from PEBA. If at any time the total premiums due add up to an amount greater than the amount of your benefit payment, PEBA will bill you for the full amount. We recommend you enroll in our no-cost Electronic Funds Transfer program. This is the most efficient, safe and accurate way to pay your insurance premiums. To enroll in the EFT program, download and complete the [Authorization Agreement for Electronic Funds Transfer](#).

If your charter school does not participate in a PEBA-administered retirement plan, you pay your health, dental and vision premiums to the charter school. The charter school sends them to PEBA. Contact your benefits office for information about your insurance premiums in retirement.

Failure to pay premiums

Health, dental and vision premiums are due by the 10th of each month. If you do not pay the entire bill, including the tobacco-user premium, if it applies, PEBA will cancel your coverage.

When your coverage as a retiree begins

After confirmation of eligibility, you must submit the necessary forms to enroll in retiree coverage. Coverage does not automatically continue at retirement. If you go directly from covered employment into retirement, your retiree coverage will begin the day after your active coverage ends. If you enroll in retiree insurance coverage upon a deferred retirement, your coverage starts on the first day of the month following your retirement. If you are enrolling due to a special eligibility situation, your effective date will be either the date of the event or the first of the month after the event, depending on the type of event. More information about special eligibility situations is on Page 19. If you enroll during an annual open enrollment

period, your coverage will be effective the following January 1.

If you worked for a state agency, public higher education institution, public school district or charter school that participates in both insurance and retirement, PEBA is your benefits administrator after you retire. If you worked for a participating optional employer or charter school that participates in insurance only, your benefits administrator is your former employer after you retire.

Information you will receive

After you enroll, PEBA will send you a letter confirming you have retiree group insurance coverage. If your coverage as an active employee is also ending, federal law requires PEBA to send you a *Qualifying Event Notice*, which tells you that you can continue your coverage under COBRA. A *Certificate of Creditable Coverage*, which gives the dates of your active coverage, the names of the individuals covered and the types of coverage, is available upon request. Contact [PEBA Customer Service](#) to request one. Typically, these letters require no action on your part.

If you are eligible for Medicare, you will automatically be enrolled in SilverScript, the State Health Plan's Medicare Part D prescription drug program. SilverScript, Caremark's Medicare Part D contractor, will send you an information packet including a letter telling you that you can opt out of the Medicare drug program and remain enrolled in the State Health Plan drug program for members who are not eligible for Medicare. The pharmacy benefits manager is required to give you 21 days to opt out.

For Medicare primary members enrolled in SilverScript or the State Health Plan's drug program, Part B prescriptions covered under the medical benefit might require prior authorization by CMS. Members should use a network retail pharmacy that accepts Medicare. Note that some specialty medications administered in a provider's office might require prior authorization.

Your insurance ID cards in retirement

You can keep and use your same insurance ID cards if you do not change plans when you retire. Your Benefits Identification Number will not change, and your health and dental cards will still be valid. You will receive a new card if

you enroll in Dental Plus or the State Vision Plan for the first time.

If you or your covered dependents enroll in SilverScript, each member will receive one prescription drug card issued in their own name. Covered family members who are not enrolled in the Medicare drug program will receive cards showing they are enrolled in the State Health Plan prescription drug program. Two cards are issued in the subscriber's name.

If your card is lost, stolen or damaged, you can request a new card from these vendors:

- State Health Plan: BlueCross BlueShield of South Carolina;
- State Health Plan prescription drug program: Caremark;
- TRICARE Supplement Plan: Selman & Company;
- Dental Plus: BlueCross BlueShield of South Carolina;
- State Vision Plan: EyeMed.

Contact information is available at the end of this guide. There is no ID card for Basic Dental.

