



PEBASM
SC Retirement Systems
and State Health Plan

Benefits Administrator Manual

2025

Serving those who serve South Carolina

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General information

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This manual outlines the rules, regulations, policies and procedures of the S.C. Public Employee Benefit Authority (PEBA) and contains an abbreviated description of insurance benefits offered by or through PEBA.

When determining benefits, the [Plan of Benefits](#) supersedes all other publications and contains a complete description of the State Health Plan. Its terms and conditions govern all health benefits under the Plan. The [Plan of Benefits](#) is available online at peba.sc.gov/publications. There are also [plan documents available](#) for the dental plans and MoneyPlus. For other benefits, the respective contract with PEBA supersedes all other publications.

The [Optional Employer Handbook](#) and [Charter School Handbook](#) detail the *Requirements for Participation* for employers that elect to join the state insurance benefits program.

The [Insurance Benefits Guide](#) provides details about the various insurance programs offered by PEBA and is available on PEBA's website. The [Insurance Summary](#) provides a high-level overview of insurance benefits offered by PEBA.

Participating employers must offer eligible individuals (active employees, retirees, COBRA participants, survivors and former spouses) the entire package of state insurance benefits for which they are eligible. They must also allow individuals to refuse all or part of the benefits package. These benefits include:

- Health insurance benefits (State Health Plan and the GEA TRICARE Supplement Plan);
- Health and wellness programs;
- Dental insurance (Dental Plus and Basic Dental);
- State Vision Plan;
- Life insurance (Basic, Optional Life and Dependent Life);
- Long term disability (Basic and Supplemental);
- MoneyPlus (all plans, as eligible); and

- Health Savings Accounts.

During open enrollment, which is October 1-31, participating employers are responsible for reviewing their insurance benefit offerings. Any individual contributing to a benefit also available through the state insurance benefits program or in direct competition with a state insurance benefit must stop contributing and can elect the state insurance benefit during open enrollment for a January 1 effective date.

Employers cannot incentivize an eligible individual to refuse all or any part of the benefits package. Participating employers cannot offer their insurance-eligible individuals an insurance benefit also available through the state insurance benefits program or in direct competition with a state insurance benefit. Employers may offer benefits not available through the state insurance benefits program; however, premiums for those benefits cannot be deducted pretax through the state's flexible benefits plan, MoneyPlus.

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

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

How to use this manual

The manual is divided into sections that address Employee Benefits Services (EBS), types of subscribers you assist and insurance billing. A table of contents is included to make it easier to locate

the information you need, and each section of the manual also includes a contents page.

EBS

EBS, ebs.eip.sc.gov, is a secure website that gives you instant, online access to insurance benefits information, reporting data and billing reports. Through EBS, you can perform several functions:

- View subscriber account and benefits information;
- Enroll new employees and make coverage changes; and
- Access billing statements and make online payments.

EBS access is required for participating employers. See the **Using the online system** chapter for information on how to sign up and use the features of EBS.

Contact PEBA

Throughout the manual, you will be referred to PEBA for assistance.

Customer Service

Contact the dedicated staff of the Employer Support Center in PEBA Customer Service at peba.sc.gov/contact-employer.

Address

202 Arbor Lake Drive
Columbia, SC 29223

Website

peba.sc.gov

Email

Select Contact Us from the EBS homepage.

When you contact PEBA on behalf of a subscriber

Be sure the subscriber has already attempted to resolve the issue by contacting the third-party claims processor, plan administrator or PEBA. There

are excellent online resources available to subscribers, and you should encourage subscribers to use them. If you do need to call PEBA:

- Provide your group number, the subscriber's name and the subscriber's BIN.
- Remember HIPAA guidelines. PEBA cannot release personal health information to you, except enrollment and premium information, unless the subscriber has signed an [Authorized Representative Form](#) and filed it with PEBA, thereby giving you access to their personal health information.

Requests for proof of insurance

Individuals often need proof of health insurance when they travel overseas, particularly if they are students or will be employed in another country. PEBA can provide these letters; however, it might take up to 10 business days to process the requests. Encourage subscribers to request proof of insurance as soon as they know they need it.

Forms on the web

The forms mentioned in this manual are available at peba.sc.gov/forms. You can view insurance forms by name or category.

PEBA Update e-newsletter

PEBA publishes an e-newsletter, *PEBA Update*, for employers to receive essential updates. The distribution list comes from contact information provided in EBS under Contacts. The authorizing agent must update the information. If you are not the authorizing agent, ask your EBS authorizing agent to add your contact information in EBS so you can receive the e-newsletter and other employer emails.

Training and resources

Employer Services is committed to supporting employers. An insurance benefits support menu is online at peba.sc.gov/employers. For training needs and to share your feedback, contact Employer Services at EmployerServices@peba.sc.gov.

Training presentations explain the benefit plans and procedures, and they are designed to help benefits administrators understand how to process PEBA insurance benefits and better inform employees about their insurance coverage and benefits. Benefits administrators and personnel/payroll staff are encouraged to view the presentations and recorded trainings at peba.sc.gov/insurance-training.

- *Insurance Benefits Training*, which is an overview of all benefits;
- *COBRA*;
- *MoneyPlus and Health Savings Accounts*; and
- *Retirement, Disability and Death*.

Additional resources, including an option to [request](#) individual training and assistance, are also available on the [insurance training webpage](#). We encourage employers to attend and participate in supplementary online training sessions held monthly and announced in *PEBA Update*.

Benefits administrators and employer personnel/payroll staff are encouraged to participate in online employer advisory group meetings hosted by Employer Services. You will learn about recent employer updates and can provide feedback to PEBA. Meetings are announced in *PEBA Update*.

Part of the role of the benefits administrator is to inform employees of their benefits. Take advantage

of the publications PEBA produces, which are all on the PEBA website at peba.sc.gov/publications. Additionally, PEBA's *Navigating Your Benefits* webpage, peba.sc.gov/nyb, includes helpful flyers and videos for employees.

Benefits administrators also have access to the PEBA Health Hub at www.PEBAHealthHub.com. Turnkey marketing toolkits for a variety of topics are available for download.

Employer contacts

PEBA depends on the employer contact information in EBS to send electronic correspondence without interruption to employers. It's good practice for EBS users to review their employer contacts on file with PEBA periodically, including email addresses. In EBS, select Contacts.

The EBS authorizing agent must update the information. If you are not the authorizing agent, ask your EBS authorizing agent to review and update the information.

PEBA:Connect

PEBA is developing a new benefits administration system called PEBA:Connect. Our goal is to configure a user-friendly and valuable system for employers, members and our agency. When we deploy the system, participating employers will experience significant changes in administering PEBA benefits. Learn more at peba.sc.gov/peba-connect.



Using the online system

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Terms

MyBenefits

[MyBenefits](#) is a secure website that allows active subscribers, retirees, survivors, COBRA subscribers and former spouses to access their own enrollment information in PEBA insurance benefits' enrollment database. Through MyBenefits, subscribers can view their enrollment information and make some enrollment changes to their coverage, as well as approve changes you make in EBS and submit to them. Most transactions are paperless, and employees can upload supporting documentation. See Page 31 for more details about MyBenefits.

Summary of Enrollment (SOE)

This document is generated when a new enrollment is completed online.

Summary of Change (SOC)

This document is generated when an enrollment change is completed online.

Summary of Intent (SOI)

This document is generated when an open enrollment change is completed online through MyBenefits. The SOI is a summary of the subscriber's intended changes but does not necessarily display their final choices, because they can make multiple changes online throughout October. At midnight on November 1, PEBA accepts the last change the subscriber submitted.

Summary of Termination

This document is generated when a termination is completed online.

Notice of Election (NOE)

Some transactions cannot be completed online and require a *Notice of Election* (NOE) form. Find the NOEs at [peba.sc.gov/forms](#).

Active Termination Form

Some terminations cannot be completed online and require an *Active Termination Form*. Find the form at [peba.sc.gov/forms](#).

Comptroller General (CG) agencies

Some state agencies process payroll and remittances through the CG's office. For these agencies, some processes and EBS features are not applicable or differ from other employer types.

Employee Benefits Services (EBS)

Access to [EBS](#) is required for authorized users to administer PEBA insurance benefits. EBS offers multiple features, and access must be determined and approved by the employer's designated authorizing agent.

Signing up

To access EBS, you need internet access with a compatible browser and Adobe Acrobat Reader software.

A compatible browser

PEBA web applications support the current and previous major releases of Internet Explorer, Chrome, Firefox and Safari running on the Windows or Mac OS operating system. Each time a new version of a browser is released, PEBA begins supporting that version and stops supporting the third-most recent version.

Adobe Acrobat Reader software

Many modern browsers include a built-in PDF viewer. PEBA supports the built-in PDF viewers in Chrome, Firefox and Safari, and it supports the latest version of Adobe Acrobat Reader.

EBS access forms

You must request access to gain a valid user ID and password. The user ID is assigned by PEBA and is a vital part of protecting confidential information. It also is used to track who is using the system, how

often and the exact functions used by the individual.

- [EBS Confidentiality Agreement](#) – Required one per employer prior to users accessing EBS.
- [EBS Authorizing Agent Designation Form](#) – Each employer must designate an authorized person (authorizing agent) to control EBS access for designated employees and any third-party enrollers. The authorizing agent is also responsible for updating the employer’s contacts in EBS and maintaining the access of users on an annual basis.
- [EBS Designated Employee Confidentiality Agreement](#) – Required to issue a user ID and password for EBS access or to change the access of a current user. Review the provisions on this form carefully. Any violation may result in termination of EBS access. The authorizing agent must approve and sign this form. Select the appropriate systems to access.

If your employer uses a third-party enroller (TPE), complete these additional forms:

- [Memo of Understanding \(for Third-Party Enrollers\)](#); and
- [TPE Designated Employee Confidentiality Agreement](#).

The EBS access forms are available at peba.sc.gov/forms by category, under Employer. Return completed forms via mail only to PEBA, Attn: Insurance Operations at 202 Arbor Lake Drive, Columbia, SC 29223.

PEBA mails EBS credentials via USPS. A confidential user ID is mailed first. A confidential password will follow in a separate mailing.

If you fail to enter your password correctly, you could be locked out of EBS. Use the Forgot Password/Unlock Account link to reset your password or unlock your account.

Annual recertification process

An annual recertification process requires the authorizing agent to complete an annual review and approval of EBS users and access. Failure to recertify will result in the loss of EBS access. To assist the Authorizing Agent, the EBS950 accounting report is available. See the **EBS reports** chapter for information on this report.

Duo Security

For additional security, PEBA uses Duo Security for two-factor authentication to access EBS. New users are required to enroll in Duo upon your initial login to EBS. [Learn more about Duo Security](#).

EBS homepage

The buttons on the left side of the homepage are accessible to you based on your *Confidentiality Agreement*. If your user ID does not allow access to a function, the button for that function will be grayed out.

Manage Subscribers

View and manage subscriber coverage and more.

Manage Groups

View enrollment reports and billing statements, manage contact information, remit online payments and more.

BA Console

The tool in the middle section of the EBS homepage that allows you to manage your subscribers’ coverage. See Page 28 for more information about the BA Console.

Manage Subscribers

Inquiry

View detailed information about a subscriber within your group(s). Search by SSN, BIN or last name. You can also search Subscriber Summary of Change (SOC) documents by SSN.

Under Suspense Inquiry, view transactions that are in suspense. Select the transaction to learn more about the status and if additional information is required by PEBA. Use this feature to stay aware of transactions that might need immediate attention, such as errors and incomplete transactions.

Manage

Enroll new subscribers, make changes to current subscribers, terminate coverage for a subscriber, submit a Request for Review (RFR) or reinstate coverage for a subscriber.

Enroll

Enroll a new employee or an employee who is transferring from another employer. Select how to complete the enrollment, either by the employee in MyBenefits or through EBS.

See the Enrollment File Upload section for information on initiating multiple online enrollments in one transaction.

If you select MyBenefits Enrollment, complete the required information on the Enrollee Data tab, including a valid email address, salary and date of hire. Select Apply.

EBS will create a transaction in *Pending Subscriber Enrollment* status on the Suspended tab. The transaction will also show under Suspense Inquiry in an N status.

Employees will receive an email with a link to complete their enrollment elections. Provide the [Insurance Enrollment Guide for New Hires](#) flyer. The Suspended tab transaction includes a *Resend Email Link* option, if needed.

Once the employee submits their enrollment, the transaction moves to the Approval tab in a Pending Employer Approval status. If the employee enrolled in a MoneyPlus flexible spending account or Health Savings Account, select the number of annual pay periods from the drop-down list. View and confirm any supporting documents. If necessary, upload any supporting documents for the employee. Retain a

copy of the SOE and any supporting documents for the employee's file. Approve the transaction.

The weekly *MyBenefits New Hires* report (HAC475) summarizes the MyBenefits enrollment new hire elections. The report includes an indicator if a new hire does not make their online elections within 31 days of hire. In this case, the employee defaults to no insurance coverage.

If you select EBS Enrollment, tabs will appear for you to enter the required information. System edits prompt the required data and return error messages, where applicable.

Because you are entering the information and elections for the employee, retain written confirmation from the employee of their elections.

On the Dependents tab, if the subscriber is married, the spouse must be listed, regardless of whether the spouse is covered. To choose coverages, select Activate from the drop-down list or leave the status blank if you are not adding the dependent to benefits. The Medicare coverage question defaults to No. If applicable, change to Yes and complete the required information. Upload a copy of the Medicare card prior to approving the enrollment.

On the Coverage tab, Tobacco-use defaults to Tobacco Coverage if you elect the Standard or Savings Plan. Change to Refused if the subscriber and dependents do not use tobacco or e-cigarettes.

To elect Optional Life, select the coverage level from the drop-down list. If the employee wants a higher level of coverage, the employee must complete and submit an online MetLife *Statement of Health* and a paper *Notice of Election* form. Employers will submit a *Life Insurance Statement of Health Request* in EBS by selecting the Life Ins SOH button on the homepage. This will initiate the process, and then MetLife will email employees a link to an online *Statement of Health* within 10 days. Employees must register on MetLife's portal, which is also called MyBenefits. View detailed instructions on the [Electronic life insurance Statement of Health process training resource](#).

Dependent Life-Spouse will populate automatically, based on whether a spouse was entered on the Dependents tab. Select a coverage level of either \$10,000 or \$20,000. If the employee wants a higher level of coverage, they must complete and submit an online MetLife *Statement of Health* and a paper *Notice of Election* form. This field will not appear if there is no eligible spouse. Employers will submit a *Life Insurance Statement of Health Request* in EBS by selecting the Life Ins SOH button on the homepage. This will initiate the process, and then MetLife will email employees a link to an online *Statement of Health* within 10 days. Employees must register on MetLife's portal, which is also called MyBenefits. View detailed instructions on the [Electronic life insurance Statement of Health process training resource](#).

If electing SLTD, select the coverage type from the drop-down list. The system will pull the salary from the Enrollee Data tab.

The Pretax Group Insurance Premium feature field will default to Refused. If electing the Pretax feature, select Active.

MoneyPlus accounts and Health Savings Accounts are listed based on the health plan selected. If enrolling, enter the annual contribution amount for each account, then select the Total Annual Pay Periods from the drop-down list.

On the Beneficiaries tab, if the desired beneficiary is a spouse or child listed on the Dependents tab, select Add, next to Add from existing dependent list. Select the dependent(s) from the list and select Add Selected Dependents to Beneficiaries. The information and relationship of the dependent(s) will populate. Additional beneficiaries can be added by selecting the number from the drop-down list and selecting Add. Complete the required beneficiary information and designate the beneficiary elections.

The Review tab is a complete list of all information entered on the previous tabs. You can return to any tab by selecting the tab at the top of the page if changes or corrections are needed. Retain a copy of

the Summary of Enrollment (SOE) and note any required Supporting Documents.

You may Suspend, Cancel or Apply the transaction by selecting the applicable button (top right of page).

- **Suspend** will allow you to keep what has already been processed, and you may retrieve it later. It will be on the Suspended tab of the BA Console and will be listed as Incomplete. You will receive a SUSPEND message box to add the reason for suspending the transaction.
- **Cancel** will remove the entire transaction. Once you confirm to cancel, it cannot be recovered.
- **Apply** will submit the transaction to either:
 - MyBenefits; or
 - Current EBS.

Select MyBenefits for the employee to review, approve and upload any supporting documents. The transaction will appear on the BA Console under the Approval tab as Pending Subscriber Approval. The subscriber must log in to MyBenefits to review and complete the transaction.

If no documentation is required, the transaction will move from the Approval tab to the Acknowledgement tab on the BA Console. PEBA records will be updated. Once you acknowledge the transaction, a copy of the SOE is available. Do not mail any documents to PEBA.

If the subscriber uploaded the required documentation, review the transaction and documents on the Approval tab. If needed, upload additional documentation. Approve the transaction. Do not mail any documents to PEBA.

If the subscriber did not upload the required documentation, remind them to provide the required documentation promptly; otherwise, the transaction cannot be completed. The transaction will remain on the Approval tab with a Yes for Supp. Docs and a status of Pending Employer Approval. When you receive the documentation, you can then

upload the documents. Approve the transaction. Do not mail any documents to PEBA.

If the subscriber returns the transaction due to an error or change, the transaction will remain on the Approval tab, but the status changes to Subscriber Returned. You can then edit and resubmit the transaction to return it to the subscriber for approval, or you can delete it, thereby canceling the transaction.

Select Current EBS to complete the transaction for the employee. From the Current EBS tab on the BA Console, select the transaction. To print the signature sheet, select Print Signature Sheet. The benefits administrator signature and date, as well as the subscriber's signature and date, are required on the signature page. If you need a copy of the SOE for your files or the subscriber, select Print SOE/SOC. Select Edit to make any necessary changes. Select Continue to review, upload documentation, including the signed signature sheet, and approve the transaction.

The transaction will be listed as Pending PEBA Approval on the Current EBS tab. PEBA applies the transaction once the signed signature sheet, along with any required documentation, is received. The transaction will no longer appear on the Current EBS tab.

If you choose to mail the signed signature sheet (with barcode page) and required supporting documentation to PEBA, allow additional time for processing. Place the barcode page and signed signature sheet on top and staple any required supporting documentation.

Do not delay in sending the signed signature sheet. The subscriber's file is locked until the signed signature sheet is received, processed, and PEBA applies the transaction.

Change

Changes for most family status changes can be completed in EBS. Some elections are not allowed, based on the selected reason(s) for change. Certain fields and tabs will automatically populate or might

be hidden or grayed out depending on the change reason.

Effective dates are calculated automatically based on the information entered on the *Define Your Change* screen. A summary of the changes can be viewed on the Review tab and on the Summary of Change (SOC). Required documentation is based on the change reason and/or the spouse or child(ren)'s eligibility status and can be uploaded through MyBenefits or EBS.

Select the Reason for Change from the drop-down list. You might be prompted to select a sub-reason from the drop-down list. If the change is due to a special eligibility situation, a new field, Date of Request, might appear. The Date of Request field is prefilled with the current date. Adjust this date only if necessary. You will be prompted to make elections on each tab as allowed per the change reason.

Note the following:

- Address changes processed using the Current EBS method require both the subscriber and the benefits administrator signatures.
- Changes to the subscriber's SSN or date of birth must be made on a paper NOE with the supporting documentation included.
- Changing eligibility to Ineligible terminates all coverage for the child(ren).
- Marking the Deceased box terminates all coverage for the deceased spouse or child(ren).
- For dependent gain of other coverage (state or non-state), terminate only those benefits gained elsewhere with the Coverage Status drop-down list.
- For dependent loss of other coverage (state or non-state), add only those benefits lost elsewhere with the Coverage Status drop-down list. Loss of state benefits for a spouse will allow adding Dependent Life-Spouse coverage.

- Previously covered child(ren) may be chosen from the Reactivate Dependent List and their benefits activated.

Based on the change reason, information will be prefilled. Only fields with a white background can be edited.

Note the following change reasons:

- **Marriage, newborn, adoption, custody**
Optional Life benefits may be selected or increased, and a new coverage level may be chosen from the drop-down list, where the maximum amount available without medical evidence is displayed.
- **Elections or increases of Optional Life coverage levels with medical evidence**
An online *Statement of Health* must be completed. Employers will submit a *Life Insurance Statement of Health Request* in EBS by selecting the Life Ins SOH button on the homepage. This will initiate the process, and then MetLife will email employees a link to an online *Statement of Health* within 10 days. Employees must register on MetLife’s portal, which is also called MyBenefits. View detailed instructions on the [Electronic life insurance Statement of Health process training resource](#).

For those who participate in the Pretax Group Insurance Premium feature, action must be requested within 31 days of a family status change. Approvals from MetLife should be forwarded directly to PEBA with an NOE and supporting documentation.

For those who do not participate in the Pretax Group Insurance Premium feature, requests may be processed through EBS and forwarded to PEBA with the SOC, approval letter from MetLife and supporting documentation. These requests may be made throughout the year.

Complete the required beneficiary information and any changes, if applicable.

The Review tab is a complete list of all information entered on the previous tabs. You can return to any tab by selecting the tab at the top of the page if changes or corrections are needed. Retain a copy of the Summary of Change (SOC) and note any required Supporting Documents.

You may Suspend, Cancel or Apply the transaction by selecting the applicable button (top right of page).

- **Suspend** will allow you to keep what has already been processed, and you can retrieve it later. It will be on the Suspended tab of the BA Console and will be listed as Incomplete. You will receive a SUSPEND message box to add the reason for suspending the transaction.
- **Cancel** will remove the entire transaction. Once you confirm to cancel, it cannot be recovered.
- **Apply** will submit the transaction to either:
 - MyBenefits; or
 - Current EBS.

Select MyBenefits for the employee to review, approve and upload any supporting documents.

Select Current EBS to complete the transaction for the employee. The benefits administrator signature and date, as well as the subscriber’s signature and date, are required.

Terminate

Terminations are submitted directly to PEBA, and PEBA’s files are updated immediately for billing and transmission to the insurance carriers. Some types of terminations must be sent to PEBA on an *Active Termination Form*.

Select the Reason for Termination from the drop-down list. Enter the effective date and any additional information, if prompted to do so. Retain a copy of the Summary of Termination (SOT) for

your files. The termination form is transmitted to PEBA. Do not mail any documents to PEBA.

Request for Review

Complete a Request for Review (RFR) for new hires, newborns, marriage, divorce, adoption, gain or loss of health, dental and/or vision coverage not administered by PEBA, and gain or loss of PEBA-administered insurance benefits.

If there is a pending transaction for the subscriber, you will be alerted that the record has a pending suspense transaction. It will allow you to delete and rekey the transaction through the Request for Review process.

Select the change reason from the drop-down list. Enter the event date, requested effective date and reason for review. Your phone number is not required; however, PEBA encourages you to enter your phone number in case more information is needed.

The Summary of Change allows you to explain the reason for the change. Then, enter a detailed explanation of the circumstances in the Please Explain box.

You will be prompted to complete the process as you would a normal transaction. Once applied, the RFR transaction is on the RFR tab in Pending Employer Approval status. Select the transaction to save or print the signature sheet; retain a copy of the SOE/SOC for your files or the subscriber; save or print a copy of the Request for Review; and edit or delete the transaction. Select Continue to review, upload supporting documentation, including the signed Signature Sheet, and approve the transaction. Once approved, the status changes to Pending PEBA Approval.

If the RFR is approved, the transaction will apply with the requested effective date, and the transaction will no longer appear on your RFR tab.

If the RFR is rejected, an explanation of what needs to be done to correct the error will be shown on the suspended transaction.

If the RFR is denied, the status changes to PEBA Denied. The primary benefits administrator will receive an email notification. You can view the RFR Denial and denial reason and save or print prior to your acknowledgement. The employee will also receive an email notification. Provide the employee with a copy of the denial request. Remember to retain a copy of the denial for the employee's file.

View a RFR tutorial at peba.sc.gov/insurance-training.

Reinstate

The reinstate feature allows you to reinstate an employee's coverage to the effective date of the termination entered into EBS. No changes can be made to the coverage once it is reinstated. EBS will allow you to reinstate coverage to one-year prior. It is important to remember, any applicable premiums will be due.

Select the reinstatement reason. Once you have submitted the transaction, view the transaction in a Pending Employer Approval status on the Current EBS tab of the BA Console. Review and upload any supporting documentation. Retain a copy of the SOC/SOE. Approve the transaction to reinstate coverage.

Enrollment File Upload

Upload multiple enrollment records for batch processing. This feature is available only for enrollment transactions, not changes or terminations.

View the *File Upload Help* for more information, including file layout requirements for the Excel File Format and Comma Separated Value Format options. For further assistance with creating a file, download the Enrollment File Template. Choose your file and upload.

Any formatting or coverage (i.e., currently active with another employer) errors will be returned. Review the error message(s), and correct or remove the employee data from the file before uploading

the file again. Note that if errors exist, none of the data is uploaded to PEBA.

Once you submit the file, PEBA will validate it to ensure it meets all requirements and process the file. An enrollment file may be uploaded only once per day. Files submitted after 5:30 p.m. will be processed the next business day.

EBS will create a transaction in *Pending Subscriber Enrollment* status on the Suspended tab. The transaction will also show under Suspense Inquiry in an N status.

Employees will receive an email with a link to complete their enrollment elections. Provide the [Insurance Enrollment Guide for New Hires](#) flyer. The Suspended tab transaction includes a *Resend Email Link* option, if needed.

If the employee is unable to complete the enrollment online, you may convert the transaction to an *EBS Enrollment*. See [Page 20](#) for more information about completing the EBS Enrollment for the employee. You can also edit or delete the transaction, if necessary.

Once the employee submits their enrollment, the transaction moves to the Approval tab in a Pending Employer Approval status. If the employee enrolled in a MoneyPlus account, select the number of annual pay periods from the drop-down list. View and confirm any supporting documents. If necessary, upload any supporting documents for the employee. Retain a copy of the SOE and any supporting documents for the employee's file. Approve the transaction.

The weekly *MyBenefits New Hires* report (HAC475) summarizes the MyBenefits enrollment new hire elections. The report includes an indicator if a new hire does not make their online elections within 31 days of hire. In this case, the employee defaults to no insurance coverage.

Life Ins SOH

For new hires, complete the normal new hire enrollment process that allows a new hire to elect

their benefits online. Once a new hire's information is available in PEBA's system and the new hire is assigned to the employer's group, complete a *Statement of Health Request* in EBS for coverage that requires medical evidence by selecting the Life Ins SOH button.

After submitting a request, download or print a copy of the request for your records. Each Friday, employers can download Report HIS314NP, *Statement of Health Request Report*, which will list all requests submitted the previous week. Employers will be able to access up to four previous weeks of reports in EBS.

Each week, PEBA will send a file to MetLife that includes all requests received that week. MetLife will then email employees a link to an online *Statement of Health* within 10 days. Employees must register on MetLife's portal, which is also called MyBenefits. MetLife will send reminder emails to employees who have not completed the form at Day 7 and Day 14. If an employee does not submit the online form by Day 30, MetLife will mail a paper *Statement of Health* form to the employee.

Employers will continue to receive approval reports via email from MetLife and must submit the NOE with the report to PEBA once they receive approval.

You may also complete a *Statement of Health Request* in EBS for open enrollment elections that require medical evidence by selecting the Life Ins SOH button.

View detailed instructions on the [Electronic life insurance Statement of Health process training resource](#).

Manual transactions

Due to system limitations, there are some transactions that must be submitted on an NOE.

Enrollments/reenrollments

- Election changes if new hire changes their mind within 31 days, if the first enrollment has already been approved by the

employer. Enrolling new hire if employee is currently covered as a dependent on another subscriber's coverage.

- Enrolling retirees, survivors, COBRA subscribers and former spouses.
- Enrolling working retiree in active coverage.
- Enrolling an active subscriber on stipend.
- Open enrollment changes that might require two transactions, such as family status changes with effective dates in October, November or December.

Dependents

- Adding incapacitated children to coverage.
- Enrolling or keying a change for a subscriber with a National Medical Support Notice dependent.

Changes

- Social Security numbers.
- Dates of birth.
- For a subscriber who has a covered child turning age 26 prior to the change effective date.
- For a subscriber who has a covered child on Dependent Life-Child coverage turning age 25 prior to the change effective date.
- For a stipend subscriber.
- For a subscriber covering a child with a relationship code of "Temporary Custody Pending Adoption," whose end date is prior to change effective date.
- For a subscriber who already has an effective date on file that is after the new change effective date (newborn to be added in November after open enrollment has processed).

Terminations

- Due to nonpayment, military leave or those more than 31 days retroactive.
- Due to Supplemental Long Term Disability in a waiver of premium status.

Manage Groups

Enrollment reports

View reports with various enrollment information. The **EBS reports** chapter provides detailed information on formatting, frequency and samples.

Accounting reports

View reports with various accounting information, including billing statements. The **EBS reports** chapter provides detailed information on formatting, frequency and samples.

Balance

For Comptroller General (CG) agencies only.

The Accumulated Balance Report feature displays subscriber payment and balance information. Data is displayed sorted from the begin (earliest) date to the end (current) date. The Begin Date defaults to a date approximately 12 months prior to the current date. Modify the begin date if necessary. Required parameters include the employer number and SSN or BIN.

See the **EBS reports** chapter for more information about the Accumulator reports.

Contacts

The authorizing agent is required to review and update employer contact information periodically, including email addresses, in EBS. Ensuring correct email addresses are on file allows PEBA to send electronic correspondence without interruption. If needed, ask the authorizing agent for your employer to review and update the information on file for each contact.

A primary contact for the roles of benefits administrator, billing contact, executive contact and wellness contact must be assigned.

Additionally, use contacts to look up contact information for other employers. Use the Search feature to search by employer name and/or group ID.

SLTD Salary Entry

Not applicable to Comptroller General (CG) agencies.

All salaries must be reviewed and updated annually during open enrollment. You can begin entering the salaries in EBS on September 15, and the information is due to PEBA no later than October 31.

To update SLTD premiums correctly for the next plan year, PEBA needs updated salary information for your employees who are enrolled in SLTD. The salary on which SLTD premiums are based should include the employee's base rate of pay for the hours they are regularly scheduled to work, plus any of the following that apply to the employee:

- Longevity pay;
- Shift differential pay;
- Regular compensation earned by university teaching staff during regular summer sessions; and
- Contributions the employee makes to deferred compensation plans or fringe benefits (like payroll deductions for health insurance).

Do not include overtime pay, commissions, bonuses, employer contributions to benefits or any other extra compensation.

If you do not update the salary information, premiums and any benefits paid will be based on the most recent salary information submitted to PEBA.

Update salaries for any employee who has had a salary change since the previous October 1.

Example: If an employee was hired March 2024 with a salary of \$25,000, and they have received a salary increase of \$3,000, and their salary as of October 1 includes this increase, you must submit the updated salary of \$28,000 to PEBA in October 2024.

The maximum annual salary for calculating SLTD benefits and premiums is \$147,684. If PEBA receives any salary updates that exceed this amount, the updated salary will default to the maximum.

Employers who implement furloughs should use employees' non-furlough salaries to calculate premiums.

Use one of these methods to submit the updated salaries:

- Select SLTD Salary Browse to add employee salaries individually. Enter the data into each field and click on the button at the bottom of the screen to submit the information for each employee.
- Upload SLTD data text file.
- Download SLTD Coverage Data. This list includes all employees enrolled in SLTD at the time of your request. Follow the instructions to create a new text document, and then select Upload SLTD Data to upload your revised file to EBS.
- Select the Batch Entry Screen, which allows you to enter 10 employee salaries at a time.

Select Current SLTD Coverage List to receive a list of all employees currently enrolled in SLTD. Review and Confirm all SLTD salary entries when you've completed updates for your employer.

For more details, view the *Updating salary information for SLTD* resource at peba.sc.gov/insurance-training. If you have questions about submitting SLTD salary information, contact PEBA.

Online Bill Pay

Processing your payment online through EBS is easy and convenient. To use this feature, Online Bill Pay access in EBS is required. Complete a new *EBS Designated Employee Confidentiality Agreement* form, if necessary, to update access.

Log in to your EBS account and verify your email address in the lower right corner on the EBS homepage before submitting a payment. Select the

[Update My Email Address](#) link if changes are needed.

After you complete these steps, you will be able to schedule a payment; view the status of your account; view bill and payment history for the previous 12 months; and view billing statements for the previous 12 months. The minimum amount you can pay is your current balance.

BA Console

All enrollment transactions, whether initiated by you or your subscribers in MyBenefits, will appear on this console. The console consists of five tabs: Suspended, Acknowledgement, Approval, Current EBS and RFR (Request for Review). Each transaction displays a status.

You can change the number of transactions displayed (10, 25, 50 or 100).

Suspended tab

This tab includes transactions that are incomplete, including enrollments submitted with the Enrollment File Upload feature or transactions that you suspend. You can suspend a transaction for any number of reasons, including missing supporting documentation.

Enrollment transactions submitted for a MyBenefits Enrollment or through the Enrollment File Upload require action by the employee online. These are displayed on the Suspended tab as *Pending Subscriber Enrollment*. Employees have received an email from noreply@peba.sc.gov and should refer to the [Insurance Enrollment Guide for New Hires](#) flyer for instructions on enrolling.

Edit allows you to make changes or corrections to the subscriber's data. Review and apply any changes. The employee will receive a new email from noreply@peba.sc.gov.

EBS Enrollment allows you to convert an enrollment transaction that requires action by the employee online to an EBS transaction. As the

employer, you must complete the enrollment transaction on behalf of the employee.

Resend Email Link allows you to resend the enrollment email to the employee.

Delete removes the transaction. Deleting a transaction before it is applied by PEBA will cancel the transaction, and it will disappear from the Suspended tab.

Acknowledgement tab

This tab includes transactions initiated by subscribers using MyBenefits or initiated by you and sent to subscribers to approve online in MyBenefits. These transactions do not require supporting documentation.

Examples include:

- New hire enrollments that do not require documentation.
- Contact information (address, phone numbers, email address) changes; and
- Beneficiary changes.

When you acknowledge the transaction, a new window opens with the SOE/SOC for your review. Retain copies for your records. Do not mail any documents to PEBA.

Transactions more than 31 days old are highlighted in yellow. At 60 days, transactions are removed from the Acknowledgement tab automatically. However, these transactions were applied at the time the subscribers made them.

Acknowledging these transactions will remove them from the Acknowledgement tab. Notify any other applicable parties of address changes.

Approval tab

This tab includes transactions initiated by subscribers using MyBenefits or initiated by you and sent to subscribers to approve online in MyBenefits. The Status column shows what needs to be approved by you, the subscriber or PEBA. The Support Documents column shows if supporting

documents are required before approving the transaction.

You must review and approve or delete these transactions in time to allow your subscribers to make corrections or change their minds (either through MyBenefits or by completing a paper *Notice of Election*) before the end of the enrollment period, either 31 days from hire or October 31 (open enrollment). **These transactions are not applied by PEBA or sent to the third-party claims processors until after you approve them.** Retain copies for your records.

Records rejected by PEBA are highlighted in green and appear at the top of the list for your immediate attention.

Transactions more than 31 days old are highlighted in yellow. At 60 days, transactions are canceled automatically and deleted. The transaction is not applied.

Current EBS tab

This tab includes transactions initiated by you and require signatures. Select the transaction to print the Signature Sheet (with barcode page, which is required if mailing to PEBA). You can also save or print the SOE/SOC document for your records.

Select Edit to make any necessary changes. Select Continue to review, upload documentation, including the signed signature sheet, and approve the transaction. Retain copies for your records.

PEBA applies the transaction once the signed signature sheet, along with any required documentation, is received. The transaction will no longer appear on the Current EBS tab.

PEBA strongly encourages you to upload any required supporting documentation and the signed signature sheet rather than mailing it to PEBA. Transactions submitted via mail require additional time for processing.

RFR (Request for Review) tab

This tab includes Request for Review, or RFR, transactions submitted in EBS. Learn more about submitting an RFR on [Page 19](#) in the EBS Manage Subscribers section.

Monitor the tab for rejected or denied RFR transactions.

Status

Transaction statuses are explained below.

Pending Subscriber Enrollment

Transactions on the Suspended tab created by a MyBenefits Enrollment. Once the employee submits their enrollment, the transaction moves to the Approval tab in a Pending Employer Approval status.

You can resend the email link to the subscriber, and edit or delete the transaction, if necessary.

If the employee is unable to complete the enrollment online, you may irreversibly convert the transaction to an EBS Enrollment, and you must complete the enrollment transaction on behalf of the employee. Learn more about submitting an EBS Enrollment on [Page 19](#) in the EBS Manage Subscribers section.

Pending Subscriber Approval

These are transactions initiated by the employer and sent to the subscriber to approve in MyBenefits. You can review or delete the transaction but cannot make changes.

Notify the employee to log in to MyBenefits, review and approve the transaction and electronically sign.

No documentation required

Once approved by the subscriber, the transaction will move to the Acknowledgement Tab on the BA Console. PEBA's records are updated.

Documentation required

The subscriber can upload any required documentation in MyBenefits. Once approved by

the subscriber, the transaction status changes to Pending Employer Approval.

Pending Employer Approval

Select Continue to review and approve the transaction. Delete the transaction, if necessary. The enrollment/change is then canceled.

No documentation required

PEBA's records are updated once you approve the transaction.

Documentation required

Review any uploaded documentation by the subscriber, or if the subscriber provides you with the documentation, upload the documents. The transaction status changes to Pending PEBA Approval.

If the required documentation is not uploaded, a barcode page is generated. Print and send only this barcode page with the documentation attached. Do not include a copy of the SOE/SOC. Retain copies for your records.

Pending Employer Approval-Subscriber Changed

If a subscriber changes their mind about their initial open enrollment election(s), they can go into MyBenefits and edit and/or delete their changes until 11:59 p.m. on October 31.

If their employer has approved a previous transaction, this new status will appear on the Approval tab.

Pending PEBA Approval

These are transactions approved by the employer and for which supporting documentation is uploaded. You can review the transaction and documentation up until PEBA approves the transaction.

PEBA's records are updated once the supporting documentation is approved by PEBA. If the documentation submitted is incomplete or insufficient, PEBA will reject or remove the transaction.

Subscriber Returned

Documentation may or may not be required

These are transactions initiated by the employer and sent to the subscriber to approve in MyBenefits; however, the subscriber returned the transaction because of an error or change.

Select the transaction to view the subscriber's message for the correction(s) they are requesting.

Select Edit to send it back to the subscriber to review and approve in MyBenefits.

Select Review to view and print a copy of the SOE/SOC without making any changes to the document. After review, select Approve.

Your approval updates PEBA's records and sends a copy of the transaction to the appropriate third-party claims processors.

Delete the transaction, if necessary. The enrollment/change is then canceled.

PEBA Rejected

These are transactions PEBA has returned to the BA Console because the supporting documentation was incomplete or insufficient. They are highlighted in green at the top of the Approval tab.

View the rejection reason, and then obtain and upload the additional or corrected documentation. You might also need to upload a copy of the original SOE/SOC as verification of the date the subscriber initially tried to make the change. Approve the transaction. The transaction status changes back to Pending PEBA Approval.

If the required documentation is not uploaded, a barcode page is generated. Print and send this barcode page with the documentation attached.

Delete the transaction, if necessary. The enrollment/change is canceled.

PEBA Denied

These are RFR (Request for Review) transactions denied by PEBA. View the RFR Denial and denial reason, and retain a copy prior to your

acknowledgement. You must provide the employee a copy of the denial request to notify the employee of their right to an appeal. Remember to place a copy of the denial in the employee's file.

Incomplete

These are transactions on the Suspended tab that have been suspended by the employer. Incomplete transactions can be edited or deleted.

Additional statuses on Suspense Inquiry transactions include the following:

- **Advanced Keyed** - Transactions with future effective dates that are stored once keyed until PEBA runs the billing that coordinates with the date of the transaction.
- **Complete – awaiting processing** - Current EBS is pending employer approval.
- **Errored** - Transactions are marked as an error if they are rejected.
- **N** - A new enrollment has been initiated in EBS and is awaiting online elections from the employee.

Tips

If you need to retain a copy of an SOE/SOC but do not see it on your screen after you apply the transaction, check the bottom toolbar or behind other windows on your screen. Sometimes, the document will minimize. You can also use the SOC Search on the Inquiry option under Manage Subscribers.

Upload signed signature sheets as soon as possible. If the employee is not available to sign, have them complete and sign a paper NOE and upload it with the SOE/SOC.

Do not write additional instructions on an SOE/SOC. PEBA cannot key handwritten changes. Rekey the transaction in EBS.

Notify your payroll department of any changes that affect premiums.

Retain copies of any rejected transactions.

If an NOE is required because of a rejection, include a copy of the original SOE/SOC with the NOE. This verifies the original request was made within 31 days.

MyBenefits

MyBenefits allows subscribers to access their insurance information online and make some changes on their own. MyBenefits also allows subscribers to upload supporting documentation.

You can view subscriber changes made through MyBenefits on the BA Console.

When contact or beneficiary information is changed, you will receive a notice on the Acknowledgement tab.

During open enrollment, subscribers can make coverage changes for the next year. Depending on the type of change, you will receive a notice on the Approval tab.

Using MyBenefits

A step-by-step flyer on how to register for MyBenefits can be found at peba.sc.gov/nyb.

After logging in, the subscriber will see any transactions you submit for their approval, or they can choose to review their benefits, update their contact information, initiate changes as a result of a special eligibility situation, review and change their beneficiaries, and make changes during the open enrollment period.

When a subscriber initiates a change using MyBenefits, a Summary of Change (SOC) is generated, similar to what is generated in EBS. Changes and updates are in the New Value fields. To accept the change(s), they select Approve. Certification, authorization and disclaimer statements appear, which require an electronic signature. The subscriber enters the last four digits of their SSN to authorize and process the change. A final SOC is generated that the subscriber can save or print for their records.

In EBS, you can access SOEs and SOCs initiated in MyBenefits. Under Manage Subscribers, select Subscriber SOCs.

Making special eligibility changes

Subscribers can make changes using MyBenefits when a special eligibility situation occurs, such as adding a newborn, marriage, divorce or adoption. MyBenefits will display the documentation required for each change, which can be uploaded through MyBenefits. Some special eligibility situations must be initiated by the employer.

Making open enrollment changes

During open enrollment, subscribers can make changes in MyBenefits, as permitted during the open enrollment period.

Your Current Coverage

This details the subscriber's coverage and coverage levels.

Make Coverage Changes

The subscriber can enroll, change and cancel coverage for the programs allowed. Edits prevent the subscriber from enrolling in a program for which they, their spouse or their child(ren) is not eligible or from selecting a level of coverage above what is allowable.

Dependents

The subscriber can review their spouse and/or child(ren) and their coverage, add a spouse and/or

child(ren), or add or cancel coverage for their spouse and/or each child by program, as allowed.

Beneficiaries

Details the subscriber's current beneficiaries. They can add or delete beneficiaries, designate them as primary or contingent and change the percentages for Basic Life and Optional Life.

Completing open enrollment changes

Once a subscriber has completed their change(s), they will be prompted to review the change(s) before electronically authorizing and submitting. A Summary of Intent (SOI) is generated that the subscriber can save or print for their records.

The enrollment change(s) will be sent to the Approval tab of the BA Console.

If the subscriber changes their mind during open enrollment

If a subscriber changes their mind about their elections, they may go into MyBenefits and edit and/or delete their changes until 11:59 p.m. on October 31, regardless of whether the transaction has been approved by their employer.

If their employer has approved a previous transaction, a new status will appear on the Approval tab as Pending Employer Approval-Subscriber Changed.

The deadline for all open enrollment changes is October 31.



Active subscribers

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Employee eligibility rules and procedures

The Plan of Benefits defines an employee as:

A person employed by an Employer on a Full-Time basis, and who receives compensation from a department, agency, board, commission or institution of the State, including clerical and administrative Employees of the General Assembly, and judges in the State courts. Retirees who return to work with an Employer are considered Employees for purposes of eligibility under the Plan. For purposes of this Plan, the term shall include other Employees that the General Assembly has made eligible for coverage by law, including Employees of a public school district, county, municipality, or other Employer that has qualified for and is participating in, coverage under the Plan. The members of the South Carolina General Assembly and elected members of the councils of participating counties or municipalities, whose council members are eligible to participate in the South Carolina Retirement Systems, and Part-Time Teachers, are also Employees for purposes of the Plan.

The Plan of Benefits defines full-time as:

With regard to an Employee, shall mean an employee who is credited with an average of at least 30 hours of service per week. An employer may exercise a one-time, irrevocable option to elect the definition of Full-Time to mean an employee who is credited with an average of at least 20 hours per week, and to apply this definition, upon notification and acceptance by PEBA. Full-time status for purposes of eligibility to participate in the Plan is determined in accordance with the process set out in paragraphs 3.22, 3.23, and 3.24 of the Plan.

Determining eligibility for benefits

The Affordable Care Act (ACA) requires all Applicable Large Employers to offer health insurance that is affordable and provides minimum

value to all full-time employees or pay a penalty to the IRS.

To accommodate this requirement, participating employers must offer coverage to any employee who meets the eligibility requirements established by the ACA.

All employees fall into one of three categories:

- **New full-time employee (Permanent or Nonpermanent)** A newly hired employee who was determined by the employer, as of the date of hire, to be full-time and eligible for benefits. The employee is eligible to enroll in coverage within 31 days of their hire date.
- **New variable-hour, part-time or seasonal employee** A newly hired employee who is not expected to be credited an average of 30 hours per week for the entire measurement period, as of the date of hire. Therefore, the employer cannot reasonably determine their eligibility for benefits as of the date of hire. The employer must measure the employee's hours to determine whether the employee will be eligible for benefits.
- **Ongoing employee** Any employee who has worked with an employer for an entire Standard Measurement Period (see below).

To assist employers with determining an employee's eligibility for benefits, the IRS has established three safe harbor regulations: Measurement Periods, Administrative Periods and Stability Periods.

Measurement periods

A measurement period is the 12-month period an employer uses to review the number of hours worked by an employee to determine eligibility for benefits.

There are two types of measurement periods: Initial Measurement Period and Standard Measurement Period.

An **Initial Measurement Period** applies to any newly hired variable-hour, part-time or seasonal employee. An Initial Measurement Period begins the first of the month after the date of hire and ends 12 months later. The employer would not offer benefits to a newly hired variable-hour, part-time or seasonal employee at the time of hire. Instead, the employer would review the employee's hours over the Initial Measurement Period to determine eligibility.

The **Standard Measurement Period** applies to all ongoing employees and begins on October 4 of each calendar year and ends on October 3 of the next calendar year. For Plan Year 2025, the Standard Measurement Period runs from October 4, 2024, and ends on October 3, 2025.

Administrative periods

The Administrative Period is the period (immediately after the measurement period) when the employer notifies an employee of their eligibility for benefits and the plan processes the employee's enrollment, or the employer notifies an employee of their loss of eligibility for the next plan year.

There are two types of administrative periods.

Initial Administrative Period

A new variable-hour, part-time or seasonal employee credited with an average of 30 hours per week during their Initial Measurement Period may enroll during an Initial Administrative Period, which begins the day after the end of their Initial Measurement Period and ends the last day of the same month. Coverage begins the first of the month after the end of the Initial Administrative Period.

For example, if a variable hour/part-time employee is hired June 3, their Initial Measurement Period is July 1 through June 30 of the following year. The Initial Administrative Period is during that following July. Throughout this Initial Administrative Period, review the hours worked during the Initial Measurement Period to determine if the employee averaged 30 hours per week.

Standard Administrative Period

The ACA requires employers to monitor the hours of all employees to ensure eligible employees are offered benefits. An ongoing employee credited with an average of 30 hours per week during the Standard Measurement Period may enroll annually during the October enrollment period with coverage effective January 1.

The Standard Administrative Period for plan year 2025 is October 3, 2025, to December 31, 2025. Employers, however, must determine eligibility and offer coverage to eligible employees during the plan's open enrollment period, which ends October 31, 2025. All enrollments must be submitted to PEBA according to the open enrollment submission deadline (refer to Page 32, Making open enrollment changes). PEBA will use the remainder of the Standard Administrative Period (November to December 31) to process enrollments to ensure employees have access to coverage at the beginning of the Stability Period (January 1, 2026).

The Standard Administrative Period is also the period an employer must notify an employee of their loss of eligibility for the next plan year. If an employee previously determined as eligible for coverage during the Initial Administrative Period is determined not to have met the average of 30 hours per week during the Standard Measurement Period, the employee will lose eligibility at the end of his stability period.

Ongoing employee

If the employee is an ongoing employee, and they do not qualify for benefits in the next plan year, the employee will lose eligibility at the end of the current plan year.

- Notify the employee they will not be eligible for benefits in the next plan year;
- If the employee is enrolled in health, dental or vision, send the employee and their covered dependents an 18-month COBRA Notice. The COBRA Qualifying Event will be the employee's reduction of hours effective January 1; and

- Submit the termination in EBS. For the termination reason, choose Left Employment.

New variable-hour, part-time or seasonal employee

If the employee is a new variable-hour, part-time or seasonal employee, and they do not qualify for benefits based on the Standard Measurement Period, the employee will lose eligibility at the end of their Initial Stability Period. During the Standard Administrative Period, notify the employee they will not be eligible for benefits when their Initial Stability Period ends. At the end of the employee's Initial Stability Period:

- Notify the employee of their loss of eligibility;
- If the employee is enrolled in health, dental or vision, send the employee and their covered dependents an 18-month COBRA Notice. The COBRA Qualifying Event will be the employee's reduction of hours effective the end of their Initial Stability Period; and
- Submit the termination in EBS. For the termination reason, choose Left Employment.

Stability periods

The Stability Period is the period an employee remains eligible, regardless of the number of hours worked.

An Initial Stability Period for New Variable Hour, Part-Time and Seasonal Employees begins the first of the calendar month after the end of the Initial Administrative Period and ends the day before in the following calendar year. For example, an Initial Stability Period beginning on May 1 of one year would last until April 30 of the following calendar year.

A Standard Stability Period for Ongoing Employees begins January 1 of each year and ends on the following December 31.

Notes on employee eligibility

- An employee who returns to the same employer with no break in coverage or with no more than a 15-calendar-day break in employment is considered a transfer, not a new hire. For a break in service of greater than 15 calendar days, but less than 13 calendar weeks (26 weeks for academic employers), see the [Affordable Care Act frequently asked questions](#).
- An academic employee (public school districts, universities, colleges and technical colleges) who completes a school term and moves to another academic setting with another participating academic employer at the beginning of the next school term is a transfer, not a new hire.
- Eligibility for benefits is based on the number of hours the employee works for an employer. If an employee works for more than one participating entity that shares a common payroll center (i.e., CG agencies), the hours worked for both agencies should be combined to determine eligibility. In the case of a tie, both employers should offer coverage, and the employee can choose from which employer to accept coverage. See the [Affordable Care Act frequently asked questions](#).
- An employee who works for two participating employers is considered working for one employer or the other employer for insurance purposes. Their insurance coverage and premiums *cannot* be split between the two employers, nor can they combine their two salaries for Optional Life/Dependent Life Insurance purposes. See Page 69, Transfers and terminations, for additional information.
- If the employee is eligible for insurance, provide the [federally mandated notices](#) that include the [Marketplace Exchange Notice](#) and [Notice of Special Enrollment Rights](#).

Active nonpermanent full-time employees are eligible for the same insurance benefits as active permanent full-time employees. They are enrolled in benefits using an Active NOE, not a Part-time NOE. In the Eligible due to the Affordable Care Act box on the Active NOE, check Full-time nonpermanent.

While nonpermanent full-time employees are eligible for active employee insurance benefits, they might not be eligible for retiree coverage if they retire from a nonpermanent position. See Page 94 for retiree eligibility requirements, including that the last five years of active employment must be full-time, permanent and consecutive.

Note: PEBA does not verify the eligibility of employees for employers. It also does not classify employees.

Procedures to elect 20-hour threshold

Any participating employer has the option of reducing the threshold for insurance eligibility for all full-time employees from 30 hours per week to at least 20 hours per week.

To elect the 20-hour threshold, the director/head of the participating employer must send a letter to PEBA requesting this option. The letter should acknowledge the guidelines below. The director/head must sign the letter, and the original should be sent to the Operations manager at PEBA (address on Page 14).

PEBA will send a letter acknowledging receipt of the request. This letter will restate the guidelines below and will include the date the change to 20 hours will go into effect.

Guidelines for extending benefits to 20-hour employees

- Benefits must be offered to **all** employees working 20 or more hours per week.
- The decision to extend benefits to employees working 20 or more hours per week is **irrevocable**.

- Employees working 20 or more hours per week are entitled to participate in the same state benefits available to other full-time employees.
- The minimum employer contribution for these employees is the same as for other full-time employees.

Assisting a benefits-eligible employee

Use the *Enrolling a new hire* checklist at peba.sc.gov/publications under *Life event checklists*.

You can also prepare an information email/packet as outlined below.

Required information

When an employee becomes eligible for insurance benefits, provide the employee with the following items that are available online at peba.sc.gov/new-employees:

- [Insurance Enrollment Guide for New Hires](#) flyer;
- [Insurance Summary](#);
- New hire worksheet; and
- [Federally mandated notices](#) (new hire notices).

The *Insurance Orientation and Education* presentation and video provide an overview of the insurance benefits. Employers are strongly encouraged to direct employees to this presentation, also available online at peba.sc.gov/new-employees.

If system limitations prevent online enrollment, and you are enrolling on paper, provide:

- [Active Notice of Election](#) (NOE); and
- [Certification Regarding Tobacco or E-cigarette Use](#).

Available benefits

PEBA's publications provide helpful information on the following benefits. Encourage employees to

carefully review the publications and the insurance flyers and videos at peba.sc.gov/nyb. Learning about the benefits and determining their insurance elections is the responsibility of the employee. The employee must choose or refuse each of the following, based on eligibility:

Health insurance

State Health Plan (includes prescription drugs and behavioral health coverage).

State Health Plan subscribers are also eligible for [PEBA Perks](#).

The premium for tobacco or e-cigarette users is automatic for State Health Plan subscribers, unless the subscriber certifies they nor anyone they cover uses tobacco or e-cigarettes, or covered individuals who use tobacco or e-cigarettes have completed a tobacco cessation program approved by PEBA. See Page 41 for more information.

GEA TRICARE Supplement Plan is available to members of the military community.

Dental insurance

- Dental Plus; or
- Basic Dental.

Vision care

- State Vision Plan.

Life insurance

- Automatic enrollment in Basic Life with AD&D, at no cost, if enrolled in health insurance.
- Optional Life with AD&D;
- Dependent Life-Spouse with AD&D; and
- Dependent Life-Child (a child ages 19-24 must be a full-time student or certified as incapacitated to be eligible for coverage; a child older than age 24 must be certified as incapacitated to be eligible for coverage).

Long term disability insurance

- Automatic enrollment in Basic Long Term Disability, at no cost, if enrolled in health insurance.
- Supplemental Long Term Disability (SLTD).

There is a 12-month preexisting condition exclusion period related to BLTD and SLTD benefits.

MoneyPlus

- Pretax Group Insurance Premium feature for health, including the tobacco-use premium, Dental Plus, Basic Dental, State Vision Plan and up to \$50,000 in Optional Life coverage.
- Medical Spending Account (MSA).
- Limited-use Medical Spending Account.
- Dependent Care Spending Account (DCSA).

Health Savings Accounts

- Health Savings Account (HSA).

Where to find more information

Share the [how to access digital identification cards or replace cards](#) flyer for information on using the BlueCross, Express Scripts and EyeMed apps.

The [Insurance Benefits Guide](#) provides detailed descriptions of the State Health Plan and other benefits.

Refusal of coverage

An employee may refuse to enroll in any or all of the benefits plans offered by the state. **If an employee refuses health coverage, they forfeit Basic Life and Basic Long Term Disability coverage.**

To refuse coverage, an enrollment indicating **Refuse** must be submitted to PEBA.

If an employee is already enrolled as a dependent on their parent's coverage through PEBA, they may continue coverage as a dependent or enroll in coverage as an active employee. If the employee chooses to remain enrolled as a dependent, they cannot enroll in any benefits as an employee,

including SLTD and Optional Life. The dependent is also no longer eligible for Dependent Life-Child under their parent's coverage.

The employee should complete and sign a paper NOE refusing all coverage. Under Type of Change on the NOE, next to Other, specify Enrolled as child of PEBA subscriber.

Explain enrollment deadlines

Enrollments must be completed and authorized within 31 days of date of hire or a special eligibility situation.

If not completed within 31 days, the employee must wait until the next open enrollment period or a special eligibility situation to enroll in health, dental and/or vision coverage. At that time, full-time employees may be required to provide medical evidence to enroll in Optional Life and Dependent Life-Spouse and medical evidence of good health to enroll in SLTD coverage.

The new employee can change their mind about an original selection within 31 calendar days of their date of hire (not the effective date of coverage). To make a new selection, a paper NOE must be signed within the 31-day window and submitted to PEBA for processing. Indicate on the NOE that it is a revision within 31 calendar days.

Explain effective dates

New full-time employees

If the employee's first scheduled workday is the *first calendar day* of the month, coverage begins that day (on the first of the month).

If the employee's first scheduled workday is the *first working day* of the month (first day of the month that is not a Saturday, Sunday or observed holiday), but not on the *first calendar day* of the month (for example, they begin on the 2nd or 3rd of the month), then the employee may choose when coverage begins:

- The first day of that month, or
- The first day of the following month.

If the employee's first scheduled workday is *after the first calendar day and after the first working day of the month* (after the first day that is not a Saturday, Sunday or observed holiday), coverage will begin the first day of the *following* month.

Coverage of the spouse and/or child(ren) will become effective when the new employee's coverage becomes effective.

Life insurance coverage is subject to the Dependent Non-confinement Provision, as well as the Actively at Work requirement.

Explain any applicable late entrant procedures, open enrollment and special eligibility situations.

Tobacco certification

To avoid paying the tobacco-use premium, new employees must certify that neither they nor their covered spouse and/or child(ren) use tobacco products or electronic cigarettes.