Other insurance programs PEBA offers

Life insurance

If you go directly from covered employment to retirement and are eligible for retiree group insurance when you retire, you can choose to continue or convert your life insurance through MetLife, the vendor that underwrites PEBA's life insurance program. PEBA sends a bi-weekly file with employee status changes to MetLife. MetLife uses this file to mail an enrollment and conversion/continuation packet to eligible retirees. Packets are sent by U.S. Mail three to five business days after MetLife receives the file. The continuation and conversion application period is time-sensitive. If MetLife does not receive the appropriate form(s) within 31 days of the date your coverage as an active employee ends, you will forfeit your right for retiree group life insurance. If you need help completing these forms, contact your benefits administrator or PEBA. If you have questions about life insurance coverage issues, such as billing or claims, call MetLife at 866.365.2374.

Retiree life insurance coverage does not include Accidental Death and Dismemberment benefits.

If you retired before January 1, 1999, and you continued your coverage, your coverage will end after 11:59 p.m. on December 31 after the date you turn 70.

Basic Life insurance

This term life insurance, offered at no charge to you as an active employee, ends with retirement or when you leave your job for another reason. You can convert your Basic Life Insurance to an individual whole life policy, which is a permanent form of life insurance.

Optional Life insurance

You can continue or convert your Optional Life insurance through MetLife.

You can continue your term life insurance or convert your life insurance coverage to a whole life policy, a permanent form of life insurance, within 31 days of the date your coverage ends. Your coverage can be continued in \$10,000 increments up to the final amount of coverage in force on the day before you left covered employment and lost active employee coverage.

Dependent Life insurance

Any Dependent Life insurance coverage you have ends when you leave active employment. However, you can convert the coverage for your spouse or child to an individual whole life policy within 31 days of the date your coverage ends.

Continuation

As a retiree, you can continue your Optional Life coverage at the same rates you paid while you were an employee. The minimum amount that can be continued is \$10,000. You cannot increase your coverage, but you can decrease it. Rates are based on your age and will increase when your age category changes. Your coverage will reduce to 65% at age 70 and then end after 11:59 p.m. on December 31 after the date you turn age 75 if you continued coverage and retired on or after January 1, 1999. When your coverage either reduces or ends, you can convert the amount of reduced or lost coverage within 31 days, as described in the Conversion section below. Continued coverage is term life insurance.

To continue your coverage, complete the information you receive from MetLife following your retirement. Submit it to MetLife at the address or fax number provided. MetLife must receive your completed forms within 31 days of your

loss of coverage.

Term life insurance provides coverage for a specific time period. It has no cash value.

Conversion

Within 31 days of loss of coverage, you can convert your Basic Life, Optional Life or Dependent Life coverage to an individual whole life policy.

MetLife has contracted with Barnum Financial Group to help with converting coverage. To convert your Basic Life, Optional Life or Dependent Life to an individual whole life policy, call MetLife at 877.275.6387 to connect with a financial professional from Barnum Financial Group.

The policy will be issued without medical evidence if you apply for and pay the premium within 31 days. If you miss the deadline, you will forfeit your right to convert your life insurance.

If you are not eligible for retiree insurance benefits or have been approved for long term disability benefits, you have 31 days from the date your coverage ends to convert your policy. See your benefits administrator for more information.

Continuation and conversion

You can also split your coverage between term life insurance (continuation) and individual whole life insurance (conversion), but you cannot exceed your total coverage amount before retirement.

Long term disability

Disability insurance protects an employee and their family from loss of income due to an injury or an extended illness that prevents the employee from working. When you leave active employment and retire, your Basic Long Term Disability and Supplemental Long Term Disability insurance both end. You cannot continue either policy, and you cannot convert either policy to individual coverage at retirement.

MoneyPlus

MoneyPlus is not available in retirement. When you retire, however, you might be able to continue your Medical Spending Account or Limited-use Medical Spending Account on an after-tax basis through COBRA. See Page 132 for more information. If you want to continue your account,

contact your benefits administrator within 31 days of your last day at work and fill out the appropriate forms.

If you do not want to continue your MSA or Limited-use MSA, you have until March 31 of the following year or until you exhaust your account, whichever is sooner, to submit eligible MSA expenses incurred before you left employment. Any funds still in your account will not be returned to you.