When completing an online enrollment through MyBenefits or Current EBS, the tobacco and e-cigarette use certification is submitted as part of the enrollment. The certification form is not required. The effective date for the waiver (or premium if certifying as tobacco or e-cigarette user) will be the effective date of coverage.

- Subscribers may also follow up and certify later by completing the Certification form and submitting it to you for signature and submission to PEBA. The effective date for the waiver (or premium if certifying as tobacco or e-cigarette user) will be the first of the month after PEBA receives the form.

If completing a paper *Notice of Election* (NOE), also complete and attach a [Certification Regarding Tobacco and E-cigarette Use](#) form before sending to PEBA for processing. The effective date for the waiver (or premium if certifying as tobacco or e-cigarette user) will be the effective date of coverage.

- If the Certification form is not attached to the NOE and is sent later, the effective date for the waiver (or premium if certifying as tobacco or e-cigarette user) will be the first of the month after PEBA receives the form.

If a change in status occurs that changes a subscriber's status for tobacco-use (i.e., a subscriber who does not use tobacco marries and enrolls their new spouse who does use tobacco), the subscriber must indicate the appropriate tobacco and e-cigarette use on the online enrollment or complete a new certification form and submit to PEBA. The effective date for the premium will be the effective date of the coverage change.

Subscribers may apply to remove the premium once they and their covered spouse and/or child(ren) are tobacco- and e-cigarette-free for six months or if all covered individuals who use tobacco and/or e-cigarettes complete the State Health Plan's tobacco cessation program. They may certify by completing the certification form and submitting it to you for signature and submission to PEBA. The premium will be removed the first of the month after PEBA receives the form.

Certification forms should not be held. Send them to PEBA immediately after being signed and dated.

MoneyPlus enrollment

MoneyPlus is offered to all full-time employees who are also eligible for health, dental and vision coverage, regardless of whether they are enrolled in coverage. This program, administered by ASIFlex, was designed in compliance with sections 105, 125, 129 and 223 of the Internal Revenue Code (IRC).

MoneyPlus offers four features: the Pretax Group Insurance Premium feature, the Medical Spending Account (MSA), the Dependent Care Spending Account (DCSA) and the Limited-use MSA (Limited-use MSA). Participants in MSA, DCSA and Limited-use MSA accounts must reenroll each year during open enrollment. Refer to the *Insurance Benefits Guide* for eligibility rules and information regarding these features.

If an employee has more than a 30-day break and is not considered a transfer or academic transfer, they will not be able to reenroll in a MSA or DCSA until the next plan year.

Note: In 2025, the Dependent Care Spending Account (DCSA) is capped at \$1,600 for highly compensated employees. However, the \$1,600 cap is subject to adjustment in mid-year if PEBA's DCSA does not meet the *Average Benefit Test*. The test is designed to make sure highly compensated employees don't receive a benefit that is out of proportion to the benefit received by other employees. For 2025, the Internal Revenue Code defines a highly compensated employee as someone who earned \$155,000 or more in calendar year 2024.

Effect of MoneyPlus on other retirement plans

State retirement plan

Contributions to or benefits from the retirement systems administered by PEBA are based on an employee's gross salary. Participation in MoneyPlus has no effect on pension contributions or benefits.

Deferred Compensation

Contributions to a Deferred Compensation account are based on an employee's net salary. Pretax dollars set aside for MoneyPlus elections are not included in income when determining the maximum that can be contributed to a Deferred Compensation account.

Social Security

Pretax dollars set aside for MoneyPlus elections are not subject to Social Security taxes. Therefore, there may be a slight reduction in future Social Security benefits.

Employees do not typically contribute to a DCSA for more than a few years, but employees can contribute to an MSA for many years; the amounts contributed can vary significantly year to year.

Employees should consult their tax preparer or adviser to discuss their options.

If both spouses are eligible

- Each can participate in MoneyPlus, but there might be limitations/certain restrictions.
- Either spouse can claim an expense, but not both.

Effective dates for enrollment and changes

The effective dates for enrollment and changes in the Medical Spending Account (MSA) and Dependent Care Spending Account (DCSA) are the same as for health, dental and vision coverage for new hires; change in status effective dates will vary. Eligible employees have 31 days to enroll or to make changes due to a change in status.

[Review MoneyPlus features](#)

Pretax Group Insurance Premium

This feature allows employees to pay insurance premiums for health, including the tobacco-use premium, dental, vision and up to \$50,000 of Optional Life coverage before taxes. Once enrolled, the employee does not need to reenroll each year.

Be sure to forward the election to your payroll office.

An employee does not have to participate in the Pretax Premium feature to participate in the spending accounts.

Medical Spending Account and Dependent Care Spending Account

Employees can take advantage of tax-favored accounts to save money on eligible medical and dependent care costs.

Share the [MoneyPlus flyers](#) and refer employees to www.ASIFlex.com/SCMoneyPlus. Note the monthly administrative fees.

- To participate in either account, the employee must enroll and elect an **annual** contribution amount.

- They must reenroll each October to contribute the following year.
- The ASIFlex debit card is provided to MSA participants at no charge.
- Refer to the MoneyPlus COBRA section for employees who are retiring or otherwise terminating employment.

Limited-use Medical Spending Accounts are available to employees enrolled in the Savings Plan and a Health Savings Account. These employees can use a Limited-use MSA to pay for dental and vision care expenses only.

Comptroller General agencies only

PEBA sends an enrollment file to SCEIS twice a month, and SCEIS uses it to determine the amount to be deducted on the next payroll. SCEIS sends the payroll file and contribution for each employee to ASIFlex along with the funds.

Medical Spending Account and Dependent Care Spending Account rules

Refer to the *Insurance Benefits Guide* for the eligibility information regarding these accounts.

- Participants cannot be reimbursed twice for the same expense; an expense is not reimbursable if it is already covered under insurance or has been claimed through a spouse's flexible spending account.
- An employee has until December 31 to spend funds deposited in their MSA or Limited-use MSA during that year. An employee can carry over up to \$660 of unused funds into the next plan year.
- An employee has until March 15 to spend any remaining funds deposited in their DCSA from January through December of the previous year.
- An employee has a 90-day *run-out period* (until March 31) to file claims for services incurred during the previous plan year.
- An employee will forfeit any unused funds in their MSA or Limited-use MSA over the

\$660 carryover amount not claimed by March 31.

- An employee will forfeit any unused funds in their DCSA not claimed by March 31. These funds cannot be returned to the employee or carried forward to a new plan year.
- ASIFlex provides easy access to account statements online or via the mobile app. In addition, account information is provided with each reimbursement.
- PEBA, at its discretion, may elect to send statements to participants who have an available balance. The statements are sent based on participant preference of email/text alert or USPS mail, and not more frequently than quarterly.
- ASIFlex includes a reminder of the 90-day run-out period in the statements.

Medical Spending Accounts only

Generally, the expense must be incurred prior to reimbursement. Incurred means the service or supply has been provided that gives rise to the expense, regardless of when paid or billed.

- If the employee has a ASIFlex debit card, ASIFlex will auto-adjudicate debit card transactions it can match to claims received from other vendors. If ASIFlex cannot validate a claim, the employee will need to provide documentation for that transaction. The account must be reimbursed for any ineligible expenses that were paid with the card. Requests for documentation are emailed and posted online to the employee's ASIFlex account. The employee will have 52 days to respond, or the card will be deactivated. The employee will receive three notices before the card is deactivated.
- When documentation is submitted, the employee's card will be automatically reinstated.

If the employee does not have or use the ASIFlex debit card, they will need to submit a claim online or via the ASIFlex mobile app. The employee can also submit a paper claim form, along with any pertinent documentation.

Any debit card transactions not cleared by March 31 after the plan year ends are in violation of IRS guidelines and may be taxable as income. In this situation, the transactions will be reclassified by the employer and may need to be included on next year's W-2 as income.

Orthodontia

There are special rules regarding orthodontia:

- The initial service (banding) must have occurred before reimbursements may begin.
- A contract payment agreement from your orthodontist can be provided with your claim, and you can be reimbursed as payments are made based on the agreement. You must also provide proof of payment, and reimbursement is made from the plan year in which the payment is made.

Whose expenses are eligible under an MSA?

- Employee;
- Employee's spouse;
- Employee's qualifying child(ren); or
- Employee's qualifying relative.

An individual is a **qualifying child** if they are not someone else's qualifying child, and:

- Is a U.S. citizen, national or resident of the U.S., Mexico or Canada;
- Has a specified family-type relationship to the employee: son/daughter, stepson/stepdaughter, eligible foster child, legally adopted child, or child placed for legal adoption;
- Lives in the employee's household for more than half of the tax year;
- Does not reach age 27 during the taxable year; and

- Has not provided more than half of their own support during the tax year.

An individual is a **qualifying relative**, if they are a U.S. citizen, national or resident of the U.S., Mexico or Canada, and:

- Has a specified family-type relationship to the employee, is not someone else’s qualifying child and receives more than half of their support from the employee during the tax year, or
- If no specified family-type relationship to the employee exists, is a member of, and lives in, the employee’s household (without violating local law) for the entire tax year and receives more than half of their support from the employee during the tax year.
- “Qualifying relative” is a federal term and has no bearing on whether you can cover that person as a dependent under the state insurance benefits.

Note: There is no age requirement for a qualifying child if they are physically and/or mentally incapable of self-care. An eligible child of divorced parents is treated as a child of both, so either or both parents can have an MSA.

Dependent Care Spending Accounts only

Sufficient funds must be available for eligible expenses to be reimbursed. Funds are posted to participants’ accounts upon processing of MoneyPlus payrolls.

Claims for which there are insufficient funds will be held and processed as the funds become available; the employee should not need to refile. The expense (or period of service, such as a month’s worth of day care) must be incurred prior to reimbursement.

Whose expenses are eligible under a DCSA?

The employee may use their DCSA to receive reimbursement for eligible dependent care expenses for qualifying individuals. A qualifying individual includes a **qualifying child** if the child:

- Is younger than age 13 or is physically or mentally incapable of self-care;
- Is not someone else’s qualifying child;
- Is a U.S. citizen, national or resident of the U.S., Mexico or Canada;

A qualifying individual includes the employee’s **spouse** if the spouse:

- Is physically and/or mentally incapable of self-care;
- Lives in the employee’s household for more than half of the tax year; and
- Spends at least eight hours per day in the employee’s home.

A qualifying individual includes the employee’s **qualifying relative** if the relative:

- Is a U.S. citizen, national or resident of the U.S., Mexico or Canada;
- Is physically and/or mentally incapable of self-care;
- Is not someone else’s qualifying child;
- Lives in the employee’s household for more than half of the tax year;
- Spends at least eight hours per day in the employee’s home; and
- Receives more than half of their support from the employee during the tax year.

Note: If the employee is the tax dependent of another person, they cannot claim DCSA expenses for other qualified individuals. The employee cannot claim a qualifying individual if that individual files a joint tax return with a spouse. If the parents of a child are divorced or legally separated, only the custodial parent can be reimbursed for child care through the DCSA.

Health Savings Account enrollment

The Savings Plan goes hand in hand with a Health Savings Account, or HSA, which pays for future out-of-pocket medical expenses. Eligible employees may enroll in an HSA at any time. They may change their

HSA elections monthly. HSA changes become effective the first of the month following the change.

Share the [Health Savings Account flyer](#). Note the monthly administrative fees and HSA Central fees.

To participate, the employee must enroll in the Savings Plan and elect to participate in an HSA. HSA Central will automatically set up the bank account based on enrollment information from PEBA. The employee will receive a welcome email from HSA Central with instructions on how to open the account once it is set up.

HSA Central charges HSA participants a monthly maintenance fee of \$0.50, which is automatically deducted from the account.

HSA rules

If both spouses contribute to an HSA, and one of them has family coverage (employee/spouse, employee/children or full family coverage), their combined HSA contributions cannot exceed the IRS-allowed limit for family coverage. If both spouses have employee-only coverage, each can contribute up to the IRS-allowed limit for single coverage.

Expenses are reimbursable only if there are sufficient funds in the account. Participants may use their HSA debit cards from HSA Central to get funds directly out of their accounts for eligible expenses. Reimbursements are not requested through ASIFlex.

Participants cannot be reimbursed twice for the same expense. An expense is not reimbursable if it is already covered under insurance. Participants are solely responsible for maintaining proper documentation and providing it to the IRS, if requested.

HSA Central provides monthly statements online to participants.

By IRS regulations, amounts not claimed after the year's end may be carried forward to subsequent tax years.

An employee may defer reimbursements, until later tax years, as long as the eligible expenses were incurred after the HSA was established and the employee is keeping sufficient records to document the eligible expenses.

Participants will receive annual tax reports from HSA Central to use for tax filing purposes.

GEA TRICARE Supplement Plan enrollment

When enrolling an employee in the GEA TRICARE Supplement Plan, submit a copy of the employee's TRICARE Card with the enrollment.

- PEBA will process the enrollment and send information to Selman & Company.
- Selman & Company will verify the employee's eligibility with the Defense Enrollment Eligibility Reporting System (DEERS).
- If the employee is eligible, Selman & Company will send them a GEA TRICARE Supplement Plan enrollment packet.

The monthly premium includes a minimal administrative fee for the processing of premium payment, which may appear as a discrepancy between Selman & Company's billing statement and subscriber's payroll deducted amount.

Assisting a newly eligible variable-hour, part-time or seasonal employee

New variable-hour, part-time or seasonal employees are not offered benefits when they are first hired. Instead, the employer must measure the employee's hours over an initial 12-month measurement period to determine whether the employee will be eligible for benefits.

A new variable-hour, part-time or seasonal employee credited with an average of 30 hours per week during their Initial Measurement Period may enroll during an Initial Administrative Period, which

begins the day after the end of their Initial Measurement Period and ends the last day of the same calendar month. Once an employer deems an employee eligible for benefits, the employee remains eligible for 12 months during their Initial Stability Period, regardless of the number of hours the employee works.

Example: An employee hired on February 5, 2025, would not have been employed for the entire Standard Measurement Period (October 4, 2024-October 3, 2025); therefore, the employee will have their own Initial Measurement Period, Administrative Period and Stability Period:

- Initial Measurement Period: March 1, 2025-February 28, 2026
- Initial Administrative Period: March 1, 2026-March 31, 2026
- Initial Stability Period: April 1, 2026-March 31, 2027

During the Administrative Period, the employer would review the hours worked by the employee during their Initial Measurement Period. If the employee is deemed eligible for benefits, the employer would offer coverage and complete the enrollment by March 31, 2026. If the employee was deemed eligible for benefits, they would remain eligible for the duration of their Stability Period, regardless of the number of hours they work.

In accordance with the ACA and as defined in Paragraph 3.23 of the *Plan of Benefits* document, variable-hour, part-time and seasonal employees who are eligible for benefits are eligible for all benefits.

Eligible employees must elect or refuse coverage within the employee's designated Administrative Period. Coverage is effective the first of the month after the end of the Administrative Period. Employees enrolling in a health plan must also certify their tobacco or e-cigarette use.

The employee is allowed to change their mind about an original selection within the Administrative Period. To make a new selection, a

paper *Notice of Election* must be signed within the 31-day window and submitted to PEBA for processing as a revision.

Completing the enrollment

The same procedures apply for completing the enrollment of an active subscriber (see Page 20) with the following exception:

STATUS: Select the category for the type of employee who is enrolling in coverage.

- While variable-hour, part-time and seasonal employees are eligible for active employee benefits, they are not automatically eligible for retiree coverage if they retire from a nonpermanent position. See the Retiree section beginning on Page 91 for retiree eligibility requirements, including that the last five years of active employment must be full-time, permanent and consecutive.

Assisting a permanent, part-time teacher

As defined in S.C. Code Ann. §59-25-45 and in paragraph 2.55 of the Plan of Benefits document, permanent, part-time teachers of S.C. public schools, the S.C. Department of Corrections, the S.C. Department of Juvenile Justice and the S.C. School for the Deaf and Blind may be eligible for:

- Health (State Health Plan and GEA TRICARE Supplement Plan).
- Dental Plus and Basic Dental.
- State Vision Plan.
- MoneyPlus.
- Health Savings Account.

Permanent, part-time teachers are **not** eligible for:

- Basic Life insurance.
- Optional Life insurance.
- Dependent Life insurance for children or spouses.
- Basic Long Term Disability.
- Supplemental Long Term Disability.

The employee must be in a contract position and receive an EIA (Education Improvement Act of 1984) salary supplement. In addition to classroom teachers, this can also include other academic personnel, such as librarian/media specialists, guidance counselors, ROTC (Reserve Officer Training Corps) instructors, school nurses, social workers, psychologists, audiologists or other instructional staff. Call the Department of Education at 803.734.8122 for additional information pertaining to the specific law or determining eligibility of a position.

The employee must work at least 15 hours per week, but fewer than 30 hours per week. There are three part-time categories based on the number of hours worked per week (Category I = 15-19 hours; Category II = 20-24 hours; Category III = 25-29 hours). Premiums are based on the applicable category.

An employee who is eligible as a permanent, part-time teacher and also eligible as a spouse under a covered spouse's file can elect coverage as a permanent, part-time teacher or as a spouse, but not both. A permanent, part-time teacher with health, dental and/or vision coverage as a subscriber cannot be covered on the spouse's plan under any benefit (health, dental, vision or Dependent Life).

If the employee wants to remain on their spouse's coverage, complete an [Active Part-time Teachers NOE](#) refusing all coverage and send it to PEBA.

While permanent, part-time teachers are eligible for active employee benefits under §59-25-45, they are not automatically eligible for retiree coverage if they retire from a part-time teacher position. See the Retiree section beginning on Page 91 for retiree eligibility requirements, including that the last five years of active employment must be full-time and continuous.

Eligible employees must enroll within 31 days of date of hire by enrolling through EBS/MyBenefits or by completing an [Active Part-time Teachers NOE](#).

Effective dates of coverage are the same as for other new hires. The 31-day window for elections and changing elections is also the same as for other new hires.

Employees enrolling in a health plan must also certify their tobacco use.

Completing the enrollment

When completing the permanent *Part-Time Notice of Election*, select one category based on the number of hours worked each week. Confirm the accuracy of the selection.

Process for medical emergencies

If a subscriber has a medical emergency, and an enrollment or change needs to be processed the same day, complete the transaction in EBS. A BIN will be generated immediately. See the **Using the online system** chapter for more information.

- If you are unable to get the employee's signature on the SOC or SOE, include a copy of the signed *Notice of Election* form. After the transaction is complete and you have uploaded the documentation required, if any, email PEBA Customer Service at peba.sc.gov/contact-employer.
- If the subscriber's file is in suspense because of a rejection, email PEBA Customer Service at peba.sc.gov/contact-employer. The Customer Service representative will delete the suspended transaction so you can complete the transaction in EBS. After the transaction has been approved, the Customer Service representative will release it and update the third-party claims processors.

A subscriber can obtain medical services before they have an insurance card by giving their member ID to their provider.

- If the subscriber is enrolled, their member ID is ZCS, followed by their BIN.

- If the subscriber is enrolled in the GEA TRICARE Supplement Plan, their member ID is PC, followed by their BIN.

A subscriber can obtain prescription drugs before they have an insurance card.

State Health Plan subscribers can tell the pharmacist they are with Express Scripts. The pharmacist might need only the member’s name and their eight-digit claim. If the pharmacist requires more information from the card:

- **All active employees and their covered dependents should provide:**
 - RxGroup: SCPEBAX;
 - RxPCN: A4; and
 - RxBIN: 003858.
- **Retirees not enrolled in Medicare should provide:**
 - RxGroup: SCPEBAX;
 - RxPCN: A4; and
 - RxBIN: 003858.
- **Retirees enrolled in Medicare should provide:**
 - RxGroup: 7258MDRX;
 - RxPCN: MEDDPRIME; and
 - RXBIN 610014.

National Medical Support Notices

National Medical Support Notices (NMSNs) are forms sent to employers when an employee is under an existing court or administrative order to provide insurance for their child(ren). Timely completion helps ensure child(ren) have the required coverage.

If you receive an NMSN, email it to PEBA at medicalsupportnotices@peba.sc.gov as soon as possible. The format of the notice may vary, but it will always include “National Medical Support Notice” at the top of the first page, and it will have sections labeled Employer Response and Plan Administrator Response.

- Complete **only** the Employer Response section and return it to the issuing child support agency before you send a copy to PEBA.
- You do not have to complete an NOE.
- The information on the custodial parent and child(ren) contained on the NMSN must not be shared with the employee. Additionally, the NMSN must not be placed in the employee’s file unless identifying information for the child(ren) and custodial parent has been redacted. If the employee has questions concerning the coverage requirements and plan choice, refer the employee to the issuing agency.
- PEBA will complete the Plan Administrator Response and send it to the issuing agency. PEBA will also complete any extra forms or questionnaires about health insurance that might be included. You will be notified if election changes are made.

NOTE: Special eligibility situation rules do not apply to NMSNs. Subscribers cannot make changes to their benefits other than those specified in the NMSN, which PEBA will determine. Subscribers are not allowed to make coverage changes through MyBenefits.

Compliance with the NMSN is mandatory under federal law. PEBA **cannot** discontinue coverage until the issuing agency sends an updated NMSN or other order.

When an employee who is covering a child under an NMSN leaves employment, send a COBRA notice for the child to the custodial parent listed on the NMSN.

Rules and procedures for late entrants

A late entrant is an eligible person who does not enroll when first eligible but enrolls later during an open enrollment period. An employee, spouse or child(ren) who enrolls due to a special eligibility situation is not considered a late entrant.

Health plans

- The employee must wait until the next October enrollment period to enroll as a late entrant or to add a spouse or child(ren) as a late entrant.
- No medical evidence of good health is required for subscribers, their spouses or child(ren).
- There are no preexisting condition exclusions under any of the health plans offered through PEBA.

Dental

- The employee must wait until the next open enrollment period of an odd-numbered year to enroll as a late entrant or to add a spouse or child(ren) as a late entrant.
- There is no dental underwriting for subscribers, their spouses or child(ren).
- There are no preexisting condition exclusions under Dental Plus or Basic Dental.

Vision care

(Group number 9925991)

- The employee must wait until the next October enrollment period or special eligibility situation to enroll in the State Vision Plan as a late entrant or to add a spouse or child(ren) as a late entrant.
- No medical evidence of good health is required for subscribers, their spouses or child(ren).
- There are no preexisting condition exclusions under the State Vision Plan.

Life insurance

Optional Life

(Policy number 200879)

- If they do not participate in the MoneyPlus pretax premium feature, eligible participants may enroll in Optional Life or increase coverage throughout the year.
- Late entrants must provide medical evidence and be approved.
- If they do participate in the MoneyPlus pretax premium feature, eligible participants may enroll in Optional Life or increase coverage only during announced enrollment periods or within 31 days of a special eligibility situation.
- Late entrants must provide medical evidence and be approved.

Refer to Page 56 for the procedures for adding and changing Optional Life insurance coverage outside of a new hire situation.

Dependent Life-Spouse

(Policy number 200879)

- Eligible spouses can be added throughout the year.
- Medical evidence is required for spouses enrolled as late entrants.

Refer to Page 58 for the procedures for adding and increasing Dependent Life insurance coverage with medical evidence.

Dependent Life-Child

(Policy number 200879)

- Eligible dependent children can be added throughout the year.
- No medical evidence is required for children enrolled as late entrants.

Supplemental Long Term Disability

(Policy number 621144B)

- When an approval is received from The Standard, have the employee complete a paper *Notice of Election* to select the coverage for which they were approved. This can be done earlier and held for approval from The Standard.
- Send the approval from The Standard with the paper NOE to PEBA.
- Premiums start with the effective date of coverage (first of the month after approval).

Changes in status and special eligibility situations

(Health, Dental Plus/Basic Dental, State Vision Plan, Dependent Life, MoneyPlus and Health Savings Accounts)

Enrollment changes must be requested within 31 days of the changes in status that follow, and any supporting documentation must be submitted. Changes not made within 31 days of the event cannot be made until the next open enrollment period or until another change in status or special eligibility situation occurs.

If the change in status or special eligibility situation changes the tobacco-use status, the subscriber must indicate the appropriate Tobacco Coverage on the online enrollment or complete a new Certification form and submit it to PEBA with the NOE. The effective date for the premium will be the effective date of the coverage change on enrollment.

Refer to the quick reference charts on special eligibility situations in the Reference chapter.

More information on changes related to a spouse or child(ren) can be found on Page 107.

Gain of other group coverage

Effective date to drop PEBA coverage: First of the month after gaining other coverage or the first of

the month if coverage is gained on the first of the month. See exceptions for gaining Medicare and Medicaid effective dates below.

An exception to the 31-day rule exists when a spouse who gains coverage or becomes eligible for coverage *as a subscriber of a participating employer* must be dropped from the employee's coverage. If the employee fails to drop the ineligible spouse within 31 days, the spouse may be dropped retroactively to coincide with the date the spouse was added to coverage at the other participating employer.

An employee may terminate health, dental and/or vision coverage if they gain other group coverage. They can drop only the type of coverage they gained.

An employee may drop a spouse or child(ren) from coverage if their spouse or child(ren) gains other group coverage. Only the spouse or child(ren) who gained other coverage may be dropped. The spouse or child(ren) can be dropped only from the type of coverage they gained.

- However, if the spouse is gaining coverage as an employee of a *participating employer*, the subscriber must drop the spouse within 31 days; they cannot wait until the open enrollment period.
- If a spouse or child(ren) gains eligibility for coverage and attempts to enroll as an employee of a *participating employer*, PEBA will reject the enrollment, because the spouse or child(ren) must be terminated from the other coverage first.

A gain of other group coverage notice is required only if the group is **not** participating with PEBA insurance benefits. The notice must be submitted in EBS or attached to the NOE.

- The gain of coverage notice must include the effective date of coverage, the type(s) of coverage (health, dental and/or vision), and it must list all individuals who gained coverage.

- The notice must state gained health coverage to change coverage level or drop health coverage; it must state gained dental coverage to drop dental coverage; it must state gained vision coverage to drop vision coverage. *Exception:* Medicaid includes health, dental and limited vision coverage (for children only) automatically.

If the group is participating with PEBA insurance benefits, write *Gained State Coverage* at the top of the NOE.

If the subscriber has not received the gain of coverage notice, and the deadline to enroll in PEBA coverage is nearing, complete the transaction in EBS or submit the NOE without the letter. Submit the letter as soon as it is available. Changes will not be processed until all documents have been received.

Gain of Medicare coverage

Effective date to drop PEBA coverage: First of the month after the gain of Medicare or the first of the month if Medicare is gained on the first of the month. If the effective dates of Part A and Part B are different, the subscriber can make a change in coverage through PEBA only within 31 days of the confirmation letter from the Social Security Administration. The letter is typically sent when the subscriber becomes eligible for Part A.

An employee may terminate health coverage if they gain Medicare.

An employee may drop a spouse or child(ren) from health coverage if their spouse or child(ren) gains Medicare. Only the spouse or child(ren) who gained Medicare may be dropped.

A copy of the Medicare card, verifying gain of Medicare coverage, must be attached to the NOE.

Note on Medicare Part B and Medicare Part D: Most **active** employees who become eligible for Medicare at age 65 should delay enrolling in Medicare Part B, because their coverage through PEBA remains primary while they are working. Likewise, most active employees should not sign up for a separate

Medicare Part D plan, because their prescription drug expenses will continue to be covered through their plan with PEBA. If an active employee signs up for Part D, PEBA will *not* be able to drop their prescription drug coverage.

There are exceptions for employees who become eligible for Medicare due to disability or end-stage renal disease. Refer to the [Insurance Benefits Guide](#) or email PEBA Customer Service for more information.

If an individual has end-stage renal disease (ESRD), according to Medicare rules, they will become eligible for Medicare three months after beginning dialysis or the month in which they receive a kidney transplant. Contact Medicare regarding the 30-month coordination period. The coordination period might be different for covered dependent children with ESRD or who have had a kidney transplant. The coordination period applies whether the subscriber is an active employee, a retiree, a survivor, or a covered spouse or child, and regardless of whether the subscriber was already eligible for Medicare due to another reason, such as age. If the subscriber was covered by the Medicare Supplemental Plan, they will be changed to the Standard Plan during the 30-month coordination period.

Gain of Medicaid coverage

Effective date to drop PEBA coverage: Effective date of the Medicaid coverage.

Exceptions to the 31-day rule: If the subscriber and their covered family members become eligible for Medicaid or the Children’s Health Insurance Program (CHIP), the subscriber has 60 days from the date of notification to drop coverage through PEBA. If the Medicaid effective date is retroactive more than 60 days before the date of notification, then the effective date will be the first of the month after the request. If the subscriber notifies PEBA more than 60 days after they were notified by Medicaid, no changes are allowed.

An employee may terminate health, dental and/or vision coverage if they gain Medicaid.

An employee may drop a spouse or child(ren) from coverage if their spouse or child(ren) gains Medicaid. Only the spouse or child(ren) who gained Medicaid may be dropped.

A copy of the Medicaid approval letter must be attached to the NOE or submitted in EBS.

Medicaid coverage includes health, dental and vision coverage. The vision coverage includes an annual eye exam and a pair of glasses following cataract surgery. Vision coverage for children younger than age 21 includes one eye exam and one pair of glasses once a year. For most adults ages 21 and older, this dental coverage includes emergency services only, such as extractions or treatment for acute infections. Dental coverage for children younger than age 21 includes basic coverage with preventive services. For more information on Medicaid coverage, contact the Department of Health and Human Services (contact information will be on the Medicaid approval letter).

Loss of other group coverage

(Includes Medicare and Medicaid)

Effective date: The date of the loss of coverage.

Exceptions to the 31-day rule: If the subscriber and their covered family members lost coverage through Medicaid or the Children's Health Insurance Program (CHIP), the subscriber has 60 days to enroll in coverage through PEBA.

If the subscriber loses other health coverage, and they are not already enrolled in health through PEBA, they can enroll themselves, their spouse and their child(ren) in health, Dental Plus or Basic Dental and vision. The subscriber must enroll in coverage they are adding for their spouse or child(ren). They cannot drop or change their current coverage.

If the subscriber is already enrolled in health through PEBA, they cannot make changes.

If the subscriber loses other dental coverage, they can enroll in Dental Plus or Basic Dental.

If the subscriber loses other vision coverage, they can enroll in vision.

If the subscriber's spouse or child(ren) loses other health coverage, they can enroll themselves and the spouse or child(ren) who lost coverage in health, Dental Plus or Basic Dental and vision. The subscriber must enroll in coverage they are adding for their spouse or child(ren). If the subscriber is already enrolled in health, they may change plans if they add the spouse or child(ren) who lost coverage. They cannot drop their current coverage.

If the subscriber's spouse or child(ren) loses other dental coverage, they can enroll themselves and the spouse or child(ren) who lost coverage in Dental Plus or Basic Dental. The subscriber must enroll in coverage they are adding for their spouse or child(ren).

If the subscriber's spouse or child(ren) loses other vision coverage, they can enroll themselves and the spouse or child(ren) who lost coverage in vision. The subscriber must enroll in coverage they are adding for their spouse or child(ren).

If the subscriber's spouse loses other life insurance coverage, it is not a special eligibility situation. However, the subscriber may add the spouse to Dependent Life with medical evidence throughout the year. If the subscriber's spouse loses life insurance coverage as an employee of a PEBA insurance benefits-participating employer, the spouse may be added to Dependent Life (\$10,000 or \$20,000 in coverage) without medical evidence.

Documentation of dependent eligibility must be submitted in EBS or attached to the NOE.

- A marriage license or Page 1 of the employee's latest federal tax return, if filing jointly, is required to add a spouse.
- A long-form birth certificate showing the subscriber as the parent is required to add a child.

- A long-form birth certificate and marriage license naming spouse as parent is required to add a stepchild. Return the completed form to PEBA.

Documentation of loss of coverage should be uploaded in EBS or attached to the NOE.

Acceptable documentation is a creditable coverage letter or a notice that includes the effective date of the loss of coverage, the type of coverage lost (health, dental and/or vision), and the names of all individuals who lost coverage.

- If the coverage lost was through a *participating employer*, write *Lost State Coverage* at the top of the NOE. This will alert PEBA staff to access the previous coverage data on the individual.
- If the subscriber loses other health coverage, and they are not already enrolled in health through PEBA, their spouse and child(ren) can be added to health, Dental Plus, Basic Dental and vision even if they are not listed on the loss of coverage letter. The letter does not need to state subscriber lost dental or vision for them to enroll in those coverages.
- If the subscriber’s spouse or child(ren) loses other health coverage, the loss of coverage letter does not need to state spouse or child(ren) lost dental or vision for the spouse or child(ren) to enroll in Dental Plus or Basic Dental and vision.

If the subscriber has not received the loss of coverage letter, and the deadline to enroll in PEBA coverage is nearing, complete the transaction in EBS or submit the NOE without the letter. Submit the letter as soon as it is available. Changes will not be processed until all documents have been received. The effective date will remain the date of loss of other coverage.

Note about premiums

If the employee is enrolled in the MoneyPlus Pretax Group Insurance Premium feature, premiums must be paid post-tax for retroactive coverage back to

the date of loss of coverage. Premiums may be paid pretax beginning the first of the month following the date of the request.

Loss of TRICARE coverage

Effective date to drop PEBA coverage: First of the month after a subscriber or dependent is no longer eligible for TRICARE, if enrolled in the TRICARE Supplement.

Selman & Company provides employers with monthly eligibility reports. If a subscriber or dependent is no longer eligible for TRICARE, submit a paper NOE and a copy of the report from Selman & Company to PEBA to cancel coverage.

- Strike through any information that doesn’t apply to that specific subscriber or dependent.
- If the report lists more than one subscriber or dependent who lost eligibility, attach a copy of the report to each NOE.

MoneyPlus change in status rules

The rules and effective dates for changes in status are similar to those for health insurance. There are some additional changes allowed by the IRS. Refer to the [Flexible Benefits Plan](#) document for these allowed changes. For example, a child turning age 13, who is no longer eligible for dependent care, is an allowed change in status event for Dependent Care Spending Accounts.

Eligible employees have 31 days to enroll or make a change when a qualifying change in status occurs. The payroll adjustment must coincide with the effective date of the change in status.

Changes/new elections must be consistent with a qualifying family status change. For example, decreasing Medical Spending Account contributions when an adult child gets a job and coverage elsewhere is consistent with the gain of other coverage; increasing contributions is not.

- **Pretax Group Insurance Premium feature:** If the employee is eligible to change health, dental, vision or Optional Life coverage due to a change in status, they may also enroll in or drop their Pretax Group Insurance Premium feature.
- **Dependent Care Spending Account:** If a DCSA is terminated, the employee can continue to submit claims, while employed, until the end of the year or until the account is exhausted.
- **Medical Spending Account:** If an MSA is terminated, the employee can submit expenses incurred before the first of the month following the last day worked.

Refer to the Transfers and terminations section and the COBRA section of this manual for more information on continuation of MSAs at termination.

Completing the enrollment for a change in status

Use EBS when an employee wants to change their MoneyPlus account(s) due to a change in status.

Select MoneyPlus as the Reason for Change and select the Sub-Reason from the drop-down list. Enter the date of the event, not the effective date of the change. Complete the enrollment change(s) and apply to MyBenefits or Current EBS.

Note that certain changes are not allowed due to the defined change reason.

Deductions for any accounts that the employee has but does not wish to change as a result of the change in status will remain the same.

If completing the enrollment change(s) on a paper *Notice of Election* form, follow the NOE instructions and check and date all qualified change events for MSA and DCSA accounts, then return the completed form to PEBA.

If PEBA does not receive the enrollment change before the participant submits claims related to the change in status, those claims might be rejected. If

ASIFlex does not receive adjusted payroll data matching the payroll effective date or payroll amount on the form, related claims could be rejected.

Coverage changes for permanent, part-time teachers

(Health, dental and vision)

The policies and procedures regarding health, dental and vision changes for active subscribers also apply to permanent, part-time teachers.

Increase or decrease in the number of contract hours

If the increase or decrease in an employee's contracted work hours causes a change in status (i.e., from 15 to 25 hours per week, etc.):

- Submit a new NOE, reflecting the change in status.
- If this is a temporary change, you do not have to notify PEBA, and no changes should be made.
- If an increase in hours makes the employee eligible as a permanent, part-time teacher:
 - The date of hire will be the date of the contract change.
 - The effective date will be the first of the month after the date of the contract change (or the first working day of the month, if applicable).

If an employee's work hours are contractually reduced to fewer than 15 hours per week:

- Submit the termination in EBS. For the termination reason, choose Left Employment. If submitting an [Active Termination Form](#), check the T5 box, Not Eligible (Not in a Stability Period). Change is effective the first of the month after the work hours are reduced.

The employee may make new health and dental selections based on an increase or decrease in hours.

- If the decrease in hours places the employee in a lower category (e.g., they enrolled in Category III working 26 hours and the contract changes to 23 hours), they may decrease or increase their coverage.
- If the increase in hours places the employee in a higher category (e.g., they enrolled in Category I working 17 hours and the contract changes to 23 hours), they may select and/or increase their benefits.
- If the increase in hours reaches 30 hours per week, classifying them as a permanent, full-time employee, they are eligible to make all-new selections. Treat them as a new hire and offer all benefits to them, effective the first of the month after they reach permanent, full-time status.

Other coverage changes

Optional Life

To determine the allowable timeline for changes to Optional Life coverage, review whether the employee participates in the MoneyPlus Pretax Group Insurance Premium feature.

Not participating in MoneyPlus Pretax Premium feature

The 31-day rule does not apply if a subscriber is **not** participating in the MoneyPlus Pretax Premium feature. Subscribers **not** participating in the Pretax Premium feature may:

1. Add or increase coverage at any time during the year by providing medical evidence, with approval from MetLife:
 - Employers will submit a *Life Insurance Statement of Health Request* in EBS by selecting the Life Ins SOH button on the homepage to initiate the process. The employee will complete an online *Statement of Health*.

- If additional information or medical data is needed, MetLife will send a letter to the subscriber.
- MetLife allows 60 days to respond to the request for additional information. A reminder letter is sent if no response is received within 31 days. If no response is received in another 31 days, the file is closed.
- MetLife subcontracts for a paramedical exam if an exam is necessary to make a determination. If required, this step also follows the same 31- and 60-day process.

Once MetLife receives all needed information, a decision usually will be made within 10 business days. MetLife mails a Notification Statement to the subscriber and emails the employer with a determination. Contact MetLife at scpeba@metlife.com if you are not receiving the determination spreadsheet. Include your name, employer name, group number, email address and phone number.

Submit the change in EBS by selecting Optional Life Changes – Not a MoneyPlus participant as the Reason for Change and select the Sub-Reason from the drop-down list. Enter the approval date from MetLife. Complete the enrollment change(s) and apply to MyBenefits or Current EBS. A copy of the MetLife approval is required as supporting documentation.

If submitting on a *Notice of Election* form, forward a copy of the weekly *Statement of Health Report* from MetLife and the NOE showing the increase in coverage to PEBA so the subscriber's file can be updated and the billing statement adjusted. Redact information for other employees.

The effective date will be the first of the month after approval from MetLife.

2. Add or increase coverage, without medical evidence, due to a special eligibility situation:
 - The change must be made within 31 days of the special eligibility situation (marriage, divorce, birth, adoption or placement for adoption).
 - The effective date of the change will be the date of the request.
 - If the subscriber refused Optional Life as a new hire, they may add coverage, up to \$50,000 (in increments of \$10,000). If the subscriber is already enrolled in Optional Life, they may increase coverage, up to an additional \$50,000 (in increments of \$10,000 and not to exceed the maximum amount allowed).
3. Decrease coverage: Effective the first of the month after the change is requested.
4. Cancel coverage: Effective the first of the month after the change is requested.

Participating in MoneyPlus Pretax Premium Feature

Changes must be made within 31 days of the special eligibility situation, or the employee must wait until the next enrollment period. Subscribers participating in the Pretax Premium feature may:

1. Add coverage. The Optional Life request must be consistent with the special eligibility situation. If the subscriber refused Optional Life as a new hire, they may:
 - Add coverage, up to \$50,000 (in increments of \$10,000), without medical evidence. The effective date of the change will be the date of the request.
 - Add coverage, more than \$50,000 (in increments of \$10,000 and not to exceed the maximum amount allowed), with medical evidence. Complete an online *Statement of Health*. Employers

will submit a *Life Insurance Statement of Health Request* in EBS by selecting the Life Ins SOH button on the homepage to initiate the process.

Complete the special eligibility enrollment in EBS, requesting the level for which the employee is eligible without medical evidence (\$50,000), effective the date of the event. Complete the NOE for the *total amount* of coverage (with medical evidence) and hold until approval is received from MetLife.

Once approved, send the NOE, with the weekly *Statement of Health Report* from MetLife, to PEBA. Each NOE should be accompanied by a copy of the *Statement of Health Report* – not one report for multiple NOEs. Redact information for other employees.

The effective date will be the first of the month after approval from MetLife.

2. Increase coverage, up to an additional \$50,000, without medical evidence. The effective date of the change will be the date of the request.
3. Increase coverage, more than \$50,000, with medical evidence.

Complete the special eligibility enrollment in EBS, requesting the level for which the employee is eligible without medical evidence (\$50,000), effective the date of the event. Complete the NOE for the *total amount* of coverage (with medical evidence) and hold until approval is received from MetLife.

Once approved, send the NOE, with the weekly *Statement of Health Report* from MetLife, to PEBA. Redact information for other employees.

4. Decrease coverage. The Optional Life request must be consistent with the special eligibility situation. The effective date will be the first of the month after the change is requested. *Exception:* The effective date for

the death of a spouse will be the day after death, as with other benefits.

5. Cancel coverage. The Optional Life request must be consistent with the special eligibility situation. The effective date will be the first of the month after the change is requested. *Exception:* The effective date for the death of a spouse will be the day after death, as with other benefits.

Effective date note: If the employee is not *actively at work* (the employee is absent from work due to a physical or mental condition, including absence due to maternity/birth) on the date their Optional Life selection becomes effective (add Optional Life coverage or increase in the level of Optional Life), the effective date will be the date the employee resumes active work. The “Actively at Work” requirement is defined in the *Insurance Benefits Guide’s* Life insurance chapter.

If request for additional coverage is denied

If MetLife denies additional coverage, based on medical evidence:

- The employee can request from MetLife, in writing, additional information regarding the denial.
- Do not forward the NOE or denials to PEBA.
- If denied, the employee may reapply by submitting a new online *Statement of Health*.

Dependent Life

Dependent Life-Spouse

- Coverage of up to \$20,000 may be added within 31 days of date of marriage, birth, adoption or within 31 days of loss of other coverage with a participating employer, without providing medical evidence.
- Coverage may be added, increased, decreased or canceled throughout the year.
- Medical evidence is required for late entry and to increase Dependent Life-Spouse coverage beyond \$20,000, up to the maximum allowed.

Medical evidence procedures:

- Complete an NOE, listing the spouse to be added to coverage or to have coverage increased.
- Complete an online *Statement of Health*. Keep a copy to hold in the pending file. Employers will submit a *Life Insurance Statement of Health Request* in EBS by selecting the Life Ins SOH button on the homepage to initiate the process.
- Once approved, send the NOE along with the weekly *Statement of Health Report* from MetLife. Redact information for other employees.
- MetLife will notify the subscriber of the approval/denial.
- The effective date will be the first of the month after approval from MetLife.

Effective date note: Under the Dependent Non-confinement Provision, if a spouse or child (other than a newborn) is confined to a hospital or elsewhere due to a physical or mental condition on the date their Dependent Life selection should become effective (because Dependent Life coverage is added or there is an increase in the level of Dependent Life), the effective date will be the date the spouse or child is discharged or no longer confined. To be confined elsewhere means the spouse or child is unable to perform the normal functions of daily living or is unable to leave home without assistance.

If MetLife denies coverage, refer to the Optional Life Insurance denial information on this page.

Dependent Life-Child

- If there is only one child on coverage, terminate the coverage in EBS.
- Other changes **must** be made on an NOE, dated and signed by the subscriber and the benefits administrator. *Exception:* Newborns are automatically covered for 31 days from live birth. To continue coverage, add the newborn via EBS within 31 days or

submit a Request for Review in EBS if it's after the 31-day window.

- Coverage can be canceled upon request, effective the first of the month after the request is made (or up to 12 months retroactively if dropping the last eligible child due to death or if the system terminates the last eligible child).
- No death claims will be paid without certification of student status or incapacitation for dependent children ages 19-24.
- Coverage may be added throughout the year, effective the first of the month after the request. *Exception:* Legal custody/guardianship is not considered a special eligibility situation for enrolling a child in Dependent Life-Child coverage or for the subscriber to enroll themselves or increase their Optional Life coverage. The child must be legally adopted or placed for adoption to make these changes.
- If the request is made within 31 days of birth or the date you acquired the child, coverage will become effective the date of the event.
- The Dependent Non-confinement Provision for spouses and children, explained in the *Insurance Benefits Guide*, will apply, *except for newborns*.

Supplemental Long Term Disability

Changes allowed throughout the year:

- Cancel coverage, effective the first of the month following the request.
- Increase the waiting period from 90 to 180 days, effective the first of the month following the request.
- Decrease the waiting period from 180 to 90 days, which requires medical evidence, effective the first of the month following approval.

- Add coverage if late entrant, which requires medical evidence, effective the first of the month following approval.

For late entrants, medical evidence must be submitted to Standard Insurance Company for review. If approved, a copy of the approval will be mailed to the employee and the employer. The approval letter from The Standard must be attached to the NOE and submitted to PEBA.

MoneyPlus

Flexible spending accounts

Medical Spending and Dependent Care Spending accounts can be changed during the year only if an approved change in status event occurs and the election change is consistent with the event.

Health Savings Accounts (HSAs)

Pretax contribution changes to HSAs must be made on a prospective basis. **Employees cannot make retroactive changes and cannot elect an annual contribution amount less than their year-to-date contributions.**

Contributions can be started at any time and stopped or changed monthly. Changes become effective the first of the month following the change.

To change an HSA contribution, active employees must complete a paper *Notice of Election* form. Mark *Contribution Amount Change* and the new plan year total amount in Box 27C. To stop HSA contributions, enter \$0.

- As the employer, when you sign and date the form, you are also certifying the employee's eligibility to continue contributing to an HSA.
- Each employer's payroll center may specify when the enrollment form must be received to allow enough time to change the payroll withholding.

Employees may also contribute directly to their HSAs, through HSA Central, on an after-tax basis, according to IRS guidelines.

To close an HSA account with HSA Central:

1. The employee must stop contributing to their account. They must complete and submit a *Notice of Election* form, entering \$0 in Box 27C of the form to stop payroll deductions. Both the employee and benefits administrator must sign this form. Completing the NOE does not close the HSA at HSA Central.
2. To close the HSA with HSA Central, the employee must contact HSA Central.

Do not advise employees to leave their HSAs open with a \$0 balance. They should use the remaining funds and contact HSA Central to close the account. If the employee does not close their account with HSA Central, the monthly \$0.50 maintenance fee will continue. If there is money remaining in the HSA, the employee may continue to use the money for qualified medical expenses.

Beneficiary changes

Basic Life/Optional Life

Encourage subscribers to initiate a beneficiary designee change for Basic Life and/or Optional Life in MyBenefits. Share the [Designating Active Member Beneficiaries](#) flyer.

If the subscriber requests assistance, submit a change in EBS. See the **Using the online system** chapter for more information.

Select Beneficiary as the Reason for Change. Complete the change and apply to MyBenefits or Current EBS.

The effective date will be the subscriber's electronic (MyBenefits) or printed (Current EBS) signature date on the requested change.

Open enrollment for active subscribers

During the October open enrollment period, eligible employees may change their coverage without having to have a special eligibility situation. Changes become effective the following January 1.

- Employees may enroll themselves, enroll or add their eligible spouse and/or their eligible child(ren) in health insurance.
- Employees may cancel health coverage or drop their spouse and/or child(ren) from health coverage.
- Employees may change from one health plan to another.
- Employees may enroll in or drop State Vision Plan coverage for themselves, their eligible spouse and/or their eligible child(ren).
- Employees may enroll or reenroll in MoneyPlus features as follows:
 - Employees remain on the MoneyPlus Pretax Group Insurance Premium feature and do not need to reenroll.
 - Permanent full-time employees must reenroll in the MoneyPlus Medical Spending Account and/or Dependent Care Spending Account each year.
 - Medical Spending Account participants receive the debit card at no charge. Note that a new card is not sent to the participant each year; the card is valid for five years.
 - Employees participating in the MoneyPlus Pretax Premium feature may elect, make changes or cancel Optional Life. Medical evidence may be required. This does not affect the employee's eligibility to participate in an MSA or a DCSA.
- Employees do not need to reenroll in the Health Savings Account each year if they want to continue contributing the same amount. If they want to change the amount

they contribute during open enrollment, they can indicate a new amount in MyBenefits. If they want to stop contributions or are no longer eligible to contribute, enter \$0.

- Employees enrolling in an HSA and who currently have a full, not Limited-use Medical Spending Account can begin contributing to their HSA on January 1, if the MSA has a zero balance as of the last day of the previous plan year (December 31). ASIFlex will automatically convert any carryover funds in an MSA to a Limited-use MSA for employees who enrolled in the Savings Plan or an HSA.
- Changes to other benefits may be made as announced.

Dental coverage

- Employees may enroll in, cancel or add or drop spouse and/or child(ren) from Dental Plus or Basic Dental only during open enrollment of **odd-numbered years**.

Open enrollment procedures and helpful hints

You do not have to wait until October 1 to begin enrollment. You may begin early if you want.

- PEBA will make enrollment materials available as early as possible and will notify you through *PEBA Update* as they are printed and/or posted on the PEBA website. Be sure that NOEs and MyBenefits are ready before you tell your employees to start making their enrollment changes.
- Make the *Insurance Summary* available and distribute printed copies of federally mandated notices to insurance-eligible employees prior to open enrollment.

Encourage employees to use MyBenefits to initiate any open enrollment changes and upload supporting documentation.

After October 31, the employee's open enrollment decision is final; they do not have 31 days to change their mind.

When making coverage changes on dependents, any spouse or child(ren) to be added or deleted must be listed. Social Security numbers and dates of birth are required.

If using a paper *Notice of Election*, **only** the requested changes need to be marked. If anything else is marked, be sure it is marked correctly to avoid unnecessary rejections or unintended changes. Check the box Enrollment under TYPE OF CHANGE in the Administrative Information section.

- If more than one NOE is submitted, PEBA will process the NOE with the latest signature date as the final, enrollment NOE.
- NOEs must be signed by October 31.
- Upload any required documentation to EBS or staple it to the NOE.
- Do not hold enrollment NOEs. Send them to PEBA as they are completed.

All open enrollment transactions must be received by PEBA by November 15; there are no exceptions.

If there is also a change of address, complete a universal [Name/Address Change Form](#) and submit it to PEBA immediately.

New employees or transfers hired October 2-December 31

New employees

New employees should complete new hire enrollments through MyBenefits. Keep in mind that a flexible spending account election will be effective only through December 31, and the total contributions should be remitted to ASIFlex across the remaining pay periods in the plan year. If the employee wants to elect a flexible spending account for the following plan year, they must submit a

Notice of Election (NOE) indicating “New hire – OE” with an effective date of January 1.

Transfers

Employees who transfer from one participating employer to another with no break in coverage must make their open enrollment elections with the previous employer in October.

- The subscriber must advise the new employer of their open enrollment elections at the time of the transfer.
- The employee will need to complete a new hire NOE, change reason: Transfer, showing the current coverages with the new employer. The employee will also need to complete an NOE showing the open enrollment changes with the new employer. The employee and benefits administrator must sign, and the NOEs must be sent to PEBA.

Unpaid leave or reduction in hours

General leave policies

PEBA does not dictate the employment status of an employee, only the coverage available to the employee through PEBA’s programs. **While on paid leave, an employee’s eligibility for benefits continues, and the employer’s share of any premiums during the paid leave must be paid.**

This section describes how eligibility for insurance benefits is affected when an employee goes on an employer-approved leave of absence not associated with military leave or FMLA. See the Quick reference for unpaid leave or reduction in hours on Page 230 for more information.

Employees with unpaid leave or reduction of hours

Ongoing employees

Any employee employed during the Standard Measurement Period (October 4-October 3) is an

ongoing employee. Eligibility for benefits is based on the number of hours the employee worked during the Standard Measurement Period.

If the employee averaged 30 hours per week during the Standard Measurement Period, they are in a Stability Period, and a reduction in hours (even to zero) does not make the employee ineligible for benefits. As long as the employee remains employed with the employer, their eligibility for benefits continues for the remainder of the stability period.

Provide the employee with the [Your Insurance Benefits When Your Hours are Reduced](#) form, which is under Insurance Benefits/Forms/Affordable Care Act (ACA). The employee’s benefits will continue, and the employee cannot cancel coverage unless one of the following occurs:

- The employee experiences a special eligibility situation, such as a gain of other coverage. In this case, submit an NOE or SOC with the supporting documentation.
- The employee intends to enroll in coverage through the Health Insurance Marketplace. In this case, submit the termination. All active terminations should be submitted using EBS, except for those who are on military leave. For the termination reason, choose Reduction of hours. Because the employee is voluntarily terminating coverage, neither the employee nor their covered dependents are eligible for COBRA. The employee is also not eligible to be covered as a dependent spouse since they are eligible for benefits as an active employee. Once the employee cancels their active coverage, the employee may not reenroll in benefits until the next open enrollment period, if eligible, or within 31 days of a special eligibility situation.

If the employee did not average 30 hours per week during the Standard Measurement Period, they are not in a Stability Period, and a reduction in hours of

less than 30 per week makes the employee ineligible for benefits.

Provide the employee with the [Your Insurance Benefits When Your Hours are Reduced](#) form.

Because the employee's hours have been reduced, the employee is no longer employed in a benefits-eligible position. Eligibility for benefits ends the first of the month following the reduction in hours. Provide the employee with the 18-month COBRA Notice and, if enrolled in life insurance, they will receive a conversion packet from MetLife.

All active terminations should be submitted using EBS, except for those who are on military leave. For the termination reason, choose Left Employment. If submitting an [Active Termination form](#), check the T5 box, Not Eligible (Not in a Stability Period).

New full-time Employees (Not Employed for the Standard Measurement Period)

These employees are not in a Stability Period. A reduction in hours of less than 30 per week makes the employee ineligible for benefits.

Provide the employee with the [Your Insurance Benefits When Your Hours are Reduced](#) form.

Because the employee's hours have been reduced, the employee is no longer employed in a benefits-eligible position. Eligibility for benefits ends the first of the month following the reduction in hours. Provide the employee with the 18-month COBRA Notice and, if enrolled in life insurance, they will receive a conversion packet from MetLife.

All active terminations should be submitted using EBS, except for those who are on military leave. For the termination reason, choose Left Employment. If submitting an [Active Termination Form](#), check the T5 box, Not Eligible (Not in a Stability Period).

Variable-Hour, Part-time, or Seasonal Employees (Within an Initial Stability Period)

If the employee averaged 30 hours per week during their Initial Measurement Period, they are in their Initial Stability Period, and a reduction in hours

(even to zero) does not make the employee ineligible for benefits. As long as the employee remains employed with their employer, the employee remains eligible for benefits through the end of their Initial Stability Period.

Provide the employee with the [Your Insurance Benefits When Your Hours are Reduced](#) form. The employee's benefits will continue, and the employee cannot cancel coverage unless one of the following occurs:

- The employee experiences a special eligibility situation, such as a gain of other coverage. In this case, submit an NOE or SOC with the supporting documentation.
- The employee intends to enroll in coverage through the Health Insurance Marketplace. In this case, submit the termination. All active terminations should be submitted using EBS, except for those who are on military leave. For the termination reason, choose Reduction of hours. Because the employee is voluntarily terminating coverage, neither the employee nor their covered dependents are eligible for COBRA. The employee is also not eligible to be covered as a dependent spouse since they are eligible for benefits as an active employee. Once the employee cancels their active coverage, the employee may not reenroll in benefits until the next open enrollment period, if eligible, or within 31 days of a special eligibility situation.

Once the employee's Initial Stability Period ends, they become an ongoing employee, and continued eligibility should be based on their hours worked during the Standard Measurement Period (October 4-October 3). Refer to the Ongoing employees section on Page 62.

Premiums while on unpaid leave

Only employees who are within a stability period or employees who are absent from work due to FMLA or military leave may continue their coverage with their employer when their hours are reduced below

30 per week. All other employees lose eligibility for benefits when their hours are reduced below 30 hours per week, and these employees should be offered COBRA continuation coverage.

All active terminations should be submitted using EBS, except for those who are on military leave. For the termination reason, choose Left Employment. If submitting an [Active Termination Form](#), check the T5 box, Not Eligible (Not in a Stability Period).

Eligible employees are responsible for paying only the employee's share of the premium while on unpaid leave. All premiums should be paid to the employer by the first of the month. If an employee fails to pay their employer by the first of the month, the employer can cancel their coverage due to nonpayment by submitting an [Active Termination Form](#).

If an employer fails to submit an [Active Termination Form](#) to terminate coverage due to Nonpayment (TN) within the month payment is due, coverage will be terminated the first of the month after the request.

There is a 31-day grace period for employees to make payment and have coverage reinstated. If the employee makes payment before the end of the grace period, submit a Reinstatement in EBS to request the employee's coverage be reactivated, because the employee submitted payment within the payment grace period. Coverage will be reinstated retroactively to the termination date.

Cancellation due to nonpayment is not a COBRA qualifying event. No COBRA notice should be sent to the employee or their covered dependents. The employee may not reenroll in benefits until the next open enrollment period, if eligible, or within 31 days of a special eligibility situation. **Note: Returning to work is not a special eligibility situation that allows an employee to reenroll in benefits.**

SLTD and life insurance benefits while on unpaid leave

- SLTD benefits will end 31 days after the last day worked. Submit the termination via the [Active Termination Form](#).
- Life Insurance benefits end 12 months after the last day worked. Submit the termination via the [Active Termination Form](#).