You cannot continue contributing to your Dependent Care Spending Account after you retire. You can, however, continue to incur expenses through March 15 of the following year, and request reimbursement for eligible expenses until March 31 of the following year, or until you exhaust your account, whichever is sooner.

The Pretax Group Insurance Premium feature, which allows you to pay health, dental, vision and some life insurance premiums before taxes, is not available in retirement.

Changing coverage

An open enrollment period is held every October. Eligible employees, retirees, survivors and COBRA subscribers can enroll in or drop their own health coverage and add or drop their eligible spouse and children without regard to special eligibility situations. Eligible subscribers also can change health plans. This includes changing to or from the Medicare Supplemental Plan if the subscriber is retired and the subscriber or dependents are eligible for Medicare. Eligible members of the military community can change to or from the TRICARE Supplement Plan if they are not eligible for Medicare. Eligible subscribers also can enroll in or drop the State Vision Plan. During open enrollment periods held in odd-numbered years, eligible subscribers can add or drop Dental Plus and Basic Dental.

PEBA mails an open enrollment publication, the *Benefits Advantage*, to retirees, survivors, COBRA subscribers and former spouses.

More information about open enrollment is found on Page 18 in the **General information** chapter.

Dropping a covered spouse or child

If a covered spouse or child becomes ineligible, you need to drop them from your health, dental and vision coverage.

This can occur because of divorce or when a covered dependent gains coverage under the State Health Plan. To drop a spouse or child from your coverage, complete and submit to PEBA a *Retiree Notice of Election* and provide documentation within 31 days of the date your spouse or child becomes ineligible.

When your child becomes ineligible for coverage because of age, PEBA will automatically drop them from coverage. If they are your last covered child, your level of coverage will change.

A *Certificate of Creditable Coverage* is available upon request. It lists the dates of your active coverage, names of covered individuals and types of coverage. Contact [PEBA Customer Service](#) to request one.

Returning to work in an insurance-eligible job

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 is one exception to this rule.

Retirees who are not eligible for Medicare and who retired from an employer that does not participate in the state's Retiree Health Insurance Trust Fund can remain on retiree coverage if they return to work in an insurance-eligible position. Contact your previous employer if you are unsure whether it participates in the Retiree Health Insurance Trust Fund.

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. If you leave work and return to retiree group coverage before age 65, be sure to contact the Social Security Administration within 90 days of turning 65 to enroll in Medicare Part A and Part B when you become eligible.

All employees who are eligible for enrollment in the State Health Plan (the Standard Plan and Savings Plan) are also eligible for these programs:

- Dental Plus and Basic Dental;
- State Vision Plan;
- Basic, Optional and Dependent Life insurance (with the exception of part-time teachers eligible for the State Health Plan, according to S.C. Code § 59-25-45);
- Basic and Supplemental Long Term Disability insurance (with the exception of part-time teachers eligible for the State Health Plan, according to S.C. Code § 59-25-45);
- MoneyPlus, including the Pretax Group Insurance Premium feature, Medical Spending Account, Dependent Care Spending Account and Limited-use Medical Spending Account; and,
- Health Savings Account for employees enrolled in the Savings Plan and not covered by any other health plan that is not a high-deductible health plan, including Medicare.

Retirees who continued life insurance

Retirees hired in an insurance-eligible job

If you continued your Optional Life coverage as a retiree, you will have the option to keep your continued policy and pay premiums directly to MetLife, or to enroll in Optional Life as a newly hired active employee with a limit of three times your annual salary without medical evidence, up to a maximum of \$500,000. You cannot do both.

Contact MetLife within 31 days of returning to work to cancel your continued coverage if you decide to enroll in active coverage. If you refuse to enroll as an active employee, you also refuse the \$3,000 Basic Life benefit, Optional Life and Dependent Life coverage. Your active group coverage will become effective only if you discontinue the retiree continuation coverage.

If you keep your continued life insurance policy when you returned to work, your retiree policy will not be affected by leaving employment a second time.

If you enrolled as an active employee when you returned to work, you will have the option to continue or convert your life insurance within 31 days of leaving employment a second time.

If you are considered a new hire, see the **Life insurance** chapter, which begins on Page 93.

If you or a member of your family is covered by Medicare

According to federal law, Medicare cannot be the primary insurance for you or any of your covered family members while you are enrolled in coverage as an active employee. To comply with this regulation, you are required to suspend your retiree group coverage and enroll as an active employee with Medicare as the secondary payer, or you should refuse PEBA-sponsored coverage for yourself and your eligible family members and have Medicare coverage only.

If you enroll in active group coverage, you must notify the Social Security Administration, because Medicare will pay after or secondary to your active group coverage. You can remain enrolled in Medicare Part B and continue paying the premium, and Medicare will be the secondary payer. You can also delay or drop Medicare Part B without a penalty while you have active group coverage. Contact the Social Security Administration for additional information.

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. You must also notify the Social Security Administration that you are no longer covered under an active group so you can reenroll in Medicare Part B if you dropped it earlier.

If your new position does not make you eligible for benefits, your retiree group coverage continues and Medicare remains the primary payer.

When your retiree insurance coverage ends

Your coverage will end:

- If you do not pay the required minimum premium for all enrolled coverages when it is due.
- The date it ends for all employees and retirees.
- The day after your death.
- The date your optional employer withdraws from participation.

Coverage of your family members will end:

- The date your coverage ends.
- The date coverage for spouses or children is no longer

offered.

- The last day of the month your spouse or child is no longer eligible for coverage. If your spouse or child's coverage ends, they might be eligible for continuation of coverage under Continuation of coverage (see Page 25).

If you are dropping a spouse or child from your coverage, you must complete a *Retiree Notice of Election* within 31 days of the date the spouse or child is no longer eligible for coverage.

Death of a retiree

If a retiree dies, a surviving family member should contact PEBA to report the death and end the retiree's insurance coverage. If the deceased retired from employment with a participating optional employer or charter school that participates in insurance only, contact the benefits administrator who works in the benefits office of their former employer. If a retiree continued or converted their life insurance, a surviving family member should also call MetLife at 800.638.6420 to initiate a claim.

Survivors of a retiree

Spouses or children who are covered as dependents under the State Health Plan, Basic Dental, Dental Plus or the State Vision Plan are classified as survivors when a covered employee or retiree dies. Survivors of funded retirees of a state agency, public higher education institution or public school district might be eligible for a one-year waiver of health insurance premiums. Survivors of a partially funded retiree will be responsible for 50% of the employer premium during the one-year waiver period. Survivors of non-funded retirees can continue their coverage; however, they must pay the full premium.

Participating optional employers are not required to but can waive the premiums of survivors of retirees. A survivor can continue coverage at the full rate for as long as they are eligible. If you are a retiree of a participating optional employer or charter school that participates in insurance only, check with your benefits administrator to see whether the waiver applies.

To continue coverage, a *Survivor Notice of Election* must be completed within 31 days of the subscriber's date of death. A new Benefits Identification Number will be created, and new ID cards will be issued by vendors for the programs in

which the survivors are enrolled.

After the first year, a survivor who qualifies for the waiver must pay the full premium to continue coverage. At the end of the waiver, health coverage can be canceled or continued for all covered family members. If coverage is continued, no covered family members can be dropped until an annual open enrollment period or within 31 days of a special eligibility situation.

If you and your spouse are both covered as subscribers through employment, or you are funded retirees at the time of death, your surviving spouse is not eligible for the premium waiver.

Vision premiums are not waived. Dental premiums are not typically waived; dental premiums are waived only for survivors of an active or retired employee who was killed in the line of duty after December 31, 2001, while working for a state agency, higher education institution or public school district. However, survivors, including survivors of a subscriber enrolled in the TRICARE Supplement Plan, dental or vision coverage, can continue coverage by paying the full premium.