Continuing MoneyPlus while on unpaid leave

If the employee remains eligible for benefits, and they decide to continue their MoneyPlus contributions to their spending accounts, they can continue only until the end of the calendar year in which they begin unpaid leave. There are three ways to manage an employee's spending account elections during unpaid leave:

1. **Prepay.** The employee can prepay their contributions on a pretax basis.
2. **Pay-as-you-go.** The employee can pay with after-tax and/or pretax dollars (to the extent the employee receives compensation during leave).
 - Collect the contributions from the employee and include the money with the deposit covering the active employee contributions for any given payroll period.
 - The employer must send payroll funding and participant remittances to ASIFlex via ACH or mail to P.O. Box 6044, Columbia, MO 65205-6044
3. **Catch-up.** The employee and the employer agree that the employer pays the contribution on the employee's behalf during leave, and the employee repays the employer upon return. Provisions for catch-up are between the employer and the employee. This must be decided prior to leave. PEBA assumes no liability for this option.

If the employee remains eligible for benefits, and they decide not to continue their MoneyPlus contributions:

- Notify ASIFlex via the employer portal that the person is on unpaid leave and will not be continuing their contributions.
- Notify ASIFlex via the employer portal when the person returns from leave if their contributions will resume.

If the employee's unpaid leave makes them ineligible for benefits, refer to Page 78 regarding the procedures for terminating participation in MoneyPlus accounts.

Continuing a Health Savings Account while on unpaid leave

If the employee remains eligible for benefits, and they decide to continue their HSA contributions, they can continue only until the end of the calendar year in which they begin unpaid leave. There are three ways to manage an employee's spending account elections during unpaid leave:

1. **Prepay.** The employee can prepay their contributions on a pretax basis.
2. **Pay-as-you-go.** The employee can pay with after-tax and/or pretax dollars (to the extent the employee receives compensation during leave).
 - Collect the contributions from the employee and include the money with the deposit covering the active employee contributions for any given payroll period.
 - The employer must send payroll funding and participant remittances to ASIFlex via ACH or mail to P.O. Box 6044, Columbia, MO 65205-6044.
 - Employees may also contribute directly to their HSAs through HSA Central on an after-tax basis. If they choose to do this, there is nothing for the employer to report.

If the employee remains eligible for benefits, and they decide not to continue their HSA contributions:

- Notify ASIFlex via the employer portal that the person is on unpaid leave and will not be continuing their contributions.
- Notify ASIFlex via the employer portal when the person returns from leave if their contributions will resume.

Military leave

The Uniformed Services Employment and Reemployment Rights Act (USERRA) requires employers to provide certain reemployment and benefits rights to employees who serve or have served in the uniformed services. The administration of military leave is based on the employer's policy and applicable laws. The general COBRA rules are modified to allow an employer to fulfill the requirements of USERRA when an employee takes military leave. Except as noted below, military leave should be administered as regular unpaid leave.

- If the employee chooses to continue coverage, the employer must continue to pay the employer share of the premiums for any period of paid military leave, and then continue to pay the employer portion as long as the employee is in a stability period.
- If the employee chooses to terminate coverage, submit the [Active Termination Form](#) and a copy of the military orders to PEBA when the employee begins military leave. An employee on military leave is eligible for a total of 36 months of COBRA continuation coverage. Provide the employee with the 36-month COBRA Notice and, if they are enrolled in life insurance, they will receive a conversion packet from MetLife.
- When the employee returns from military leave, the employee may reenroll in coverage within 31 days of returning to work.

- If the employee terminated coverage, and they return to work within 15 calendar days or do not experience a break in coverage, the employee may reenroll in the same benefits they were enrolled in prior to military leave.
- If the employee terminated coverage, and they return to work more than 15 calendar days later or they experience a break in coverage, the employee may make elections as a new employee.
- An employee returning from military leave may reinstate their life insurance at the same level they had prior to going on military leave without medical evidence, regardless of when they return to employment, as long as they are honorably discharged.
- SLTD coverage may also be reinstated without medical evidence.

If a special eligibility situation occurred while the employee was on military leave, and they did not continue their coverage through PEBA, they may add the newly eligible spouse and/or child(ren) when they return to work by providing documentation of the special eligibility situation.

Family and Medical Leave Act (FMLA)

The Family and Medical Leave Act of 1993 (FMLA) requires qualifying employers to provide job-protected leave, continuation of certain benefits and restoration of certain benefits upon return from leave for specific family and medical reasons. The administration of FMLA leave is based on the employer's policy and applicable laws. In most cases, the employee will not make changes to benefits and will return from FMLA leave, and no action will be required. However, if they do want to make changes during FMLA, the following rules allow an employer to fulfill the requirements of FMLA when an employee takes FMLA leave.

Under FMLA, eligible employees of qualifying employers are entitled to 12 work weeks of leave in a 12-month period for:

- Birth of a child and to care for the newborn;
- Placement of a child with the employee for adoption or foster care;
- Care for a family member (child, spouse or parent) with a serious health condition;
- Their own serious health condition; and
- Any qualifying exigency arising if the employee's spouse, son, daughter or parent is a covered military member on covered active duty.

Under FMLA, eligible employees of qualifying employers are entitled to 26 work weeks of leave in a 12-month period for an employee who is a spouse, son, daughter, parent or next of kin of a covered service member with a serious injury or illness to provide care for that service member.

The FMLA regulation 29 CFR section 825.209 Maintenance of Employee Benefits states: An employee may choose not to retain group health plan coverage during FMLA leave. However, when an employee returns from leave, the employee is entitled to be reinstated on the same terms as prior to taking the leave, including family or dependent coverages, without any qualifying period, physical examination, exclusion of preexisting conditions, etc. See §825.212(c).

During FMLA leave, an employee remains eligible for benefits even if their hours reduce below 30 hours per week and even if the employee is not in a stability period. No action is required by the employer when an employee goes on FMLA leave unless the employee chooses to cancel their coverage.

If the employee chooses to keep coverage during FMLA leave, the employer must pay the employer share of the premiums for any period of FMLA leave, regardless of whether the leave is paid or unpaid.

- The employer must provide the employee advance, written notice of the terms and conditions under which the employee premium payment must be made if the premiums are not being payroll deducted.
- **There is a 31-day grace period on premium payments.** If the employee fails to make a timely payment within 31 days, the employer may:
 - Pay the employee’s share of premium payments for the remainder of the leave period and recover the amount from the employee when the employee returns to work. PEBA assumes no liability for this option.
 - Cancel the employee’s coverage. The employer must give the employee written notice at least 15 days before coverage would end. PEBA will refund a maximum of 31 days retroactive of premiums.
 - To terminate the coverage, submit an [Active Termination Form](#) marked Nonpayment (TN). If the employee returns to work before FMLA leave is exhausted, the employee may reinstate coverage the first of the month following their return to work. Write on the top of the NOE, Employee returning from FMLA.

If the employee fails to return to work after exhausting FMLA leave, the employer may make the following benefits decisions.

- The employer may allow the employee to continue employment.
- If the employee is on paid leave, benefits continue, and no action is required.
- If the employee is on unpaid leave, refer to the Unpaid leave section beginning on Page 62 to determine if the employee is eligible to continue benefits based on their status (ongoing employee, new full-time, new variable-hour, etc.).
- The employer may terminate employment.
- The employer offers the employee and their covered dependents 18 months of COBRA

continuation coverage due to a reduction in hours. The date of the COBRA qualifying event should be listed as the last day of FMLA leave. Even if the employee canceled coverage during FMLA leave, COBRA continuation coverage should be offered at the end of FMLA leave if the employee does not return to work after exhausting FMLA leave.

- See Transfers and terminations (Page 69) and COBRA subscribers (Page 80) for additional procedures.

If the employee chooses to terminate coverage during FMLA leave:

- Submit an NOE to PEBA refusing all coverage. List change reason as Employee on FMLA.
- Upon return from FMLA leave, most employees are restored to their original or equivalent positions with equivalent pay, benefits and other employment terms.
- If the employee returns before FMLA leave is exhausted, the employee’s coverage should be reinstated on the same terms and conditions without any qualifying period or medical evidence.
- The request to reinstate coverage must be made within 31 days of returning to work.
- Write on top of the NOE, Employee returning from FMLA.
- If the employee does not return to work at the end of FMLA leave, send the employee and their covered dependents the 18-month COBRA Notice. List the date of the COBRA qualifying event as the last day of FMLA leave.

Workers’ compensation

Workers’ compensation is not administered as unpaid leave. An employee on approved leave because of disability approved by the Office of Workers’ Compensation Programs **is considered to be drawing a salary from the state.**

- All coverage must continue as before during the benefit period unless a change in status/special eligibility situation occurs. Documentation might be required.
- The employee pays the employee's share of premiums to the employer's payroll office.
- The employer pays the employer portion of premiums.
- If the employee has stopped making payments for their share of the premiums, the employer may continue the coverage and request repayment of the employee's share once they return to work.
- If the employer does not wish to continue the employee's coverage because they have stopped paying their share of the premiums, consult with your legal counsel before terminating the employee's coverage.
- To terminate the coverage, submit an [Active Termination Form](#) marked Nonpayment (TN). The employee may reinstate coverage within 31 days of their return to work. Otherwise, they may enroll within 31 days of a special eligibility situation or during open enrollment.

Affordable Care Act reporting requirements

Employers who participate in the State Health Plan have certain requirements under the Affordable Care Act (ACA). Employers must provide subscribers with proof of health coverage by issuing forms to subscribers. Each year, the IRS determines the date by which employers must send the forms to subscribers.

Employers with fewer than 50 employees

- Issue IRS Form 1095-B to any active employees enrolled in health coverage at any time during the previous calendar year.

Employers with 50 or more employees

- Issue IRS Form 1095-C to any employees who were eligible for health coverage at any time during the previous calendar year.

All employers except members of the State Applicable Large Employer (ALE) group

- Issue IRS Form 1095-B to any non-Medicare retirees or COBRA subscribers enrolled in health coverage at any time during the previous calendar year.

PEBA issues Form 1095-B to any non-Medicare retirees or COBRA subscribers for members of the State ALE group. PEBA also issues Form 1095-B for employers who can designate PEBA as its Designated Governmental Entity (DGE).

Only an employer required by statute to participate in the State Health Plan (Governmental Employer) may elect to designate the S.C. Public Employee Benefit Authority (PEBA) as its designated governmental unit. To do so, the employer must complete and submit the DGE form. Optional employers are unable to designate PEBA as their DGE.

Employers must also submit Forms 1094-B or 1094-C to the IRS. Each year, the IRS determines the date by which these forms should be submitted.

To assist employers with their reporting requirements, PEBA will post a file to EBS each year containing information about employees and dependents who were enrolled in health coverage at any time during the previous calendar year. See the **EBS reports** chapter for more information about the 1095 reports.

For additional information, email PEBA Customer Service or Denise Hunter at dhunter@peba.sc.gov.

The image features a white background with two prominent blue geometric shapes. On the left, a horizontal blue bar extends from the left edge towards the center, ending in a diagonal cut. To its right, a larger, dark blue shape starts from the right edge and extends upwards and to the left, meeting the diagonal cut of the first bar. The text 'Transfers and terminations' is positioned on the left bar.

Transfers and terminations

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Assisting a transferring employee

For PEBA's insurance purposes, a **transfer** is defined as an active employee who moves from one participating employer (losing employer) to another participating employer (gaining employer) with no break in benefits or with no more than a 15-calendar-day break in employment.

An **academic employee**, who completes a school term and moves to another academic setting at the beginning of the next school term, is also considered a transfer, not a new hire. Coverage remains in effect until the start of the new term.

Generally, when they transfer, an employee will remain enrolled in the same insurance benefits. Contact PEBA for coverage information.

Transferring out (losing employer)

Once the employee notifies you of their intention to transfer to another participating employer without a 15-day break in employment or with no break in insurance coverage, submit the transfer to PEBA.

Enter the transfer as a termination in EBS. Select *Transfer* from the *Reason for Termination* drop-down list. Enter the Transfer Group ID and dates. EBS provides an *Employer Group ID Help* feature.

If the employee is on the payroll on the first day of the month, then the employee is covered by the transferring agency until the last day of the month. *Example:* Employee's date of termination from employment is May 1; employee's insurance will transfer effective June 1.

Once the transfer is applied, a *Summary of Termination* (SOT) can be saved or printed for your records. Do not mail the document to PEBA.

If the transfer cannot be completed in EBS, or a correction needs to be made after the transaction in EBS, submit an [Active Termination Form](#) with Transfer (TT) as the termination reason. Include the gaining employer name and ID number. Allow additional time for processing of paper forms.

PEBA will produce an active benefits transfer form for the new employer. The form lists an employee's benefits and their covered spouse and/or child(ren). The employee may change their address, telephone number, Basic Life and Optional Life beneficiaries on the form, if necessary.

The gaining employer does not have to wait until receipt of the transfer form to complete the enrollment in EBS.

COBRA applies to transfers

COBRA notification for continuation of health, dental and vision coverage must be sent to transferring employees, their covered spouses and covered dependent child(ren).

When an employee transfers, COBRA notification is not required for MoneyPlus accounts, but you may send notification. PEBA will notify the MoneyPlus administrator of any transferring employee who has a MoneyPlus account.

Academic transfers

Employees of public school districts, charter schools and public higher education institutions are considered academic employees and are subject to the termination and transfer rules below.

These rules apply, regardless of when you receive the resignation.

- Academic employees, who complete a school term and move to another participating academic employer, are considered academic transfers.
- The losing academic employer must continue to cover academic transfer employees until the start of the academic transfer's new school term, pay the employer share of premiums, collect premiums from the employee and terminate coverage at the beginning of the gaining employer's new school term to avoid a break in coverage.
- Exceptions may be made for academic positions that begin employment prior to the start of the new school term, such as,

but not limited to, coaches, principals and superintendents. If you use an NOE, be sure to write the employee's position at the top of the NOE so PEBA staff will know this is an exception.

- If *not* transferring or if working for the summer:
 - Academic employees who are leaving employment and do not plan to transfer to another academic setting will be terminated from coverage effective the first of the month following the date of termination from employment. If an academic employee terminated employment after the school term ends but returns to an academic setting when the new school term begins, they are still considered a transfer. The employee must pay the back premiums to their losing employer to avoid a break in coverage.
- If the academic employee was planning to return to an academic setting for the new school term, **but decided to retire retroactively**, coverage will be terminated effective the first of the month following the date of termination from employment. If the employee is eligible for retiree coverage but has missed the 31-day window to enroll, they should contact PEBA.
- Academic employees who work after the school term ends but before the new school term begins **and are not transferring to another academic setting for the new school term** will be terminated from coverage effective the first of the month following the date of termination from employment.
- The academic employer determines the eligibility status by contract with each employee and position. Working between school terms may or may not be considered permanent, full-time employment.

- The termination from coverage effective date from the losing academic employer will coincide with the effective date of the gaining academic employer, **reflecting no break in coverage**.
- Academic employees who are retiring effective July 1 should be terminated from active coverage effective July 1.

Permanent, part-time teacher transfers

A permanent, part-time teacher, who transfers from one academic employer to another with no more than a 15-calendar-day break in employment or with no break in coverage, should be considered a transfer and must keep the same coverage. The health and/or dental premium may change if the number of contract hours places the teacher in a different category. They may make changes based on the increase or decrease in hours as explained in the Active Subscribers section of this manual.

Change in status during the transfer

If a change in status or special eligibility situation occurs, and:

- The effective date of the change in status event falls before the effective date of the employee's transfer, the employee must contact the losing employer to complete an NOE for the change. Forward the completed NOE, along with any required documentation, to PEBA. PEBA will send a new transfer form to the gaining employer.
- If the effective date of the change in status falls on or after the effective date of the employee's transfer, the employee must contact their new employer to complete an NOE for the change. Coverage changes or add/drop a spouse and/or child(ren) cannot be completed as part of the transfer.

Transferring in (gaining employer)

Confirm the employee is a transfer from another participating employer:

- You may have received a transfer form from PEBA if the losing employer completed the termination in a timely manner; or
- The employee may give you a copy of their termination and/or creditable coverage letter. PEBA can provide *Certificates of Creditable Coverage* upon request.

You do not have to wait until you receive the transfer form to enter the transferring employee into EBS.

Contact PEBA if you have any questions about the status and eligibility of the transferring employee.

If you have questions about the transferring employee's MoneyPlus status, verification of contribution amounts can be found on the HIS763NP report in EBS. You can also contact ASIFlex.

Be sure the transferring employee is offered the same orientation given to new employees with your group and review the COBRA regulations.

Documentation, such as proof of dependent eligibility, court orders and incapacitated child certification, is **not** needed if previously established.

The effective date of the gaining employer should coincide with the termination from coverage effective date from the losing employer, reflecting no break in coverage. If the employee is on the payroll on the first day of the month, then the employee is covered by the losing employer until the last day of the month.

If the effective date of coverage loss under the losing employer is before the hire date for the gaining employer, but within 15 days, the employee's date of hire should be entered in EBS as the effective date of coverage loss under the losing employer.

Academic transfers

The termination from coverage effective date from the losing academic employer should coincide with the effective date of coverage of the gaining

academic employer, **reflecting no break in coverage.**

They must be enrolled in the same coverage they had previously. Contact PEBA for coverage information.

Their previous employer must:

- Pay the employer share for their coverage, retroactively, for the summer to avoid a break in service, unless the employee works in a position that is an exception as explained on Page 71.
- Collect the employee share of coverage, retroactively, from the employee and include it with the employer payment.

Enrolling the transferring employee through EBS

When you receive an active benefits transfer form from PEBA, complete the transfer in EBS by initiating an enrollment. You do not have to wait until the transfer form is received to enter the transferring employee into EBS.

Have the employee review the transfer form and make any necessary and/or allowed changes. The employee's information and coverage levels will be prepopulated in EBS. A spouse and/or child(ren) may not be added to, or deleted from, any benefit, unless a qualifying change in status has occurred.

Apply the transaction to MyBenefits for the employee to electronically approve and sign or Current EBS for a signature page to be signed by the employee. The transfer form can also be uploaded and submitted with the signed signature page. Refer to Page 20 for more information.

Active benefits transfer form

The active benefits transfer form lists the employee's benefits and their covered spouse and/or child(ren). The employee may change their address, telephone number, Basic Life and Optional Life beneficiaries on the form, if necessary. Coverage and dependent changes are not allowed.

If the transfer is not completed in EBS with an enrollment transaction, complete the transfer form and return it to PEBA. Allow additional time for processing of paper forms.

Note the following about section A:

- **Effective Date:** Should reflect no break in coverage between employers. Verify there was no more than a 15-calendar-day break in employment or no break in insurance coverage to confirm the transfer status.
- **Annual Salary:** List the annual contract salary. Do not include any additional pay other than the contract salary. Groups affected by furloughs should use the non-furlough salary. This salary will be used to calculate the SLTD premium if the transfer has SLTD coverage.
- **Employment Date:** First day physically at work.
- **Pay Periods:** Number of annual pay periods.
- **Pretax (MoneyPlus):** Y, N or Blank. You might need to confirm this with PEBA or the previous employer.

Mailing address, email address or telephone number changes are allowed. The employee should mark a single line through any information that needs to be updated and legibly print the new information.

Coverage through Medicare or another policy for a subscriber, spouse or child is included, if applicable.

Coverage and levels are included in the Coverage section. The employee may make limited changes to their life and SLTD coverage by completing an NOE. See Using an NOE instead of EBS on Page 75.

The spouse and/or child(ren) on file at the time of the transfer from the previous employer is included. The benefits under which each spouse or child is covered is indicated with an X beside the spouse or child's name.

The employee may correct any spelling of names, dates of birth, SSNs (copy of card required if not a

keying error by PEBA) or add any missing information by submitting an NOE.

A spouse and/or child(ren) may not be added to, or deleted from, any benefit, unless a qualifying change in status has occurred. *Exception:* Dependent Life coverage may be added or dropped throughout the year.

The beneficiaries are listed as reflected in PEBA's records. **Changes are allowed in this section.** If the employee wants to make a beneficiary change:

- They should mark through the beneficiary including the asterisk (*), initial the mark-through, and write or type in the new beneficiary, including all necessary information, on the first available line.
- They must indicate the benefit (Basic Life, Optional Life) with an asterisk (*) in the space under the benefit.
- If enough space is not available to list the new beneficiaries, they should write SEE ATTACHMENT and staple the attachment to the transfer form.
- If more than one beneficiary is designated, they must indicate the appropriate percentages and whether each beneficiary is primary or contingent.

If the employee has health coverage, a beneficiary for Basic Life must be indicated. If this field is blank, the employee must add a Basic Life beneficiary.

The employee and benefits administrator must sign and date the form. Make a copy for your files and the subscriber. Return the original to PEBA for processing.

Change in status during transfer

If a change in status or special eligibility situation occurs, and:

- The effective date of the change in status event falls before the effective date of the employee's transfer, the employee must contact the losing employer to complete an NOE for the change. That employer must

send the completed NOE, along with any required documentation, to PEBA. PEBA will send a new transfer form to the gaining employer.

- If the effective date of the change in status event falls on or after the effective date of the employee's transfer, the employee must contact their new employer to complete an NOE for the change. Coverage changes or add/drop a spouse and/or child(ren) cannot be completed as part of the transfer.

Using an NOE instead of EBS

Use a *Notice of Election* (NOE) only when:

- The losing employer has not terminated the transferring employee. If NOE is received before the employee is transferred, it will be rejected.
- A change in status or special eligibility situation has occurred. If you have an active benefits transfer form, attach the NOE and any required documentation and send to PEBA for processing. See Change in status during transfer on Page 74.

If using an NOE, it must be completed in its entirety.

- Check Transfer at the top of the NOE.
- Contact PEBA to obtain levels of coverage.
- Remember to attach any required documentation.

Transfers — new employer created or lateral transfer

New employer created by interdepartmental transfers or lateral transfers from one employer to another (restructuring).

Employer ID numbers will change on all files (PEBA insurance benefits, PEBA retirement benefits and all plan administrators) for employees of new employer groups created by interdepartmental or agency reorganizations.

The same policies and procedures govern employees who are laterally transferred from one employer to another.

Each employee's coverage will be terminated from the old employer and added to the new employer, with no break in coverage and with the same coverage.

Other coverage changes are permitted only if a special eligibility situation occurs. Documentation might be required.

Old employer procedures (losing employer)

Before the effective date of the transfer:

- Resolve all rejections for any employees being transferred.
- Process and send to PEBA any eligible changes in status for applicable benefits and coverage or Optional Life changes occurring before the effective date of transfer.
- The employees' names, SSNs, old employer ID number and new employer ID number with effective date of transfer must be sent to PEBA.
- Give all benefits documentation, including COBRA notification letters, to the new employer at the time of transfer.

New employer procedures (gaining employer)

Before the effective date of the transfer:

- Send letter of notification to PEBA with the following information:
 - Departing employer and ID number;
 - New employer and ID number;
 - Effective date of change; and
 - SSN and name of each employee being transferred.
- Send a copy of the notification letter to the losing employer.
- Place a copy of the notification letter in each employee's file.

The new employer must process any eligible family status changes that occur after the effective date of transfer.

Transfers — dual employment

Employee working for two participating employers

If an employee is working for two participating employers, they are considered working for one employer or the other for insurance purposes. They cannot be considered working for both employers.

The employee **cannot** have their insurance coverage and premiums split between the two employers, nor can they combine their two salaries for Optional Life/Dependent Life insurance purposes.

If an employee starts working for a second participating employer and wants their insurance coverage to be with the new employer, they are considered a transfer. They have 31 days to have their transfer processed. If the 31-day window is missed, their coverage remains with the first employer.

The standard procedures for transferring the employee apply, including the procedures for transferring out, transferring in and COBRA notification as explained earlier in this section.

Terminations

General rules for terminating active employees

Submit terminations in EBS immediately. Enter these dates in EBS:

- The *date of termination* from employment is the date the employee is formally terminated from employment. The employee is no longer earning wages; however, a final paycheck may be issued at a later date;
- The *last day of earned compensation* is the last day the employee earned compensation. It must be the same as or

prior to the employee's date of termination from employment. It cannot be later than the date of termination from employment;

- The *date of final paycheck* (optional) is the date of the employee's last paycheck; and
- The date of death, when applicable.
- The *last attendance date*, when applicable, is the last day the employee met the Actively at Work requirement. Actively at Work is defined in the *Insurance Benefits Guide* and referenced in this manual.

All changes in employment or special eligibility situations resulting in a termination of coverage must be processed within 31 days.

If submitting a termination outside of the 31 days, complete and send an [Active Termination Form](#). Mark only one reason for termination.

Retroactive terminations

Maximum 31 days retroactive (to be calculated from the date received by PEBA)

Terminations can be no more than 31 days retroactive. *Exception:* If PEBA receives an [Active Termination Form](#) more than 31 days retroactive, it will be accepted and processed only if it is accompanied by an NOE (such as a COBRA NOE or Retiree NOE) showing the subscriber is continuing coverage, and with no break in their coverage.

If a termination is received **more than 31 days** from the date of loss of eligibility, PEBA will cancel coverage the first of the month after the date of receipt.

During December, retroactive terminations should be submitted on an [Active Termination Form](#), rather than through EBS, if the subscriber makes a change with an effective date of January 1.

Academic employees

If not transferring or if working during the summer:

- Academic employees who are leaving employment and do not plan to transfer to another academic setting will be

terminated from coverage, effective the first of the month following the date of termination from employment.

- If an academic employee terminated employment at the start of summer but returns to an academic setting in the fall, they are still considered a transfer. The employee must pay the back premiums for the summer months to their losing employer to avoid a break in coverage.
- Academic employees who work during the summer session, **but who are not transferring to another academic setting in the fall**, will be terminated from coverage effective the first of the month following the date of termination from employment.
- The academic employer determines the eligibility status by contract with each employee and position. The summer session may or may not be considered permanent, full-time employment.
- Academic employees who are retiring effective July 1 should be terminated from active coverage effective July 1.
- You must refund overpaid premiums if the premiums are deducted on a prorated scale to cover the summer months. Advance deduction of premiums does not constitute continuous coverage.

COBRA notification required

If an employee's coverage is terminated due to leaving employment, a reduction in hours, or service or disability retirement, notify the employee and dependents, if applicable, of continuation of coverage as a COBRA participant. Refer to the **COBRA** chapter for information on COBRA notification procedures.

Termination due to unpaid leave or a reduction in hours

Refer to the **Active subscribers** chapter.

Termination due to nonpayment of premiums

Coverage is terminated effective the first of the month *following the last month in which premiums were due and paid in full*.

If an employee fails to pay their premiums, submit an [Active Termination Form](#) to PEBA as soon as possible. Mark the reason for termination as Nonpayment (TN).

If a termination is received more than 31 days from the date of loss of eligibility, PEBA will cancel coverage the first of the month after the date of receipt.

If coverage was terminated due to an administrative error, or because the employee subsequently paid the employer within the 31-day grace period, complete a Reinstatement (Reinstate) in EBS. Otherwise, the employee and any eligible spouse and/or child(ren) must wait until the next open enrollment period or until a special eligibility situation occurs and enroll as late entrants.

Optional employers should complete the appropriate NOE to terminate coverage for retiree, COBRA and survivor subscribers.

If the subscriber is terminated due to nonpayment of premiums, do not send COBRA notification letters, since COBRA does not apply.

If the employee returns to work after coverage has been terminated, reinstatement of coverage must be requested within 31 days of returning to work. Otherwise, the employee and any eligible spouse and/or child(ren) must wait until the next open enrollment period or until a special eligibility situation occurs and enroll as late entrants.

Other termination information

Life insurance

If terminating employment, the employee may convert their Basic Life, Optional Life, Dependent

Life-Spouse and/or Dependent Life-Child coverage to an individual whole life policy. To convert Basic Life, Optional Life, Dependent Life-Spouse and/or Dependent Life-Child coverage to an individual policy at termination of employment, the election must be made within 31 days of the date coverage would otherwise terminate.

MetLife will mail terminated employees a conversion packet via U.S. mail three to five business days after MetLife receives the eligibility file from PEBA; therefore, it is important to submit terminations in EBS in a timely manner. To convert coverage, an employee must follow the instructions in the packet from MetLife. Coverage must be converted within 31 days the date of coverage is lost. It is the employee's responsibility to contact MetLife regarding conversion.

Long term disability

Basic Long Term Disability cannot be continued or converted to an individual policy at termination.

Supplemental Long Term Disability (SLTD) may be converted within 31 days of termination if:

- The individual has had SLTD coverage for at least one year;
- The individual is not disabled; and
- The individual is not a retiree.

A [Request for Long Term Disability Conversion Materials](#) form is available on PEBA's website.

MoneyPlus

Medical Spending Account (MSA) A terminated participant has through the plan year to submit expenses incurred before the first of the month following the last day worked unless they are continuing participation on an after-tax basis through COBRA.

If continuing an MSA through COBRA, the debit card will be canceled as of the date of termination from employment submitted to PEBA.

If the termination is due to the death of the employee, their eligible spouse and/or child(ren)

may elect to continue the MSA through the end of the plan year. In this case, eligible spouse and/or child(ren) means IRS-qualified tax dependents as defined in IRS Publication 502. Otherwise, the spouse and/or child(ren) have through the run-out period to submit any eligible claims incurred through the employee's date of death.

If an employee returns to employment with an employer who participates in PEBA-administered insurance within 30 days, their original MSA elections will automatically be reinstated. If an employee returns to employment with an employer who participates in PEBA-administered insurance after 30 days, they cannot participate in an MSA for the remainder of the plan year. The employee can, however, reenroll during open enrollment for the next plan year. If an employee returns to employment with an employer who participates in PEBA-administered insurance but did not participate in a MoneyPlus spending account while employed with their previous employer, they may elect to contribute to a MoneyPlus spending account and make an election as a new hire.

Dependent Care Spending Account A terminated participant has until the end of the year or until the account is exhausted, whichever occurs first, to submit expenses.

If an employee returns to employment with an employer who participates in PEBA-administered insurance within 30 days, their original DCSA elections will automatically be reinstated. If an employee returns to employment with an employer who participates in PEBA-administered insurance after 30 days, they cannot participate in a DCSA for the remainder of the plan year. The employee can, however, reenroll during open enrollment for the next plan year. If an employee returns to employment with an employer who participates in PEBA-administered insurance but did not participate in a MoneyPlus spending account while employed with their previous employer, they may elect to contribute to MoneyPlus spending account and make an election as a new hire.

Health Savings Account

A terminated participant may continue to contribute to their HSA as long as they are covered by a high deductible health plan, whether it is the Savings Plan or another high deductible plan offered by another insurer. They cannot be covered by any other type of health plan. Because they have terminated employment, they would contribute on an after-tax basis directly to HSA Central or other Health Savings Account custodian. They can then include these after-tax contributions on their tax returns according to IRS guidelines.

- **If they decide to close their HSA with HSA Central**, it is a two-step process. In addition to the termination with PEBA, they must call the HSA Central HSA Account Holder customer service line at 833.571.0503.
- **Do not advise employees to leave HSA bank accounts open with a \$0 balance.** They should contact HSA Central to close the account. If the bank account with HSA Central remains open, the monthly \$0.50 service charge will continue.

Reinstating coverage after termination

If an employee has terminated employment, coverage can be reinstated, if done quickly.

If the date of termination was within the past 15 days, submit the reinstatement via the reinstate function under Manage Subscribers in [EBS](#).

If the date of termination was more than 15 days ago, the employee is considered a new hire, and coverage cannot be reinstated. Submit an enrollment for the new hire.

Exception: Academic transfers. Send a revised Active Termination Form to PEBA explaining the employee is an academic transfer and include the employee's name, SSN and effective date of transfer. Be sure to follow the academic transfer procedures explained on Page 71.

Affordable Care Act reporting requirements

Employers who participate in the State Health Plan have certain requirements under the Affordable Care Act (ACA). Employers must provide subscribers, including terminated employees, with proof of health coverage by issuing forms to subscribers. Each year, the IRS determines the date by which employers must send the forms to subscribers. Learn more on Page 68.



COBRA subscribers

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What is COBRA?

Consolidated Omnibus Budget Reconciliation Act

COBRA is a federal law that prevents covered employees and their covered dependents from losing group health, dental, vision and/or medical spending account coverage as a result of certain qualifying events.

COBRA regulations require that continuation of group insurance coverage be offered to eligible individuals who lose their group medical coverage due to a qualifying event. These qualifying events are listed in the Notices that address 18-, 29- (Extend) and 36-month COBRA continuation.

The following coverage can be continued under COBRA:

- State Health Plan;
- Dental Plus and Basic Dental;
- State Vision Plan; and
- MoneyPlus Medical Spending Account only through the end of the year.

COBRA notification procedures for continuing a Medical Spending Account are different than for health, dental or vision coverage. See Page 89 for information about COBRA procedures for Medical Spending Accounts.

Under COBRA, it is the responsibility of the covered employee, and/or the qualified beneficiary, to notify the benefits office within 60 days of a qualifying event.

View the COBRA employer insurance training materials at peba.sc.gov/insurance-training.

Who is the COBRA administrator?

PEBA coined the term COBRA administrator to identify who collects COBRA premiums and receives notices from COBRA participants.

PEBA serves as the COBRA administrator for former employees of:

- State agencies;
- Public school districts;

- Charter schools that participate in both insurance and retirement; and
- Public higher education institutions.

Benefits administrators of optional employers and charter schools that participate in insurance only serve as the COBRA administrator for their former employees.

Required COBRA notices

The required COBRA notices are available at peba.sc.gov/forms under the COBRA category.

Each COBRA notice includes an instruction sheet summarizing the notification procedures for that notice. These instruction sheets are helpful, so be sure to read them before you proceed. Download the forms and enter the subscriber and COBRA information where prompted. Routinely check PEBA's website for updated forms.

Benefits administrators of participating employers, not PEBA, are responsible for completing and mailing these COBRA notices:

- [Initial COBRA Notice](#) and *Your Rights and Responsibilities under COBRA*;
- [18-month COBRA Notice](#) and *Important Information about Your COBRA Continuation Coverage Rights*; and
- [36-month COBRA Notice](#) and *Important Information about Your COBRA Continuation Coverage Rights*.

Retain a copy of the entire notice for the employee's file. See Important note for National Medical Support Notices (NMSNs).

Mailing requirements for all COBRA notices

Follow the detailed instructions, available within each notice, for issuing the notice(s).

Send the notice via first-class mail to each covered employee and spouse. The notice to a covered spouse is notification to all covered dependents. One notice to the home satisfies the requirement if

the spouse and child(ren) live at the same address as the employee. No proof of receipt is required.

Hand delivery to the employee is **not** considered notice to a covered spouse or child(ren). A separate notice must be mailed to the spouse and child(ren). The employee must sign for receipt of notice if using hand delivery.

Important note for National Medical Support Notices (NMSNs)

Do not retain copies of any NMSN dependent notices in the employee's file. This ensures the privacy of the NMSN dependent(s).

Initial COBRA Notice

First required notice

Send this notice of the right to purchase temporary extension of group health, dental or vision coverage when coverage is lost due to a qualifying event.

The initial notification provides a broad summary of the COBRA law and procedures, outlines the obligations of employers, and explains the rights and responsibilities of employees and their dependents, including the 60-day notification requirement. Federal law states the *Initial COBRA Notice* must be mailed within 60 days of effective date of coverage.

Send the [Initial COBRA Notice](#) when:

- A new employee elects health, dental, vision or a Medical Spending Account for themselves and/or their spouse and child(ren);
- An employee adds a spouse or child(ren) due to a special eligibility situation; or
- Anyone (employee and/or dependents) newly covered at open enrollment.

Follow the detailed instructions, available within each notice, for issuing the notice(s).

Notification is not required if the employee, their spouse and child(ren) do not enroll in health, dental, vision or a Medical Spending Account.

If this notice has not been provided to your covered employees, spouse and child(ren), send a notice immediately.

You must review the employee file for coverage level information. If the employee is covered with dependent(s), carefully follow the notice instructions for how to complete and address the notice(s) and envelope(s).

60-day COBRA notification requirement for spouses and children

Spouses and children must meet this requirement to be eligible to continue coverage under COBRA.

Under COBRA, the employee, spouse or other covered family member must notify their benefits office within 60 days of the date when coverage would have been lost to be eligible to continue coverage under COBRA.

This rule applies to all spouses and children enrolled in health, dental and/or vision coverage.

If a qualifying event is not reported to the benefits office within 60 days of when coverage would have been lost, had it been reported in a timely manner, COBRA rights for that individual(s) are forfeited. In this situation, no COBRA coverage should be offered, and no second notification should be sent.

This 60-day requirement is included in the initial COBRA notice.

COBRA qualifying events and notices

Qualified beneficiaries

A qualified beneficiary is an individual eligible to continue coverage if coverage is lost due to a qualifying event. They must be covered (under health, Dental Plus, Basic Dental, State Vision Plan

and/or MoneyPlus Medical Spending Account) on the day before the qualifying event.

- Includes a **covered employee**, the **covered spouse** of the covered employee or a **covered child** of the covered employee.

Each qualified beneficiary has independent rights to elect COBRA.

Who is a qualified beneficiary?

- Active and retired employees.
- Spouses and dependent children of employees or retirees.
- Newborns or children placed for adoption with the covered former employee or retiree, if added to COBRA coverage within 31 days of birth or adoption, or during open enrollment.

Two situations may occur during the COBRA coverage period that would cause a child, who was not covered at the time of the qualifying event, to gain the status of a qualified beneficiary. These are:

- A child born to, adopted by or placed for adoption with a *covered employee* during a period of COBRA coverage.
- A child receiving benefits pursuant to a Qualified Medical Child Support Order or a National Medical Support Notice, if the support order or notice requires the *covered employee* to provide coverage.

Qualified beneficiaries under COBRA are eligible to elect individual health plans if desired, but they must complete separate NOEs.

Who is not a qualified beneficiary?

- Individuals not meeting the definition of qualified beneficiaries who are added as dependents onto a qualified beneficiary's coverage during open enrollment or because of a special eligibility situation.
- Newborn or adopted children placed with individual on COBRA who is not the covered former employee or retiree.

- Non-resident aliens with no source of income in U.S.

Not every spouse or child who is added to coverage during the COBRA coverage period would be a qualified beneficiary, eligible to extend their COBRA coverage if a second qualifying event occurs, such as divorce. *Example:* If a subscriber on COBRA coverage gets married and adds their new spouse to their coverage, they are *not* a qualified beneficiary and would not be eligible to extend their coverage to 36 months should the couple divorce one year later.

If a spouse or child is found not to be eligible for coverage due to an audit or other event, the individual is not eligible for COBRA coverage.

Second required notice

The benefits administrator sends this notice to eligible qualified beneficiaries notifying them of their right to elect COBRA coverage when a qualifying event occurs.

The individual must be covered on the day before the qualifying event by health, dental and/or vision to continue coverage under COBRA. Each individual, including spouses and child(ren), covered under the plan is a qualified beneficiary and has independent election rights.

After a qualifying event has occurred, eligible individuals should be notified of their rights to continue health, dental and/or vision coverage.

If the employee became eligible for Medicare within 18 months before the employee's termination of employment or reduction of hours, the maximum period of COBRA coverage for their covered spouse and/or child(ren) is 36 months from the date the employee became eligible for Medicare. This is known as the *Medicare Entitlement Rule*.

Depending on the tobacco and e-cigarette use status before and whether that status has changed for the new COBRA subscriber, a new [Certification Regarding Tobacco and E-cigarette Use](#) form may

need to be completed and attached to the [COBRA NOE](#).

18-month COBRA qualifying events

Provide the 18-month notice when an employee:

- Leaves employment;
- Transfers;
- Retires; or
- Has a reduction of hours and is not in a stability period (full-time to part-time, strikes, layoffs and leave of absence). Note: For information about administering COBRA for an employee who goes on a leave of absence, see Page 62.

Extending COBRA coverage to 29 months

The Omnibus Budget Reconciliation Act of 1989 added a provision to COBRA that affects the 18-month continuation period. The intent is to provide additional coverage protection for disabled qualified beneficiaries.

If a qualified beneficiary is approved for Social Security disability benefits according to Title II or XVI of the Social Security Act, they are entitled to extend the 18 months of COBRA coverage to 29 months from the date of the qualifying event, so long as these criteria are met:

- The qualifying event must be the covered employee's **termination of employment or reduction of hours**;
- The qualified beneficiary must be determined under the Social Security Act to have been **disabled at any time before or during the first 60 days after loss of coverage**. It is the qualified beneficiary's responsibility to obtain the disability determination from Social Security Administration;
- The qualified beneficiary **must notify the COBRA administrator of the Social Security disability determination within 60 days after the latest of:**

- The date of the Social Security disability determination;
- The date of the qualifying event (i.e., the employee's date of termination from employment or reduction of hours);
- The date the qualified beneficiary loses (or would lose) coverage as a result of the qualifying event; or
- The date the qualified beneficiary is informed, through the initial COBRA notice, of the responsibility to provide the notice of disability determination and the procedures for providing such notice to the COBRA administrator.

The qualified beneficiary must notify the COBRA administrator of the Social Security determination **before the end of the 18-month period following the qualifying event** (i.e., the employee's date of termination from employment or reduction of hours).

The extension of coverage to 29 months is not limited just to the disabled qualified beneficiary. *It applies to all individuals who are qualified beneficiaries as a result of the same first qualifying event. This is true even if the disabled qualified beneficiary does not elect to continue or extend coverage under COBRA.*

If the disabled qualified beneficiary extends coverage, the COBRA administrator can increase the premium to 150% for all qualified beneficiaries during the extended 11-month COBRA period. If the disabled qualified beneficiary does not extend coverage, the COBRA premium remains 102%.

A qualified beneficiary, whose coverage is extended, must notify the plan administrator within 31 days if a final determination is made that they are no longer disabled. They should complete and submit to their COBRA administrator a [Notice to Terminate COBRA Continuation Coverage](#).

Extending COBRA coverage to 36 months

A second qualifying event may occur during the 18- or 29-month period of coverage (i.e., divorce, child becomes ineligible).

In such a case, the 18- or 29-month period of coverage may be extended to 36 months, but only for those individuals listed below.

Second qualifying events must be reported within 60 days of the event and within the original 18- or 29-month period. The subscriber should complete and submit to their COBRA administrator a [Notice to Extend COBRA Continuation Coverage](#), along with the documentation requested on the form. They do not need to complete a COBRA NOE.

No qualifying event can extend the maximum coverage period beyond 36 months from the date of the first qualifying event.

Second qualifying events are:

- Death of former employee
 - The covered spouse and covered child(ren) are eligible for up to 36 months of continuation coverage.
- Divorce/legal separation
 - The covered spouse and covered child(ren) are eligible for up to 36 months of continuation coverage.
- Child(ren) becomes ineligible
 - The covered child(ren) who turns 26 during the original COBRA continuation period is eligible for up to 36 months of continuation coverage.
- Military leave.
 - The employee is eligible for up to 36 months of continuation coverage.
- The COBRA subscriber can complete a [Notice to Extend COBRA Continuation Coverage](#) if there has been a second qualifying event that may extend COBRA coverage. They should attach any documentation requested on the form.
- The completed form should be returned to their COBRA administrator.

Procedures for determining COBRA eligibility

Determine if a COBRA-qualifying event has occurred. Document the date you are notified of the event. Confirm the date the initial notice was mailed and that it included the 60-day notification requirement.

Calculate the date of loss of coverage had the event been reported in a timely manner. Count 60 calendar days from the date determined to be the coverage loss date. If the qualifying event was reported within this 60-day period, offer COBRA and send [Notice of COBRA Qualifying Event](#); if not or if ineligible, do not offer COBRA. Use the [COBRA Ineligibility Form for Dependents](#) form. Retain appropriate documentation.

Example

Date of qualifying event: September 15, 2024

Date BA notified of event	January 20, 2025
Date initial COBRA notice mailed	November 20, 2001
60-day notification language included in notice?	Yes
Date of coverage loss if reported in timely manner	October 1, 2024
60 calendar days from date of coverage loss	November 29, 2024 (60 days from October 1, 2024)
Qualifying event reported within this period?	No
Action	Do not offer COBRA. Document file with COBRA Ineligibility Form for Dependents.

If the employee is not eligible to retire

Use the *Leaving Employment before Retirement Eligibility* checklist at peba.sc.gov/publications under *Life event checklists*.

Benefits administrators of participating employers, **not PEBA**, must offer the employee and their covered spouse and/or child(ren) COBRA enrollment information by letter, except if:

- The termination was due to nonpayment of premiums;
- The termination was due to gross misconduct. Consult your legal counsel before making this determination; or
- The employee, whose spouse is also a covered employee or retiree, may apply for health, dental or vision on their spouse's coverage within 31 days of termination.

If the employee is eligible to retire

You must offer the retiring employee and their covered spouse and/or child(ren) COBRA enrollment information by letter, even though they are eligible for retiree insurance benefits.

COBRA election period

Once the qualifying event notification has been sent, each qualified beneficiary has a period of time to make the decision to elect COBRA continuation coverage.

The qualified beneficiary has 60 days after the date of loss of coverage or the date the notification of COBRA rights is sent (whichever date is later) to elect to continue coverage under COBRA.

- During this period, an employer cannot take any action to rush an election or a waiver of COBRA coverage.

An election is deemed made on the date postmarked on the NOE sent to the COBRA administrator.

- If a qualified beneficiary signs a waiver of COBRA coverage, the waiver can still be

revoked at any time during the 60-day election period.

- Once a qualified beneficiary has elected COBRA coverage, they cannot waive afterward, even if time remains in the 60-day election period.

Qualified beneficiaries who are enrolled under COBRA continue with the same health insurance plan. There is an exception:

- A qualified beneficiary can change *from* the Standard Plan *to* the Savings Plan. Keep in mind that any deductible amounts accrued under the previous plan will *not* carry over to the Savings Plan. A beneficiary who changes to the Savings Plan must meet the full deductible before benefits are payable.

COBRA Termination Notice

Third required notice

PEBA sends this notice directly to qualified beneficiaries when COBRA continuation requirements have been met and COBRA coverage is ending (the end of the 18, 29 or 36 months of required continuation coverage). This notice is sent via first-class mail to the last known address.

Do **not** send this notice. PEBA can provide a *Certificate of Creditable Coverage* upon request.

Other coverage may end COBRA eligibility

Eligibility for health, dental and/or vision coverage under COBRA may end sooner than the periods discussed earlier in this section. Eligibility will also end when:

- The subscriber or an eligible spouse or child(ren) enrolls in Medicare (Part A, Part B or both) *after* COBRA coverage is elected.
 - If the individual has Medicare *and then elects* COBRA, they can take COBRA for secondary coverage. Medicare will be primary.

- After the subscriber has elected COBRA, the subscriber or an eligible spouse or child becomes covered under other group coverage for which there is no exclusion or limitation for any preexisting condition that the individual may have.
 - If the individual *already* has the other coverage when they elect COBRA, they can have both. The plan that covers the subscriber as an employee will be primary to the plan that covers them as a spouse.

The loss of COBRA eligibility applies only to the person who enrolls in Medicare or other coverage. Covered people who do not enroll in Medicare or other group coverage can continue their COBRA coverage as long as they are otherwise eligible.

To end COBRA coverage, the subscriber completes and submits to their COBRA administrator a [Notice to Terminate COBRA Continuation Coverage](#), along with the documentation requested on the form.

Initial premium payment period

The qualified beneficiary is allowed 45 days from the date of election to make their initial payment as explained in this section. If the 45th day falls on a weekend or holiday, the first payment is due the following business day.

The initial payment must include the COBRA premiums back to the date of the loss of coverage.

Example

Qualifying event: Divorce

Date of qualifying event	May 28
COBRA start date	June 1
COBRA election date	July 22
First payment due	September 5 If date falls on a weekend or holiday, the next business day.
First payment includes	COBRA premiums for June, July and August

COBRA coverage will not be activated, and claims will not be paid until the initial 45-day premium payment is received.

To activate COBRA coverage immediately so benefits can be paid, the initial 45-day premium payment, as described above, must accompany the COBRA NOE. Exception:

- Optional employers collect the premium payment before submitting the COBRA NOE to PEBA.

If the amount due is not paid within this period, COBRA coverage can be terminated retroactively, and the subscriber may be liable for any benefits paid during the period.

Following the initial premium payment, subsequent payments are due on the 10th of the month for that month. COBRA subscribers have a 31-day grace period to pay.

- In the example above, the premium for September would be due September 10, and the subscriber has until October 10 to pay it. If the subscriber does not make a payment within the 31-day grace period, their coverage is terminated, and they lose all continuation rights under the plan.

Administrative fee for optional employers

PEBA charges optional employers a \$3-per-month administrative fee for COBRA subscribers. This administrative fee cannot be passed along to the COBRA subscriber. See more information in the [Optional Employer Handbook](#).

By law, the maximum premium the COBRA administrator can charge the subscriber is 102% of the total premium (employer and employee shares) charged to an active employee. There is one exception: when 18-month COBRA coverage is extended to 29 months, the COBRA administrator can charge 150% of the total premium for active employees (see Page 87).

Benefit changes

Qualified beneficiaries are entitled to the same rights as active employees. These rights include participating in open enrollment periods, changing plans, special eligibility situations and adding a newly acquired spouse or child(ren).

COBRA procedures for the Medical Spending Account

IRS Code Section 125 allows an employee to continue their Medical Spending Account under COBRA if certain conditions are met. The Medical Spending Account can be continued only for the rest of the plan year. Employees cannot reenroll for the next year.

The subscriber must be enrolled in the Medical Spending Account at termination.

The subscriber must, on a timely basis, elect to maintain continuous contributions, on an after-tax basis to the Medical Spending Account.

The monthly administrative fee will be added to the amount due.

- COBRA rules allow an additional administrative fee for continuing the

Medical Spending Account of 2% of the monthly amount in all cases, except disability. The fee is calculated and included with the payment.

Procedures at termination

- PEBA will send ASIFlex a file to report COBRA qualifying events.
- ASIFlex will then notify the participant of their COBRA rights and include a *COBRA Continuation Coverage Election Form*.
- The monthly contribution amount will already be filled in on the form.
- The notification will include information regarding when and how payments should be made.
- When ASIFlex receives the election form from the participant, ASIFlex will process the application and send payment coupons to the participant for future monthly payments. Remember, participants can continue only their Medical Spending Accounts and coverage through the end of the year.
- The participant has 45 days from the date the election is signed to make the initial payment.
- The initial payment must include the cost of the continuation coverage from the time the coverage would have otherwise terminated, up to the time they make their initial payment.
- The monthly contribution amount and the amount of the initial payment will be included in the payment coupons that will be sent to the participant.
- If no payment is received within 45 days, the individual will lose all continuation rights under the plan.
- Subsequent payments are due by the first day of the month coverage is provided. If payments are made on or before the due date, coverage will continue without any break.

- There is a 31-day grace period for payment. Payments must be postmarked by this date, and if ASIFlex does not receive payment by the end of the grace period, coverage will end as of the last paid-through date.

Benefits administrators with MoneyPlus COBRA questions can call ASIFlex at 833.SCM.PLUS. Employees should call ASIFlex at 833.SCM.PLUS.

Affordable Care Act reporting requirements

Employers who participate in the State Health Plan have certain requirements under the Affordable Care Act. Employers must provide subscribers with proof of health coverage by issuing forms to subscribers. Each year, the IRS determines the date by which employers must send the forms to subscribers. Learn more on Page 68.

COBRA quick reference

Action type	Required COBRA notice
New hire	Initial Notification
Special eligibility situations (<i>adding someone to coverage</i>): <ul style="list-style-type: none"> • Marriage • Birth • Adoption/placement for adoption • Gaining custody • Loss of other coverage 	Initial Notification
Open enrollment (<i>adding someone to coverage</i>): <ul style="list-style-type: none"> • Employee • Spouse • Child(ren) 	Initial Notification
Open enrollment (<i>dropping someone from coverage</i>): <ul style="list-style-type: none"> • Employee • Spouse • Child(ren) 	No notice required, unless due to a qualifying event (separation, divorce or child becomes ineligible).
Gain of other coverage	No letter required
Legal separation	36-Month Qualifying Event Notice
Divorce	36-Month Qualifying Event Notice
Child becomes ineligible	36-Month Qualifying Event Notice
Transfers	Losing employer sends the 18-month Qualifying Event Notice. Gaining employer sends the Initial Notification.
Leaves employment (for reasons other than gross misconduct or nonpayment of premiums)	18-month Qualifying Event Notice
Retires	18-Month Qualifying Event Notice
Working hours reduced (not in a stability period)	18-Month Qualifying Event Notice



Retiree subscribers

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Requirements for retiree insurance

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.

PEBA recommends an employee review the requirements for retiree group insurance in the Retiree group insurance chapter of the *Insurance Benefits Guide* before they confirm their retirement date. Share the retiree insurance flyers, available at peba.sc.gov/nyb, with employees.

In addition to qualifying for retirement, an employee's last five years of employment must be served consecutively in a full-time, insurance-eligible permanent position with an employer that participates in the State Health Plan to qualify for retiree insurance.

PEBA insurance benefits **cannot** confirm eligibility over the telephone or by email. If an employee's anticipated retirement date is **within 90 days**, direct them to submit an [Employment Verification Record](#) with a [Retiree NOE](#).

If an employee's anticipated retirement date is **three to six months away**, direct them to submit an [Employment Verification Record](#), and PEBA will provide confirmation of their eligibility.

PEBA will not confirm eligibility for retiree insurance **more than six months** before an employee's anticipated retirement date.

Assisting an eligible retiree

Retiree packet information

The *Retiree Packet*, available at peba.sc.gov/forms, is a comprehensive packet that includes the retiree insurance flyers, *Employment Verification Record*, *Retiree NOE* and helpful information for retirees.

Administrative information

PEBA acts as the benefits administrator for retirees, except retirees of optional employers and charter schools that participate in insurance only. Benefits administrators serve as the main point of contact for retirees of optional employers and charter schools that participate in insurance only.

Retirees do not have to receive a retirement benefit check from PEBA to be eligible for retiree insurance. However, they must be eligible for retirement and must meet the retiree insurance eligibility requirements explained in the Retiree group insurance chapter of the *Insurance Benefits Guide*.

Retirees continue to use the same health and dental ID cards (if they do not change plans) and the same [Insurance Benefits Guide](#).

PEBA will send open enrollment information to retirees at their last known address in PEBA's records.

For optional employers only

An optional employer or charter school does not have to participate in a PEBA-administered retirement plan for its eligible retirees to participate in the State Health Plan. Eligibility is determined as if the retiree was a member of the South Carolina Retirement System.

Benefits administrators serve as the main point of contact for retirees of optional employers.

For PEBA to determine eligibility, the [Employment Verification Record](#) must be verified and signed by the employer.

Optional employers must offer all eligible retirees the entire package of state insurance benefits for which they are eligible and must allow retirees to refuse all or any part of the benefits package.

Optional employers are billed for all retirees and must collect all premiums for their retirees.

An optional employer can choose the amount, if any, it wishes to contribute toward health and

dental coverage for its eligible retirees. If your optional employer wants to make contributions, you must develop your own premium tables by adjusting the non-funded retiree premiums in the *Insurance Benefits Guide* to reflect your optional employer's contribution.

Notes regarding academic retirees

If active employee insurance premiums are deducted on a prorated scale to cover the summer months, you must refund any overpaid premiums that result when a teacher or academic employee retires after the spring semester.

Advanced deduction of premiums does not constitute continuous coverage throughout summer months unless the employee is actively working on a full-time basis during that time.

Important retirement information

Health insurance

The same certification and documentation required of active subscribers, spouses and children applies to retirees and their spouses and children (i.e., eligibility documentation, spouse is a state group employee/retiree, spouse lost coverage, incapacitated child, etc.).

If both the retiree and spouse are covered retirees and both are enrolled in the same health plan, the family deductible will apply.

- Both retirees must enroll individually. Some exceptions may apply.
- Only one parent can enroll a child. However, one parent can cover the child under health and the other parent can cover the child under dental, for example.

When the retiree becomes eligible for Medicare

Applies also to covered spouses and children.

Due to age:

- PEBA will notify the retiree in advance of their 65th birthday that their coverage will change automatically to the Medicare Supplemental Plan when they turn age 65.
- Advise your retirees to enroll in Medicare Parts A and B when they become eligible to have optimal coverage.
- Eligibility for the GEA TRICARE Supplement Plan will end.
- Retirees must submit a copy of their Medicare card to PEBA.

Due to disability/before age 65:

- The retiree or covered spouse or child must notify PEBA within 31 days of becoming eligible for Medicare due to disability or due to end-stage renal disease and submit a copy of their Medicare card to PEBA.
- When an individual begins dialysis for end-stage renal disease, they become eligible for Medicare three months after beginning dialysis. At this point, they begin a "coordination period" of 30 months. During this time, their coverage through the State Health Plan remains primary. When the coordination period ends, Medicare becomes primary. The coordination period applies whether the subscriber is an active employee, retired, a survivor or a covered spouse or child, and regardless of if the subscriber was already eligible for Medicare due to another reason, such as age.
- Eligibility for the GEA TRICARE Supplement Plan will end.

Medicare Part D

State Health Plan retirees, survivors, COBRA subscribers and their dependent spouses and children enrolled in Medicare are eligible for Express Scripts Medicare, a group-based, Medicare Part D Prescription Drug Plan (PDP). PEBA has

determined most subscribers covered by the Medicare Supplemental Plan or the Carve-out Plan will be better served if they remain enrolled in this Medicare Part D plan sponsored by PEBA.

- Each fall, before Medicare’s annual enrollment period, PEBA is required to send a notice to subscribers who are eligible for Medicare notifying them of their options.
- If a Medicare-eligible subscriber or their eligible spouse or child enrolls in a Medicare Part D plan not sponsored by PEBA, they will lose their prescription drug coverage through their plan with PEBA, and their health insurance premiums will not decrease.
- Most individuals enrolled in Medicare who have coverage through PEBA should not enroll in a separate Medicare Part D plan, because PEBA has determined its prescription drug coverage offered through the Medicare Supplemental Plan or Carve-out Plan is considered to be creditable coverage.
- Under Part D, the federal government offers a program to help pay monthly premiums and a program to help pay copayments/coinsurance for people with limited resources. To apply for limited income assistance, individuals can complete an application online at www.socialsecurity.gov or call the Social Security Administration at 800.772.1213.