As a surviving spouse, you can continue coverage until you remarry. If you are a child, you can continue coverage until you are no longer eligible. If you are no longer eligible for coverage as a survivor, you might be eligible to continue coverage under COBRA. If your spouse retired from a state agency, public higher education institution, public school district or charter school that participates in both insurance and retirement, contact PEBA for more information. If your spouse retired from an optional employer or a charter school that participates in insurance only, contact the benefits administrator at their former employer.

A surviving spouse or child of a military retiree should contact Selman & Company about TRICARE coverage.

As long as a survivor remains covered by health, dental or vision insurance, they can add health and vision coverage at open enrollment or within 31 days of a special eligibility situation. Dental coverage can be added or dropped, but only during an open enrollment period in an odd-numbered year or within 31 days of a special eligibility situation. **If a survivor has health, dental and vision coverage, and drops all three, they are no longer eligible for survivor coverage and cannot reenroll, not even during an**

annual open enrollment period.

If a surviving spouse becomes an active employee of a participating employer, they can switch to active coverage. When the surviving spouse leaves active employment, they can go back to survivor coverage within 31 days of the date their coverage ends if they have not remarried.

Until you become eligible for Medicare, your health insurance pays claims the same way it did when you were an active employee. For more information, see the Health insurance chapter and the chart on Page 32.



Helpful terms

Here are definitions for some terms used in the *Insurance Benefits Guide*. For more information, refer to the pages listed or contact your benefits administrator.

Allowed amount

The maximum amount the Plan allows for a covered service, procedure or supply. Network providers have agreed to accept the Plan's negotiated rates as their total fee.

Authorized representative

An individual with whom a health plan has permission to discuss a covered person's Protected Health Information. An authorized representative can be named by completing an *Authorized Representative Form*, which is available on PEBA's [Forms webpage](#).

Balance bill

The difference between what a health plan pays for a service and the provider's actual charge. State Health Plan network providers cannot balance bill members. See also out-of-network differential.

Benefits administrator

A staff member who works at your employer and assists with insurance enrollment, changes, retirement and terminations. Benefits administrators are not agents of PEBA, and their actions cannot bind PEBA.

Certificate of Creditable Coverage

A certificate that lists the dates of your active coverage, names of covered individuals and the types of coverage. A copy is available upon request.

Change in status

An event, such as marriage, divorce or birth of a child that might allow a change to a Medical Spending Account or a Dependent Care Spending Account. For more information, see Page 19.

Coinsurance

A percentage of the cost of healthcare a member pays after their deductible has been met. Under the State Health Plan, the coinsurance rate is different for network services, out-of-network services, infertility treatment and fertility drugs.

Coinsurance maximum

The amount of coinsurance a member is required to pay each year before they are no longer required to pay coinsurance.

Coordination of benefits

A system to determine how claims are handled when a person is covered under more than one insurance plan. For information about how health claims are coordinated, see Page 39. For information about how dental claims are coordinated, see Page 82.

Copayment

A fixed amount a subscriber must pay for a drug or service. Savings Plan members do not pay copayments. Standard Plan members pay prescription drug copayments and copayments for office visits, emergency care and outpatient facility services. For more information, see Page 36.

Coverage review

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

Deductible

Generally, the amount a member must pay yearly for covered healthcare before the Plan begins to pay a portion of the cost of their care. The deductible might not apply to all services.

Dependent

An eligible spouse or child covered by your health plan.

Drug quantity management

A type of coverage review the State Health Plan uses to make sure prescriptions are filled at levels the U.S. Food and Drug Administration considers safe.

Explanation of Benefits

A report created when your insurance plan processes a claim. An EOB shows you:

- How much your provider charged for services.
- How much the Plan paid.
- The amount you will be responsible for, such as your copayment, deductible and coinsurance.
- The total amount you might owe the provider (does not include any amount you've already paid).

Exclusion

A condition for which, or a circumstance under which, an insurance plan will not pay benefits.