Medicare Supplemental Plan

For Medicare-eligible retirees enrolled in the Medicare Supplemental Plan:

- Claims will be paid according to the Standard Plan provisions for covered family members who are not eligible for Medicare.
- The private duty nursing deductible starts with the effective date of the Medicare Supplemental Plan, even if the yearly deductible under the previous plan (Standard Plan, etc.) has already been met.

- The *Insurance Coverage for the Medicare Eligible Member handbook*, available at peba.sc.gov/forms,
- is a comprehensive publication that includes helpful information for retirees eligible for Medicare.

Dental insurance

The retiree group dental coverage is the same as the active group dental coverage. The retiree may elect dental coverage, even if they refuse health coverage.

Vision insurance

The State Vision Plan coverage is the same as the active group vision coverage. The retiree may elect the State Vision Plan, even if they refuse health coverage.

Life insurance

At retirement, the employee can continue or convert their Optional Life coverage. They can convert their Basic Life, Dependent Life-Spouse and/or Dependent Life-Child coverage to an individual whole life policy.

MetLife will mail the retiree a conversion/continuation packet via U.S. mail three to five business days after MetLife receives the eligibility file from PEBA. The eligibility file is created from terminations submitted to PEBA by the employer.

To continue or convert coverage, the retiree must follow the instructions in the packet from MetLife. Coverage must be continued/converted within 31 days of the date coverage is lost due to approved retirement or approved disability retirement.

- Premiums for continued or converted coverage are due by the payment due date.
- If the individual is billed monthly, their policy will be canceled 60 days from the billing date of the first unpaid or partially paid bill. Approximately 10 days after the first bill’s due date, MetLife will bill again.

The due date will be 21 days later. If neither of these bills is paid in full, the individual's coverage will cancel on the 60th day.

- If the individual is billed quarterly, semi-annually or yearly, their policy will be canceled 60 days from the billing date of the first unpaid or partially paid bill. The individual will not receive another bill or a reminder notice.

Death benefits within 31 days after retirement

If a retiree, their spouse or their child dies within the 31-day period in which they are entitled to have a conversion and/or continuation policy issued, the amount of group life insurance the retiree, their spouse or their child was eligible to continue or convert will be paid to the designated beneficiary. Complete and submit the claim to MetLife. More on filing life insurance claims is in the **Claims and appeals** chapter.

If death occurs after the 31-day period, benefits will not be paid, unless the retiree submitted an application and paid the premium for the conversion/continuation.

In the case of a living benefit, the remaining percentage can be continued through the continuation or conversion provision, if the employee is retiring due to service or disability. If the employee is not retiring due to service or has not been approved for disability by The Standard or PEBA, the remaining percentage can be converted. Refer to the *Insurance Benefits Guide* for information on the living benefit and continuation of life insurance in retirement.

Basic Life

Within 31 days of retirement, Basic Life coverage may be converted to an individual whole life policy through MetLife. The retiree should follow the instructions in the packet they receive from MetLife if they are interested in converting this coverage.

Optional Life

Within 31 days of retirement, Optional Life coverage may be continued as a term policy with no cash value; or converted to an individual whole life policy through MetLife.

The minimum amount of coverage that can be continued as a term policy is \$10,000. The retiree should follow the instructions in the packet they receive from MetLife.

The subscriber may also choose to split their coverage and continue a portion as a term policy and convert a portion to an individual policy. If the retiree does not continue their coverage, they *cannot* reenroll later (e.g., during open enrollment or if a special eligibility situation occurs). You might want to make a note in their file if they do not want to continue or convert this coverage. Accidental death and dismemberment coverage is available only to active employees; it cannot be continued into retirement.

Retirees with questions about their life insurance coverage can call MetLife at 888.507.3767.

Dependent Life

Within 31 days of retirement, Dependent Life coverage may be converted to an individual whole life policy through MetLife.

If the retiree does not convert coverage, they *cannot* reenroll their spouse or child(ren) later (e.g., during open enrollment). They also cannot add a new spouse or child to Dependent Life coverage later if a special eligibility situation occurs. You might want to make a note in their file if they do not want to convert this coverage.

- The spouse or child must be covered when the employee leaves employment.
- The 31-day rule applies to converting life insurance into retirement.

The retiree should follow the instructions in the packet they receive from MetLife.

Long term disability

Basic Long Term Disability and Supplemental Long Term Disability cannot be continued or converted to an individual policy at retirement.

MoneyPlus

Flexible spending accounts

Generally, a retiree cannot continue to participate in MoneyPlus in retirement, except:

- A Medical Spending Account participant may *continue coverage on an after-tax basis*, under COBRA, through the end of the plan year. As an alternative, a terminated retiree can waive COBRA coverage and elect to prepay all remaining contributions on a pretax basis to continue coverage through the end of the plan year. Otherwise, the retiree cannot use their Medical Spending Account after they leave employment and cannot access any remaining funds.
- Refer to the *Insurance Benefits Guide* for specific eligibility information regarding the Pretax Group Insurance Premium feature and the Dependent Care and Medical Spending Accounts.

Health Savings Account

If a retiree is not eligible for Medicare and is continuing coverage under the Savings Plan or other high deductible health plan, they may continue to contribute to their Health Savings Account (HSA).

- A retiree cannot contribute to their HSA on a pretax basis.
- A retiree can contribute directly to HSA Central, custodian for HSAs, or to another HSA custodian.

Assisting a new retiree with enrollment

Eligible retirees may enroll in and add or drop their spouse or child(ren) from health, dental and/or

vision coverage within 31 days of the date of retirement.

Refer to the *Service retirement* checklist at peba.sc.gov/publications under *Life event checklists*.

Completing the *Retiree NOE*

Refer to the instructions on the back of the *Retiree NOE* for details about completing the form. Use only this form when enrolling a retiree.

- An *Active NOE* with “Retiree” written across the top will be rejected by PEBA.

Important reminders

Eligibility

Indicate the type of retiree and provide the years, months and days of service. Attach an *Employment Verification Record* if the form has not previously been sent to PEBA, to determine eligibility.

If applicable, check whether there is a 5-14-year, 15-24-year, or age 55/25-year and corresponding end date.

Benefits administrators of optional employers must verify retirement eligibility for their employees and sign the *Retiree NOE*.

Coverage

The retiree must select coverage, and if refusing coverage, must check *Refuse*.

Medicare

If the retiree or any family members are eligible for Part A or B of Medicare, this section must be completed. A copy of the Medicare card(s) must be provided to PEBA.

Certification and authorization

The retiree should read this section, then sign and date it.

If the tobacco and e-cigarette use status has changed for the retiree and/or their dependents, complete a [Certification Regarding Tobacco or E-cigarette Use](#) form and attach it to the Retiree NOE.

Changing coverage in retirement

Regular rules for coverage changes during open enrollment apply. If a retiree does not pay their complete bill, **all their coverage** will be canceled, effective the last day of the month in which they paid their premiums in full. This includes all premiums for health insurance, such as the tobacco and e-cigarette use premium, Dental Plus, Basic Dental and the State Vision Plan. Benefits that require no retiree contribution (i.e., Basic Dental) are included in this cancellation policy. The retiree may re-enroll in coverage within 31 days of a special eligibility situation or during open enrollment.

Retiree returns to work

If a retiree, who is covered under the state retiree group, returns to an insurance-eligible position, they must return to active coverage status or refuse all PEBA-sponsored coverage. If the retiree, their eligible spouse or any of their children are eligible for Medicare, they must be offered active group coverage. See Medicare on Page 52 for additional information. 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.

A part-time teacher who is not eligible for Medicare may choose to stay on retiree group insurance coverage.

Life insurance

Retirees returning to work should review their current life insurance coverage and needs carefully before deciding how much coverage they need.

Optional Life

If the retiree continued their Optional Life (OL) coverage at retirement, they must decide whether to keep their continued coverage or cancel it and enroll in OL as an active employee.

- If the retiree elects to enroll in OL coverage as an active employee, they must contact MetLife to cancel their continued retiree coverage due to their return to active status.
- A return-to-work retiree cannot keep their continued policy and elect OL coverage as an active employee.

If the retiree converted their OL coverage at retirement, they may keep the converted policy and enroll in OL as an active employee. In the event of a claim, both policies would pay, provided the premiums are paid.

Dependent Life

Since Dependent Life (DL) coverage can be converted only at retirement, if the retiree returns to work and enrolls as an active employee, they are not required to drop any converted DL coverage to enroll their spouse and/or child(ren) in DL as an active employee.

Medicare

If a return-to-work retiree, including a part-time teacher, their eligible spouse or any of their children are eligible for Medicare, they can:

- Change to one of the active group plans. Medicare will be the secondary payer to the active group coverage. They must notify Social Security that Part B will be the secondary payer to their active coverage; or
- Refuse all PEBA-sponsored health coverage, which includes prescription coverage (they must disenroll), and keep their Medicare coverage. However, you cannot offer an incentive for the employee to refuse active group coverage.
 - If the employee is not enrolled in Medicare drug coverage or other Medicare creditable prescription drug coverage for 63 days or more at any time after their initial enrollment period ends, they will be subject to a Medicare Part D late enrollment penalty as long

as they have Medicare drug coverage. Visit [medicare.gov](https://www.medicare.gov) for more information.

- The employee may keep their dental and vision coverage offered through PEBA.

When the return-to-work retiree leaves active employment and their active group coverage is terminated, they will be eligible to return to retiree group coverage. They must submit a *Retiree NOE* to return to the state retiree group within 31 days of termination.

- In addition, they must notify the Social Security Administration that they are no longer covered under an active group, so Medicare can become their primary payer or so they can reenroll in Medicare Part B during the special enrollment period, if Part B was canceled. The cost of Part B will not increase. Call the Social Security Administration at 800.772.1213 with questions.

Affordable Care Act (ACA) reporting requirements

Employers who participate in the State Health Plan have certain requirements under the ACA.

Employers must provide subscribers with proof of health coverage by issuing forms to subscribers.

Each year, the IRS determines the date by which employers must send the forms to subscribers.

Learn more on Page 68.



Survivors

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General rules about survivor coverage

A survivor is a spouse or child(ren) on the coverage of an active employee or retired subscriber who has died.

A survivor can continue health, dental and/or vision benefits as long as they are eligible.

If Dependent Life-Spouse and/or Dependent Life-Child coverage was in place when the subscriber died, that coverage can be converted within 31 days of the subscriber's date of death.

If survivor was not covered at the time of subscriber's death

A surviving spouse or child(ren), who is not enrolled when the covered subscriber dies, is not eligible for coverage as a survivor.

The survivor will not be eligible to enroll later during open enrollment, nor will they be eligible to enroll due to a special eligibility situation.

If survivor was covered at the time of subscriber's death

A surviving spouse or child(ren), who is enrolled in health, dental and/or vision coverage when the subscriber dies, is eligible to continue that coverage as a survivor.

The survivor can continue only the coverage they had at the time of the subscriber's death. They may change health plans within 31 days of gaining coverage as a survivor.

The survivor may add other coverage during open enrollment or within 31 days of a special eligibility situation, such as loss of other coverage.

If the covered surviving spouse or covered child(ren) terminates health, dental **and** vision coverage, they lose their eligibility for coverage as a survivor. They will no longer be eligible to reenroll during open enrollment, nor will they be eligible to enroll otherwise due to a special eligibility situation.

If the covered surviving spouse or covered child(ren) terminates health, dental **or** vision coverage, but they still retain at least one of the other coverages, they keep their eligibility for coverage as a survivor. They may reenroll in the other coverage(s) during open enrollment or when a special eligibility situation occurs.

A surviving spouse may add eligible child(ren) to coverage during open enrollment or when a special eligibility situation occurs.

Survivors of deceased active employees are classified as survivor subscribers under the retiree group.

Assisting a survivor

Refer to the *Death of a covered employee* checklist at peba.sc.gov/publications under *Life event checklists*.

If applicable, notify PEBA retirement benefits regarding the death and any refund or monthly benefit that might be due.

Submit the termination in EBS. For the termination reason, choose Death. If submitting an [Active Termination Form](#), check the T1 box, Deceased. Terminate the coverage as soon as the death is confirmed.

If the deceased was killed in the line of duty, attach the appropriate verification documents.

If the deceased was an active employee subscriber

If the subscriber was enrolled in Optional Life and/or enrolled in a health plan, and thus has Basic Life coverage, file for life insurance with MetLife. See Page 95 for more information.

If the subscriber was enrolled in Long Term Disability and receiving benefits at the time of death, call The Standard to report the death for any potential benefits payable to eligible survivors.

- Any BLTD benefits remaining unpaid will be paid to the employee's estate.

- Any SLTD benefits remaining unpaid will be paid to the person or people eligible to receive the survivor benefit that is defined in the SLTD policy. In case there are no eligible survivors as defined in the SLTD policy, survivor benefits would not be paid, and any SLTD benefits remaining unpaid would then be paid to the employee's estate.

MoneyPlus Medical Spending Accounts (MSA) and Dependent Care Spending Accounts (DCSA) are not refundable to the survivor. These accounts are terminated effective the date of death of the subscriber, unless the IRS-qualified spouse, child(ren) or beneficiaries elect to continue the MSA under COBRA through the end of the plan year.

If the subscriber had an HSA, advise the survivor/beneficiary to contact HSA Central to settle the account. HSA Central will require proof of death for the deceased and identification for the beneficiary.

Procedures to continue coverage as a survivor

You must notify survivors about enrollment, cost of premiums, premium collection, coverage changes and terminations.

When PEBA receives the termination, PEBA will notify any covered survivor(s) that health coverage may be continued at no cost for one year (if eligible for the premium waiver) or by paying survivor premiums.

A [Survivor NOE](#) must be completed within 31 days of the subscriber's date of death. If, as a result of the death, the tobacco and e-cigarette use status for the survivor has changed, complete and attach a [Certification Regarding Tobacco or E-cigarette Use](#) form.

The survivor will receive new ID cards with a new benefits ID number (BIN). Also, see Which SSN/BIN to use for claims on Page 105.

PEBA will bill for continuation of dental and vision coverage if the survivor was covered and while the survivor is on a health premium waiver.

Optional employers are responsible for premium collection.

The survivor can pay premiums:

- Through deduction from a monthly PEBA retirement benefit check;
- By automatic bank draft; or
- By direct billing.

For any child(ren) covered by the deceased subscriber, if both parents were covered as active employees or retirees:

- **Health:** Add child(ren) to the surviving parent's health plan within 31 days of the ending date of the premium waiver.
- **Dental:** Add child(ren) to the surviving parent's dental plan within 31 days of the loss of coverage under the deceased's plan.
- **Vision:** Add child(ren) to the surviving parent's State Vision Plan within 31 days of the loss of coverage under the deceased's plan.

Premium waiver rules

A spouse and/or child(ren) must be enrolled in the State Health Plan, under the deceased employee's or employer-funded retiree's coverage, at the time of death to be eligible for coverage and the one-year waiver of premium for health insurance. Spouses and children who are eligible for coverage under the Plan as an active employee or retiree are not eligible for survivor coverage, including any premium waiver.

The waiver of health premium is effective the day after the date of death.

The premium waiver applies only if there was an employer premium contribution. This includes survivors of employees who work at least 20 hours a week if the employer has elected the 20-hour threshold.

Survivors of deceased permanent, part-time teachers are not eligible for the premium waiver.

Optional employers may elect, but are not required, to waive the health premiums for survivors of retirees.

Survivors not eligible for the waiver may continue coverage by paying the full survivor premiums. Refer to the *Insurance Benefits Guide* for additional information on survivor coverage.

A surviving spouse is not entitled to a premium waiver if they feloniously or intentionally kill their active or retired spouse.

After the one-year waiver, survivors must pay the full cost to continue health coverage.

- *Exception:* If the deceased was “Killed in the Line of Duty” while working for an employer that participates in the South Carolina Retiree Health Insurance Trust Fund, the surviving spouse or child(ren) may continue coverage, if they are eligible, at the employer-funded rate after the waiver ends. Optional employers may elect, but are not required, to fund this survivor coverage. Survivors not eligible for employer-funded premiums may continue coverage by paying the full survivor premiums.
- “Killed in the Line of Duty” means the death of an active employee was a natural and proximate result of an injury by external accident or violence while the employee was performing acts connected with, or resulting from, duties assigned, required, or authorized by their employer. An employee is not considered to have been Killed in the Line of Duty if: (i) the death of the employee was caused by the employee’s intentional misconduct or intention to bring about their own death; (ii) the employee was voluntarily intoxicated at the time of

death; or (iii) the employee was performing their duties in a grossly negligent manner at the time of death.

There is no premium waiver for Dental Plus, Basic Dental or the State Vision Plan.

- *Exception:* If the deceased was Killed in the Line of Duty while working for a participating employer, the dental premium of a surviving spouse or child(ren) will be waived for the first year after the employee’s death.

All policies and procedures apply to survivors during the premium waiver period (i.e., changes due to family status changes, open enrollment, gaining coverage as an employee of a participating employer, etc.).

PEBA notifies survivors when the waiver period ends and when plan policies and procedures change. Optional employers receive a copy of this notification sent to survivors.

Survivors may drop health coverage within 31 days of the waiver end date. Otherwise, they must wait until open enrollment or a special eligibility situation.

Premiums

View monthly premiums at peba.sc.gov/monthly-premiums.

- Survivors of active employees, funded and partially funded¹ retirees:
 - State Health Plan premiums waived for one year.
 - After the waiver, survivor pays the full cost of the premiums.
- Survivors of non-funded retirees pay full cost of premiums from date of retiree’s death.
- Survivors pay full cost of dental and vision premiums from date of retiree’s death.

¹ Survivors of partially funded retirees pay half the employer share during the waiver year.

- Survivors of optional employer retirees must contact employer for premiums.

Which SSN/BIN to use for claims

Continue to file claims for services provided to the deceased subscriber under their SSN or benefits ID number (BIN).

Effective the day after the date of death, the BIN for the surviving spouse and child(ren) is the surviving spouse's SSN or BIN, if the surviving spouse is covered. Otherwise, a BIN will be generated for the surviving spouse.

If survivor coverage is for child(ren) only, the BIN is the SSN or BIN of the youngest child, unless Medicare covers one of the children. Then, the BIN is the SSN or BIN of the child with Medicare. A BIN will be generated for the youngest child or the child with Medicare coverage, whichever is applicable.

New ID cards with the new BIN will be issued to the survivor(s).

For any child(ren) covered by the deceased subscriber, if both parents were covered as active employees or retirees:

- **Health:** During the waiver period, if applicable, claims should be filed using the SSN or BIN of the child. If there is more than one child, this would be the BIN of the youngest child.
- **Dental:** Dental claims should be filed using the surviving parent's SSN or BIN.
- **Vision:** State Vision Plan claims should be filed using the surviving parent's SSN or BIN.

Optional Life benefits for survivors

Once MetLife receives the completed life insurance claim and required documentation, MetLife will determine eligibility and pay the life insurance proceeds and any accidental death and dismemberment benefits, if applicable, such as:

- Accidental Death Benefit (based on the death certificate);
- Seat Belt and Air Bag benefit (based on the police report and/or accident report);
- Dismemberment benefits (based on the accident report);
- Felonious Assault Benefit (based on the police report/death certificate);
- Day Care Benefit (paid to beneficiaries, younger than age 7, who are enrolled in day care); and
- Dependent Child Education Benefit (paid to qualified beneficiaries).

MetLife also offers legacy planning resources and beneficiary financial counseling. Share the *MetLife Advantages* flyer available at peba.sc.gov/nyb and view the MetLife folder on the [Health Hub](#).

The subscriber may assign benefits to a third party, such as a funeral home. However, 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, and the subscriber files the original instrument or a certified copy with MetLife's home office, and MetLife sends the subscriber an acknowledged copy. For more information, contact MetLife or see the *Insurance Benefits Guide*.

More information on life insurance claims is in the Claims and appeals section, beginning on Page 128.

When survivor coverage ends

Spouse

The surviving spouse's eligibility to continue health, dental and/or vision coverage as a survivor ends upon remarriage.

Continuation of coverage under COBRA must be offered. The 36-month COBRA continuation period starts when eligibility for survivor coverage ends, regardless of when the survivor notifies their COBRA administrator. *Example:* Surviving spouse remarries but fails to notify their COBRA administrator for 12 months. They are thus eligible

for COBRA coverage only for the remaining 24 months.

Gaining eligibility through participating employer

Eligibility for survivor coverage ends if a surviving spouse or child(ren) becomes eligible for coverage as an active employee with a participating employer. They cannot remain on survivor coverage and must enroll as an active employee.

If the survivor is on waiver status, they must pay the employee share of the premium, unless they are the survivor of an employee who was Killed in the Line of Duty. They may return to survivor coverage when they leave employment or continue coverage as a retiree, if eligible. They must enroll in survivor or retiree coverage within 31 days of when their active coverage ends. The remainder of the waiver period would not apply.

Any covered child who is not employed with a participating employer may remain on the waiver until it ends.

Children

A child may continue coverage until no longer eligible. Coverage ends the first of the following month after they become ineligible.

Continuation of coverage under COBRA must be offered. The 36-month COBRA continuation period starts when eligibility for survivor coverage ends, regardless of when the survivor notifies their COBRA administrator. *Example:* Surviving child becomes eligible for employer-sponsored group health coverage but fails to notify their COBRA administrator for 12 months. They are thus eligible for COBRA coverage only for the remaining 24 months.

Spouses and children

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Spouses: special eligibility requirements and changes in status

The subscriber is required to submit documentation to enroll a spouse as a dependent. See the [Supporting Documentation for Insurance Enrollments](#) flyer. If they fail to submit the required documentation, the dependent will be removed from coverage. 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.

The eligibility of a spouse is subject to review by PEBA. In general, an eligible spouse may be added to coverage within 31 days of the special eligibility situation. Otherwise, a spouse may be added to coverage during open enrollment. Ineligible spouses must be dropped from coverage within 31 days of the event that makes them ineligible for coverage.

Details and exceptions are outlined in each of the situations that follow. Refer to the quick reference charts on special eligibility situations in the Reference chapter.

Both spouses employed by participating employers

If legal spouses are employed by participating employers and eligible for coverage as employees, neither may be covered as a dependent spouse. When a spouse gains eligibility with a participating employer, even if the spouse refuses coverage, they may not continue to be covered as a dependent.

A spouse is not required to carry the same health coverage. However, family deductibles will not apply unless the spouses elect the same health plan. Spouses cannot cover the same child(ren) under the same benefit (health, dental, vision, Dependent Life).

Spouse gains eligibility as an employee of a PEBA-participating employer

When a spouse gains eligibility as an employee, their coverage as a dependent must be dropped.

The effective date to drop a spouse as a dependent is the date the spouse's employee coverage begins.

- *Exception:* If a spouse goes to work as a part-time teacher with a participating employer, they may be covered as an employee or a spouse, but not both.

Spouse is retiree subscriber

A legal spouse who is also an employer-funded retiree is not eligible for coverage as a dependent.

Spouse gains eligibility as a retiree subscriber

When a spouse gains eligibility as an employer-funded retiree, their coverage as a dependent must be dropped. The effective date to drop a spouse as a dependent is the date the spouse's retiree coverage begins.

Marriage

Refer to the *Adding a dependent due to Marriage* checklist at peba.sc.gov/publications under *Life event checklists*.

The eligible employee may enroll themselves, existing eligible dependents, their new spouse and new stepchild(ren) in health, dental and/or vision coverage within 31 days of the date of marriage.

- If the employee is already enrolled in health, they may change plans if they are adding their spouse or stepchild to health.

The effective date of coverage is the date of marriage for health, dental and vision coverage.

The eligible employee may add Dependent Life-Child, Dependent Life-Spouse (\$10,000 or \$20,000 without medical evidence) and Optional Life (up to \$50,000 without medical evidence) within 31 days of date of marriage.

Dependent Life-Child coverage begins the first of the month after the date of the request.

Optional Life and Dependent Life-Spouse coverage begin the first of the month following the date of the request if the employee is actively at work. If not actively at work, the effective date is the first of the month following the return to work.

The eligible employee may be able to make changes to their Medical Spending Account or Dependent Care Spending Account. The eligible employee must be on the plans or added with the spouse and/or child(ren).

Documentation

A marriage license or Page 1 of the employee's latest federal tax return, if filing jointly, is required to add a spouse.

A long-form birth certificate showing the name of the natural parent plus proof natural parent and subscriber are married is required to add a stepchild.

Note about premiums

If the employee is enrolled in the MoneyPlus Pretax Group Insurance Premium feature, premiums must be paid post-tax for retroactive coverage back to the date of marriage. Premiums may be paid pretax beginning the first of the month following the date of the request.

Spouse of foreign national employee

Add to coverage

A legal spouse of an eligible foreign national employee may be added to health, dental, vision and Dependent Life coverage within 31 days of arrival in the U.S. A copy of the visa/visa stamp, showing the arrival date, and a copy of the marriage license are required to add the spouse as a dependent. The effective date of coverage is the date the spouse entered the U.S.

Drop from coverage

A spouse of an eligible foreign national employee may be dropped from coverage within 31 days of departure from the U.S. A copy of the visa/visa stamp showing the departure date is required to drop the spouse. The effective date is the date the spouse left the U.S.

Separated spouse

Separation is not recognized as a legal status in South Carolina, and therefore is not a special eligibility situation in which a subscriber can make changes to their coverage. If the subscriber has a court order from a jurisdiction that recognizes legal separation as a legal status, PEBA will honor that order and allow the subscriber to drop coverage as a result of a special eligibility situation. It's important to note, however, that in these cases, reconciliation is not a special eligibility situation.

Former spouse/divorce

Refer to the *Dropping a dependent due to Divorce* checklist at peba.sc.gov/publications under *Life event checklists*.

When a divorce is final, the subscriber must drop the former spouse from all benefits within 31 days of the divorce. A copy of the first page of the divorce decree and the page with the judge's signature must be submitted to confirm the drop in coverage.

The effective date is the last day of the month in which the divorce becomes final.

- Exception: If the subscriber fails to drop the former spouse within 31 days of the divorce, the effective date will be the first of the month after the request is made.

The subscriber may enroll in or increase Optional Life coverage up to \$50,000 without medical evidence. The subscriber may be able to make changes to their Medical Spending Account or Dependent Care Spending Account.

Required to cover former spouse by divorce decree or court order

If a divorce decree or court order requires a subscriber to continue to cover a former spouse under the State Health Plan, the former spouse is required to have their own policy at the full cost of the premium. The subscriber is thus permitted to cover a current spouse as a dependent under their policy.

A former spouse must enroll using the [Former Spouse NOE](#) within 31 days of the date the court order or divorce decree is filed with the clerk of court. A copy of the first page of the divorce decree or court order, the page with the judge's signature and pages related to insurance coverage, must be included. The divorce decree or court order must state that the subscriber is directed to provide insurance for the former spouse. It is important the former spouse understands they are responsible for ensuring their enrollment documents are submitted to PEBA in a timely manner.

The effective date of former spouse coverage is the first of the month after the divorce becomes final.

Death of covered spouse

Refer to the *Death of a covered dependent* checklist at peba.sc.gov/publications under *Life event checklists*.

Upon the death of a covered spouse, the spouse must be dropped from coverage within 31 days of the date of death. The effective date is the day after the spouse's date of death.

- Exception: If the subscriber fails to drop the spouse within 31 days of the death, the request to change the level of health, dental, vision and Dependent Life, if applicable, may be changed retroactively, up to 12 months.

The subscriber may decrease or drop their Optional Life coverage within 31 days of their spouse's death.

Dependent Life-Spouse coverage

Eligibility requirements

The employee is the beneficiary for proceeds from Dependent Life-Spouse insurance. Spouses enrolled in Dependent Life are covered for Accidental Death and Dismemberment benefits. They are eligible for the Seat Belt and Air Bag benefit, Child Care benefit and Dependent Child Education benefit.

The employee may enroll their spouse in Dependent Life-Spouse coverage within 31 days of initial eligibility or within 31 days of loss of other coverage through a participating employer without medical evidence.

Medical evidence is required if the requested coverage is greater than \$20,000 or the spouse is not added within 31 days of initial eligibility, which is the:

- Date of hire, if spouse is not an eligible employee;
- Date of marriage; or
- Date spouse is no longer eligible as an active employee.

Note: A spouse, who is a retiree subscriber, may be covered on Dependent Life-Spouse as a spouse within 31 days of the date they retire or during a specified enrollment period.

Follow the same procedures as outlined under Optional Life beginning on Page 56 for submitting medical evidence. The Actively at Work requirement and the Dependent Non-confinement Provision, as explained in the *Insurance Benefits Guide*, apply.

Children: special eligibility requirements and changes in status

The subscriber is required to submit documentation to enroll a child as a dependent. If they fail to submit the required documentation, the dependent will be removed from coverage. 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.

The eligibility of a child is subject to review by PEBA. Eligible children may be added to coverage within 31 days of the special eligibility situation. Otherwise, a child may be added to coverage during open enrollment.

Special eligibility situations allowing a subscriber to enroll themselves and their eligible child(ren) in health, dental and/or vision coverage include marriage, birth, adoption/placement for adoption, placement of a foster child, gaining legal custody, other court order or loss of other coverage.