Formulary

A pharmacy benefits manager's network list of preferred drugs, including generics and brand-name drugs. The PBM's Pharmacy and Therapeutics Committee of physicians and pharmacists continually reviews and compares the medications on a pharmacy network's formulary. As a result, some safe and effective drugs become "preferred," and others might become "non-preferred." The formulary guides the copayment you pay for a prescription drug.

Individual whole life insurance

A permanent form of life insurance.

Itemized statement

An *Explanation of Benefits*, bill or receipt from a healthcare or dependent care provider that shows the provider name and address, name of person receiving the care, description of the service or supply, date the service was provided (regardless of when it was paid) and the dollar amount of the service/supply.

Member

A person covered by a health, dental or vision plan.

Negotiated rate

The maximum amount you might pay a network provider for a covered service. Network providers have agreed to accept the Plan's negotiated rates as their total fee. The negotiated rate is the same as the allowed amount.

Network

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

Optional employer

Any participating group other than a state agency, public higher education institution or public school district. Pursuant to Section 1-11-720 of the Code of Laws, optional participation in the state insurance benefits program is available to political subdivisions of the state of South Carolina, such as counties, municipalities and special purpose districts, as well as governmental agencies or instrumentalities of such political subdivisions.

Out-of-network differential

A State Health Plan member pays 40% coinsurance, rather than 20%, when they use a provider that is not in the network. For more information, see Page 42.

Outpatient facility services

Services provided in a hospital for patients who do not stay overnight, or services provided in a freestanding medical center.

Pay-the-difference policy

If a member buys a brand-name drug when a generic drug is available, they will be charged the generic copayment plus the difference between the allowed amounts for the generic drug and the brand-name drug. Only the copayment for the generic drug will apply toward their prescription drug copayment maximum. For more information and charts illustrating the policy, see Page 71.

The pay-the-difference policy does not apply to SilverScript, the State Health Plan's Medicare Part D program.

Plan of Benefits

A document establishing eligibility requirements and benefits offered to individuals covered by the State Health Plan.

Prior authorization

To require prior authorization is to require that a member get permission from the Plan before they receive a particular service, supply or piece of equipment. For example, Medi-Call preauthorizes some services for State Health Plan members. The term prior authorization is also used by the State Health Plan pharmacy benefits program and certain specialty medications covered by the medical benefits program. In these instances, a prior authorization is a type of coverage review that might be needed when a medication is prescribed for which there is an effective and safe, lower-cost alternative

Premium

The amount a covered person pays for insurance coverage.

Qualifying event

A change in a person's life, such as a reduction in working hours, job loss or loss of eligibility for insurance coverage, that makes them or their dependents eligible to enroll in continued coverage provided under COBRA.

Special eligibility situation

An event that allows an eligible employee, retiree, survivor or COBRA subscriber to enroll in or drop coverage for themselves and for eligible family members outside an open enrollment period. The coverage change must be made within 31 days of the event.

Specialty medication

Typically defined as prescription drugs used to treat complex, chronic and rare conditions. They might also require special handling and administration.

Step therapy

A type of coverage review the State Health Plan uses to encourage use of low-cost prescription drugs of equal effectiveness and safety before trying more expensive alternatives.

Subrogation

A claim is subrogated when someone else is responsible for a member's injury. To the extent provided by South Carolina law, health Plans offered through PEBA have the right to recover payment in full for benefits provided to a covered person under the terms of the Plan when the injury or illness occurs through the act or omission of another person, firm, corporation or organization. If a covered person receives payment for such medical expenses from another who caused the injury or illness, the covered person agrees to reimburse the Plan in full for any medical expenses paid by the Plan.

Subscriber

An individual, such as an employee or a retiree, who is covered by an insurance plan. Because the individual is eligible and covered, members of their family might also be eligible to enroll in the plan.

Term life insurance

Life insurance coverage that is provided for a specific period of time. It has no cash value. All life insurance offered through PEBA is term life.

Third-party claims processor (claims processor)

A company, such as BlueCross BlueShield of South Carolina, that is under contract to PEBA to process claims for members.

Vendor

A company under contract to PEBA.



Contact information

S.C. PEBA

202 Arbor Lake Drive | Columbia, SC 29223

8:30 a.m.-5 p.m., Monday - Friday

- Customer Service: 803.737.6800 or 888.260.9430
- Retiree billing: 803.734.1696
- peba.sc.gov

2027 Insurance vendors

BlueCross BlueShield of South Carolina

State Health Plan Standard Plan, Savings Plan, Medicare Supplemental Plan

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

- Customer Service: 803.736.1576 or 800.868.2520
- Behavioral health services and population health management: 877.505.7390
- BlueCard Program: 800.810.BLUE
- 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 100185, AX-315 | Columbia, SC 29202

- Customer Service: 803.736.1576 or 800.868.2520
- Precertification: 800.868.1032
- Case management/behavioral health coaching: 800.868.1032, ext. 25835
- Nicotine cessation: 866.784.8454
- www.CompanionBenefitAlternatives.com

Health coaching

- 855.838.5897
- Fax: 803.264.4204

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

Selman & Company

TRICARE Supplement Plan

Attn: Claims Department

P.O. Box 21611 | Eagan, MN 55121

- Claims submission fax: 800.310.5514
- Customer Service and enrollment: 800.638.2610, Option 1
- info.selmanco.com/peba

Caremark

State Health Plan Prescription Drug Program, SilverScript Employer PDP

- Caremark Claims
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 No.: 9925991)

- Claims:
EyeMed
Vision Care OON Claims
P.O. Box 8504
Mason, OH 45040-7111
- Customer Care Center: 877.735.9314
- www.member.eyemedvisioncare.com/peba/en-us

MetLife

Basic Life, Optional Life, Dependent Life (Policy No.: 200879-1-G)

MetLife Recordkeeping and Enrollment Services
P.O. Box 14401 | Lexington, KY 40512-4401

- Statement of Health: 800.638.6420, Option 1
- Claims: 800.638.6420, Option 2
- Continuation for retirees: 888.507.3767
- Conversion: 877.275.6387
- Conversion fax: 866.545.7517
- www.metlife.com/scpeba

Standard Insurance Company

Long Term Disability (Group No.: 621144)

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

- Customer Service: 800.628.9696
- Fax: 800.437.0961
- Medical evidence: 800.843.7979
- www.standard.com/my-benefits/scpeba

ASIFlex

MoneyPlus

P.O. Box 6044 | Columbia, MO 65205-6044

- Customer Service:
833.SCM.PLUS (833.726.7587)
asi@asiflex.com
- www.asiflex.com/SCMoneyPlus

HSA Central

Health Savings Accounts

- Consumer Services: 833.571.0503
- schsa.centralbank.net

Other helpful contacts

Medicare

- 800.633.4227
- TTY: 877.486.2048
- www.medicare.gov

Social Security Administration

- 800.772.1213
- TTY: 800.325.0778
- www.socialsecurity.gov



MyBenefits

MyBenefits offers easy access to your PEBA-administered insurance benefits. Visit [MyBenefits](#) to create your account today and start managing your insurance information.

With MyBenefits, you can:

- 1 Access your insurance benefits coverage information.
- 2 Update your contact information.
- 3 Access your eight-digit Benefits Identification Number.
- 4 Review and update your life insurance beneficiaries.
- 5 Make changes to your coverage during the annual open enrollment period.
- 6 Initiate or approve coverage changes made as a result of certain special eligibility situations.



**Log in to MyBenefits
to get started.**

Need help registering?

We have resources to help. Visit our [Navigating Your Benefits webpage](#) to view the “Setting Up a New MyBenefits Account” video and access the *Setting Up a New MyBenefits Account* flyer.



South Carolina Public Employee Benefit Authority

Serving those who serve South Carolina

202 Arbor Lake Drive | Columbia, SC 29223

803.737.6800 | 888.260.9430

peba.sc.gov



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