Two employees cannot cover the same child(ren) under the same benefit (health, dental, vision, Dependent Life).

Child younger than age 26

A child who is younger than age 26 is eligible if either:

- The child is the employee's natural or adopted child, stepchild, foster child or child for whom the employee has legal custody; or
- The employee is required to provide health insurance because of a court order.

The subscriber must submit proof of the child's relationship to the subscriber within 31 days of enrollment and at other reasonable times.

Birth

Refer to the *Adding a dependent due to birth* checklist at peba.sc.gov/publications under *Life event checklists*.

A newborn may be added to coverage within 31 days of the date of birth. The eligible employee may enroll themselves, an eligible spouse, existing eligible dependents and the newborn in health, dental and/or vision coverage within 31 days of the date of birth.

- If the employee is already enrolled in health, they may change plans if they are adding their spouse or newborn to health.

The effective date of coverage is the date of birth of the newborn for health, dental and vision coverage.

Newborns are covered under Dependent Life-Child automatically for 31 days from live birth. A request must be submitted to continue Dependent Life-Child coverage beyond 31 days. The eligible employee may add Dependent Life-Child, Dependent Life-Spouse (\$10,000 or \$20,000 without medical evidence) and Optional Life (up to \$50,000 without medical evidence) within 31 days of the date of birth. The subscriber must complete an online *Statement of Health* for any requested coverage amounts more than \$20,000 for Dependent Life-Spouse.

Dependent Life-Child coverage continues the first of the month after the date of the request. Optional Life and Dependent Life-Spouse coverage begin on the first of the month following the date of the request if the employee is actively at work. If not actively at work, the effective date is the first of the month following the return to work.

The employee may be able to make changes to their Medical Spending Account or Dependent Care Spending Account.

The eligible employee must be on the plans or added with the spouse and/or newborn.

If the 31-day window to add the newborn is missed, the subscriber has 90 days (from the date on the

rejection letter if the NOE is submitted after 31 days, or 90 days after the initial 31-day window) to send a written explanation and request for reconsideration to PEBA.

If the subscriber misses the 31-day window and 90-day appeal period explained above, coverage may be provided only from the date of birth through the end of the month after the first 31 days. To process claims for these 31 days of coverage, PEBA will need an NOE to add the infant for claims payment for the first 31 days and another NOE to drop coverage, effective the first of the month after the 31-day period. The request/NOEs to add and then drop may be submitted retroactively, up to 12 months.

Documentation

A long-form birth certificate showing the subscriber as the parent is the preferred document to add the newborn. However, if the child needs immediate service before the birth certificate can be obtained and the provider will not render services without proof of insurance, PEBA will accept an official document from the hospital signed by the attending physician or other hospital staff. The document must include the child's name, date of birth and parents' names.

A marriage license or Page 1 of the employee's latest federal tax return, if filing jointly, is required to add a spouse.

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.

Note about premiums

If the employee is enrolled in the MoneyPlus Pretax Group Insurance Premium feature, premiums may be paid pretax beginning the first of the month following the date of the request.

Adoption/placement for adoption (child younger than age 18)

Refer to the *Adding a dependent due to adoption* checklist at peba.sc.gov/publications under *Life event checklists*.

A child younger than age 18 may be added to coverage within 31 days of the date of the adoption/date of placement for adoption. The eligible employee may enroll themselves, an eligible spouse, existing eligible dependents and the newly adopted child in health, dental and/or vision coverage within 31 days of the date of the adoption/date of placement for adoption.

- If the employee is already enrolled in health, they may change plans if they are adding their spouse or newly adopted child to health.

The effective date of coverage is the date of birth for health, dental and vision coverage if the baby is adopted or placed for adoption within 31 days of birth. If adopted or placed for adoption after 31 days of birth, the effective date is the date of adoption or placement for adoption.

The eligible employee may add Dependent Life-Child, Dependent Life-Spouse (\$10,000 or \$20,000 without medical evidence) and Optional Life (up to \$50,000 without medical evidence). The subscriber must complete an online *Statement of Health* for any requested coverage amounts more than \$20,000 for Dependent Life-Spouse.

Dependent Life-Child coverage is effective the date of birth if the baby is adopted or placed for adoption within 31 days of birth. If adopted or placed for adoption after 31 days of birth, the effective date is the date of adoption or placement for adoption.

Optional Life and Dependent Life-Spouse coverage begins the date of the request if the employee is actively at work. If not actively at work, the effective date is the date the employee resumes active work.

The eligible employee may be able to make changes to their Medical Spending Account or Dependent Care Spending Account.

Exception: International adoptions. The effective date of coverage must be either:

- The date of adoption on the adoption paperwork (required documentation); or
- The date the child entered the U.S. A copy of the visa/visa stamp is required if using this date as the effective date of coverage.

If the adopted child is a newborn, see the Birth section on Page 112 for additional requirements if the 31-day window to add the child is missed.

The eligible employee must be on the plan or added with the spouse and/or newly adopted child.

Documentation

Acceptable documentation to add the newly adopted child includes a long-form birth certificate showing the subscriber as the parent; a copy of legal adoption documentation from a court, verifying the completed adoption; or a letter of placement from an adoption agency, an attorney or the Department of Social Services (DSS), verifying the adoption is in progress.

A marriage license or Page 1 of the employee's latest federal tax return, if filing jointly, is required to add a spouse.

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.

Note about premiums

If the employee is enrolled in the MoneyPlus Pretax Group Insurance Premium feature, premiums may be paid pretax beginning the first of the month following the date of the request.

Custody or guardianship

A subscriber who gains custody or guardianship over a child may add the child within 31 days.

The eligible employee may enroll themselves only or any eligible spouse and/or child with new legal custody in health, dental and/or vision coverage.

- If the employee is already enrolled in health, they may change plans if they are

adding their spouse or child with new legal custody to health.

The eligible employee may add Dependent Life-Child for eligible children (a foster child is not eligible for Dependent Life coverage). The effective date of coverage is the date of custody or guardianship for health, dental, vision and Dependent Life-Child coverage.

The eligible employee may be able to make changes to their Medical Spending Account or Dependent Care Spending Account. The eligible employee must be on the plan or added with the spouse and/or newborn.

Documentation

Acceptable documentation to cover a child with new legal custody includes a court order or other legal documentation from a placement agency or the S.C. Department of Social Services, granting custody or guardianship of a child/foster child to the subscriber. The documentation must verify the subscriber has guardianship responsibility for the child and not merely financial responsibility.

A marriage license or Page 1 of the employee's latest federal tax return, if filing jointly, is required to add a spouse.

Note about premiums

If the employee is enrolled in the MoneyPlus Pretax Group Insurance Premium feature, premiums must be paid post-tax for retroactive coverage back to the date of gaining custody or guardianship. Premiums may be paid pretax beginning the first of the month following the date of the request.

Divorce decree or court order

A child may be added to coverage. The child should be added to coverage within 31 days of the decree/court order. The effective date of coverage is the first of the month after the court orders' date stamp from the clerk of court.

If the subscriber fails to drop the separated spouse within 31 days of the date on the order, the subscriber must wait until open enrollment or until

another special eligibility situation occurs to add the child(ren).

Former stepchildren are not eligible and may not be covered, even if it is specified in the court order.

Special eligibility rules do not apply to National Medical Support Notices (NMSNs). See Page 49 for more information about NMSNs.

Documentation

A copy of the entire divorce decree or court order is required.

- The document should list what insurance the subscriber is directed to provide (i.e., health, dental, vision).
- The document must list the name(s) of those to be covered.

Only the insurance listed may be provided for the child(ren) listed in the document.

Note about premiums

If the employee is enrolled in the MoneyPlus Pretax Group Insurance Premium feature, premiums must be paid post-tax for retroactive coverage back to the date of gaining custody or guardianship. Premiums may be paid pretax beginning the first of the month following the date of the request.

Child of foreign national employee

Add to coverage

A child of an eligible foreign national employee may be added to health, dental, vision and Dependent Life coverage within 31 days of arrival in the U.S.

A copy of the visa/visa stamp showing the arrival date, and a copy of the long-form birth certificate showing the subscriber as the parent, are required to add the child as a dependent.

A copy of the visa/visa stamp showing the arrival date, a copy of the long-form birth certificate showing the name of the natural parent and proof that the natural parent and subscriber are married, are required to add a stepchild as a dependent.

The effective date of coverage is the first of the month after arrival in the U.S.

Drop from coverage

A child of an eligible foreign national employee may be dropped from coverage within 31 days of departure from the U.S.

A copy of the visa/visa stamp showing the departure date is required to drop the child.

The effective date of coverage is the first of the month after departure from the U.S.

Child gains employment with coverage

A child who becomes eligible for other employer-sponsored group health coverage as an employee or as a spouse may continue their dependent coverage through the subscriber.

- If the child chooses to be covered under their parent's insurance as a dependent child, they are eligible only for benefits offered to children. The child is not eligible for Basic Life, Optional Life, Dependent Life-Child or Long Term Disability insurance.
- The child cannot be covered as a child on one insurance program, such as health, and then enroll for coverage as an employee or spouse on another, such as vision.
- The child should complete an *Active NOE* with their employer, refusing coverage. Under Type of Change on the NOE, next to Other, specify *Enrolled as child of PEBA subscriber*.
- If the child loses their coverage through their employer, and the child is otherwise eligible for coverage through the subscriber, the child may be reenrolled within 31 days of the loss of coverage event or during open enrollment.
- If the child later decides to enroll in coverage as an employee, rather than as a dependent, they must complete an *Active NOE*.

The subscriber may drop the child within 31 days of when the child becomes eligible for other employer-sponsored group health coverage. The

effective date is the first of the month after gaining coverage.

Note about premiums

If the employee is enrolled in the MoneyPlus Pretax Group Insurance Premium feature, premiums must be paid post-tax for retroactive coverage back to the date of gaining custody or guardianship. Premiums may be paid pretax beginning the first of the month following the date of the request.

Death of covered child

Refer to the *Death of a covered dependent* checklist at peba.sc.gov/publications under *Life event checklists*.

Upon the death of a covered child, the child must be dropped from coverage within 31 days of the date of death. The effective date is the day after the child's date of death.

- Exception: If the subscriber fails to drop the child within 31 days of the death and this is the last eligible child, the request to change the level of health, dental, vision and Dependent Life, if applicable, may be changed retroactively, up to 12 months.

Note about premiums

If the employee is enrolled in the MoneyPlus Pretax Group Insurance Premium feature, premiums must be paid post-tax for retroactive coverage back to the date of gaining custody or guardianship. Premiums may be paid pretax beginning the first of the month following the date of the request.

Incapacitated child

An incapacitated, unmarried child who is incapable of self-sustaining employment because of mental illness or intellectual or physical disability and who is principally dependent (more than 50 percent) on the covered employee, retiree, survivor or COBRA subscriber for maintenance and support is eligible if:

- The child is covered at the time of incapacitation and has been continuously

covered by a health insurance plan from the time of incapacitation;

- The child remains unmarried; and
- The incapacitation is established no earlier than 90 days before the child's 26th birthday, but no later than 31 days after their 26th birthday.
- For the child to be covered under Dependent Life-Child, the incapacitation is established no earlier than 90 days before the child's 19th birthday, but no later than 31 days after their 19th birthday, or within 31 days of loss of student status.

PEBA determines whether the child is eligible to be considered for incapacitated child status.

Coverage for an incapacitated child may continue beyond age 26, when coverage would otherwise end, as long as the child remains eligible (this does not apply to children covered under COBRA). PEBA reserves the right to require the subscriber to submit satisfactory proof of such incapacity and dependency at any time. This proof is typically required within 31 days of initial enrollment, upon attaining age 26, and at other reasonable times, but not more frequently than annually.

A child who becomes incapacitated after age 26 is not eligible.

Incapacitated child certification procedures

If a covered child will turn age 26 within 90 days or the child is ages 19-25 and covered under Dependent Life-Child and incapable of attending school full-time, *and* if the child is incapacitated due to a mental or physical disability, the subscriber should complete an [Incapacitated Child Certification](#) form and send it to PEBA for a determination of eligibility.

If establishing incapacitation at age 26, this form should be sent to PEBA no earlier than 90 days before the child's 26th birthday and no later than 31 days afterward.

If establishing incapacitation within 31 days of loss of student status for Dependent Life-Child coverage,

the subscriber must submit a completed [Incapacitated Child Certification](#) form and attach:

- A copy of the letter of withdrawal from the educational institution, verifying full-time student status up to the date of incapacitation; and
- A copy of the latest tax return, verifying the child is principally dependent on the subscriber. Tax schedules do not need to be included, and the tax return may be redacted, as necessary.

Completing the *Incapacitated Child Certification* form

The subscriber must complete and sign Section A and the shaded areas of Section B.

If the child is ages 19-25, attach a copy of the letter of withdrawal from the educational institution, verifying full-time student status up to the date of incapacitation.

The dependent's physician must complete the remainder of Section B and sign Page 4.

The subscriber should also complete and attach an [Authorized Representative Form](#), signed by the incapacitated child, to confirm permission for PEBA to discuss or disclose the child's protected health information to the particular person who acts as the child's Authorized Representative.

- If the child is incapable of signing the Authorized Representative Form, PEBA may accept, instead, documentation verifying the representative's authority to act on behalf of the child in these matters (i.e., guardianship papers or a power of attorney).

The subscriber returns the completed forms to PEBA for review, approval/denial and processing.

PEBA will forward the completed forms to The Standard for a review of the medical information provided, as well as the terms of the plan of benefits, and a recommendation. The Standard may request additional information from the subscriber

and/or the child's health care providers. The Standard will forward its recommendation to PEBA, which makes the final determination based on the recommendation and documentation provided.

PEBA will notify the employer and the subscriber of its decision. Under HIPAA, no personal health information is disclosed to the employer.

If the child's eligibility as incapacitated is denied, the subscriber can appeal the decision by writing to PEBA within 90 days of receipt of the denial letter. If the denial is upheld by PEBA, the subscriber has 30 days from receipt of the denial letter from PEBA to seek judicial review as provided by S.C. Code Ann. 1-11-710 and 1-23-380. For more information regarding the appeals process, see Page 139.

The subscriber may be required periodically to recertify the child's incapacitation.

Child in full-time military service

A child in full-time military service is not eligible for Dependent Life-Child coverage.

Child turns age 26

Unless the child is approved to continue coverage as an incapacitated child, the child must be dropped from the subscriber's coverage when they reach age 26.

The effective date is the first of the month after the child's 26th birthday.

Important note: The child will be dropped from coverage automatically, and any ineligible claims will not be paid.

Dependent Life-Child coverage

Eligible children may be added or dropped throughout the year, effective the first of the month after the request or effective the date of the event, if added within 31 days of birth, adoption, etc. No medical evidence is required.

If both parents are eligible for PEBA insurance benefits, only one can carry Dependent Life coverage for eligible children.

The Dependent Non-confinement Provision applies.

The subscriber pays one Dependent Life-Child premium to insure all covered children, and the subscriber is the beneficiary. There are no accidental death or dismemberment benefits for Dependent Life-Child.

Newborns are covered under Dependent Life-Child automatically for 31 days from live birth. A request must be submitted to continue Dependent Life-Child coverage beyond 31 days.

To be eligible for coverage, the child must be:

- Unmarried;
- Supported by the subscriber (however, a foster child is not eligible for Dependent Life coverage); and
- Younger than 19 years old; or at least 19 years old but younger than 25 and a full-time student, not employed on a full-time basis; or any age while certified as incapacitated.

Full-time students

A child who is at least 19 years old but younger than 25 and enrolled in and attending school in a full-time student status may be eligible for Dependent Life coverage as a full-time student.

- School includes high school, college or university (including graduate school), accredited technical, vocational or trade school or academic military academy.
- Full-time student status is defined by the institution.
- The student must be working toward a diploma or degree. Internet classes do qualify, provided they are offered through a school as defined earlier.

The child may be added to Dependent Life-Child coverage within 31 days of when they become a

full-time student. The effective date is the first of the month after attaining full-time student status.

For students already covered, 90 days before a covered child's 19th birthday, PEBA provides a letter in EBS for you to give to the subscriber. The child's coverage will continue unless the subscriber notifies you that the child is no longer a full-time student or incapacitated child.

No Dependent Life claims will be paid for children who are at least 19 years old but younger than age 25 who were not eligible as full-time students.

Dependent Non-confinement Provision

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 the subscriber's insurance is effective.

Eligibility for MoneyPlus spending accounts

A list of who qualifies for reimbursement from a Medical Spending Account or Dependent Care Spending Account is in the [Insurance Benefits Guide](#). For more information, consult with a tax adviser.

COBRA notification by subscriber required

COBRA notification by the employee, spouse or other family member is required within 60 days for spouses and children when eligibility for health, dental and/or vision coverage ends. Upon notification, issue the appropriate second notice to the employee, spouse or other family member. See the COBRA section for additional details.

Adoption Assistance Program

When funds are available and authorized in the state's budget, it is the policy of the State of South Carolina to provide financial assistance to eligible employees who are adoptive parents of a child, including a special needs child. This program is administered through PEBA.

Qualified applicants will receive:

- When there are not enough funds available or authorized to meet every qualified applicant's expenses, funds will be divided evenly among the applicants. Those who adopted a special needs child will receive twice the amount as those who adopted a non-special needs child.

To be eligible, the adopting employee must be covered by PEBA insurance and must be employed when the adoption is finalized, when the application is submitted and when the payment is made.

As it relates to the Adoption Assistance Program, a **child** means any person younger than age 18. A stepchild is not eligible for adoption assistance benefits.

As it relates to the Adoption Assistance Program, a **special needs child** means a child, as defined above, who meets other specific requirements established in PEBA's *Adoption Assistance Policy*. For information on these requirements, contact PEBA's Insurance Finance department at 803.734.1696 or insuranceaccounting@peba.sc.gov.

Financial assistance under the Program is not available for the adoption of a child who has a legal parent unless the legal parent's parental rights are terminated as part of the adoption process; for the adoption of a stepchild; or for any other adoption involving an eligible employee who resides in the same home as the adopted child and the adopted child's parent.

Applications must be submitted between July 1 and September 30 for adoptions finalized the previous

fiscal year (July 1-June 30). Following the September 30 deadline, payments will be sent to employees by the end of the following November. Payments cannot be sent to service providers.

Payments will be made to employees for costs related directly to the adoption, such as:

- Medical costs of the biological mother not covered by other insurance, Medicaid or other available resources;
- Medical costs of the child not otherwise covered;
- Licensed adoption agency fees, legal fees and guardian ad litem fees; and
- Allowable travel fees associated with the adoption process.

Adoption assistance is subject to taxes

Financial assistance through the Adoption Assistance Program is subject to federal income and FICA payroll taxes, but it is not subject to state income taxes. PEBA will withhold Social Security and Medicare payroll taxes (7.65%) from the benefit payment. *These withholdings will be forwarded to the employer.*

- The employer is responsible for the employer payroll tax match. This amount must be reported at the end of the year on the individual's W-2 in Box 3 (Social Security wages), Box 5 (Medicare wages) and Box 12 (using Code T — Miscellaneous Income).
- The employee is responsible for determination and payment of any federal income tax liability.

According to IRS Publication 15-B, *Employers Tax Guide to Fringe Benefits*, an employer must report all qualifying adoption expenses reimbursed to an employee under an adoption assistance program for each employee. IRS Publication 15-B is available online at www.irs.gov.

Comptroller General (CG) Agencies

If your employer is a CG agency, you are not responsible for reporting FICA taxes for adoption

benefits. SCEIS will forward the employee and employer FICA taxes to the IRS and report the adoption benefit and withholdings on the employee's W-2. A check for the net reimbursement from the Adoption Assistance

Program will be issued to the employee, along with a letter explaining the deduction.

For more information or for an application, employees can contact PEBA.



Disability subscribers

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Training

View the Retirement, Disability and Death (RDD) employer insurance training materials at peba.sc.gov/insurance-training.

Workplace Possibilities

The odds of an employee returning to work after a disability diminish with time. The best chance for an employee to return to work is to do so as quickly as possible. The Standard's Workplace Possibilities program may be able to help your disabled employee remain productive. The Workplace Possibilities program is an additional benefit that provides a disability consultant based in South Carolina who can help covered employees overcome barriers to job performance caused by their medical condition. The services are included in PEBA's disability policy.

Benefits administrators may refer an employee for Stay at Work services while the employee is still working. The goal is to help the employee perform their job tasks. Return to Work services are provided soon after an employee goes out of work. The goal is to quickly return the employee to work.

Learn more about the program [online](#).

How can I request services from the Workplace Possibilities team?

The first step is for the employee's manager to discuss the issue with the employee. Then, you should submit a [Stay at Work Request for Services](#) form and give the employee a one-page [Stay at Work Medical Information Request](#) form for their doctor to fill out and send to The Standard. The employee will also need to complete an [Authorization to Obtain and Release Health Information](#). Once The Standard receives this information, a Workplace Possibilities consultant will contact your employee.

Eligibility

An employee may be eligible for retiree group insurance if they are approved for disability retirement benefits through one of the defined benefit plans administered by PEBA.

Disability retirement eligibility for South Carolina Retirement System (SCRS) members is based on entitlement to Social Security benefits. Police Officers Retirement System (PORS) disability retirement claims are evaluated by a disability determination provider and a medical board.

State Optional Retirement Program (State ORP) does not provide disability protection. However, a State ORP participant may be eligible for insurance as a disability retiree if they meet the requirements for a disability benefit from SCRS and provide an approval for disability by the Social Security Administration.

State ORP participants and employees of optional employers who do not participate in a PEBA-administered retirement plan may meet the disability retirement eligibility requirements for retiree group insurance through disability approval by the Social Security Administration.

For more information about disability retirement, see Chapter 7 of the PEBA retirement benefits [Covered Employer Procedures Manual](#). For more information about retiree disability insurance, see the Disability retirement section in the Retiree group insurance chapter of the [Insurance Benefits Guide](#).

Applying for disability benefits

An employee should apply for disability benefits as soon as they become disabled and **before leaving covered employment**. They may be eligible for optional life insurance benefits through MetLife and long term disability through The Standard.

1. Complete and submit an *Application for Disability Retirement* to PEBA, if applicable.

2. Complete and submit optional life insurance information to MetLife, if applicable.
3. Complete and submit long term disability information to The Standard, if applicable.

If the employee is unable to file, you may file on their behalf. The process can always be canceled if the employee recovers.

Assisting a disabled employee

Refer to the *Disability retirement* checklist at peba.sc.gov/publications under *Life event checklists*.

If an employee is leaving employment due to disability:

- Follow the procedures in the **Transfers and terminations** chapter.
- COBRA notification rules apply.
- If eligible for disability retirement, refer the employee to PEBA for assistance with filing for disability retirement.

If the employee applied for disability retirement with PEBA before they left covered employment, and they are terminated from employment before they receive approval, they may continue coverage through COBRA.

- They have 31 days from the date they leave employment to apply for conversion of their life insurance with MetLife.
- If they are later approved for disability retirement, they may apply for retiree insurance within 31 days of the date of notification from PEBA. If they do not apply within 31 days of the date of notification, they must wait for a special eligibility situation or open enrollment to enroll as a retiree.

If the employee is covered as an active employee until they receive disability approval, they may apply for retiree insurance within 31 days of the date of notification from PEBA.

- If eligible, retiree coverage will be effective the first of the month following their

termination from active coverage, provided they are terminated from active coverage on or after the date of retirement.

- If they do not apply within 31 days of the date of notification, they must wait for a special eligibility situation or open enrollment to enroll as a retiree.
- They have 31 days from the date of notification from PEBA to apply for continuation/conversion of their life insurance with MetLife.

Employees who are approved for BLTD/SLTD benefits cannot use that approval to apply for retiree insurance.

The effective date for insurance will be the first of the month following the date on the approval letter from PEBA (disability retirement). The retiree must apply for coverage within 31 days of the date of the approval letter.

Review the deductible income/offset rules and overpayment potential for BLTD and SLTD benefits as explained in the Long Term disability chapter of the *Insurance Benefits Guide*.

If the employee becomes eligible for Medicare as a disability retiree through Social Security, advise the disabled employee they will need to enroll in Medicare Parts A and B. They must also notify PEBA within 31 days of eligibility and provide a copy of their Medicare card. They will no longer be able to contribute to an HSA if they enroll in Medicare.

If the individual has end-stage renal disease, read Page 91 in the **Retiree subscribers** chapter for additional information about Medicare's coordination period.

If the employee does not qualify for retiree insurance but enrolls in COBRA, they must notify PEBA when they are approved for Social Security disability benefits so PEBA can determine their eligibility for the 11-month extension of COBRA coverage. Refer to the **COBRA** chapter for further instructions.

Optional Life

If the employee takes a leave of absence due to a total disability (as determined by the employer), their Optional Life (OL) coverage continues for up to 12 months by paying the premiums, beginning the first of the month after the last day worked.

- If they retire while on a leave of absence, they can choose to continue or convert their coverage within 31 days of leaving active employment, as explained below.

If the employee does not return to work at the end of 12 months, terminate their coverage. They may be able to continue or convert their coverage within 31 days of their termination. Read Continuation/conversion below for more information and instructions.

- The employee can be considered eligible for Dependent Life coverage on their spouse's coverage, if applicable, when their eligibility for OL as an employee ends or if they convert coverage. They are not eligible if they choose to continue their coverage.

Continuation/conversion

If the employee is approved for PEBA disability retirement and/or BLTD/SLTD, but does *not* qualify for retiree insurance benefits, they may continue or convert their OL coverage.

- They may also choose to split this coverage and continue a portion as a term policy and convert a portion to an individual policy.

If the employee is not approved for PEBA disability retirement or BLTD/SLTD, they can only convert their OL coverage.

The procedures for continuing and converting Optional Life coverage are explained beginning on Page 96.

Accelerated benefits

The accelerated benefits option may be available to active employees on a leave of absence who are

terminally ill with a life expectancy of no more than 12 months. Claiming this benefit, which is up to 80% of their OL coverage, will reduce the amount of any optional life coverage and will reduce any optional life coverage eligible for continuation or conversion.

Complete a MetLife Accelerated Benefit Option claim. Refer to the **Claims and appeals** chapter for further instructions.

Basic Long Term Disability and Supplemental Long Term Disability

Eligibility for benefits

Eligibility for BLTD and SLTD benefits is based on criteria using terminology from The Standard:

- Own occupation is a person who is unable to perform their own occupation as it is performed in the national economy during the benefit waiting period and the first 24 months for which LTD benefits are paid.
- Any occupation is a person who is unable to perform any occupation from the end of the own occupation period to the end of the maximum benefit period.
- Partial disability.

See the BLTD and SLTD plan certificates at peba.sc.gov/publications for details.

Note regarding partial disability

An employee may work in another occupation while they meet their own occupation's definition of disability. If the employee is disabled from their own occupation, there is no limit on their earnings in another occupation. However, the employee's earnings may be deductible income — BLTD/SLTD benefits may be reduced by this income.

BLTD/SLTD claim information

Refer to the **Claims and appeals** chapter for the procedures for filing claims and appeals. Below is some general information regarding claim documentation.

Satisfactory written proof that the employee is disabled and entitled to BLTD and/or SLTD benefits

must be provided. Claims may be submitted online, via telephone or on paper.

Time limits for filing and substantiating claims

An employee should submit a completed claim to The Standard as soon as possible, but within 90 days after the end of the benefit waiting period.

In situations in which the employee is unable to obtain the information to submit a completed claim to The Standard within the time frame above, The Standard will accept completed claims up to one year after the 90-day period following the waiting period (see above).

If a completed claim is not filed within one year after the 90-day period following the waiting period, the employee's claim will be denied.

These time limits do not apply while the employee lacks legal capacity. In this situation, contact The Standard for additional information and instructions.

Documentation

If The Standard asks the employee to provide documentation to complete a claim, the employee must provide that documentation within 45 days of The Standard's request. Otherwise, the claim will be denied. The cost for providing the requested documentation is the employee's responsibility.

If The Standard asks a provider to provide documentation to complete a claim, the provider must provide that documentation within 45 days of The Standard's request. Otherwise, the claim may be denied.

BLTD/SLTD payments

The Standard may pay BLTD and/or SLTD benefits within 60 days after The Standard receives satisfactory proof of loss. BLTD and/or SLTD benefits will be paid to an employee at the end of each month they qualify for benefits. The payment should be received by the first of the month for the previous month.

Any BLTD benefits remaining unpaid upon employee's death will be paid to the employee's estate.

Any SLTD benefits remaining unpaid upon employee's death will be paid to the person or people eligible to receive the survivor benefit defined in the SLTD policy. In case there are no eligible survivors as defined in the SLTD policy, survivor benefits are not paid, and any remaining SLTD benefits unpaid would be paid to the employee's estate.

No assignment

The rights and benefits of the SLTD and BLTD plans cannot be assigned (paid to a third party).

Advise of adjustments and potential overpayments

Remind any employee who is applying for BLTD and SLTD benefits that these benefits are reduced by other forms of deductible income, or offsets, as outlined in the *Insurance Benefits Guide*.

- These offsets are applied against BLTD and SLTD benefits, according to an individual's eligibility to receive them, regardless of whether they actually do receive them.

Eligibility for any benefits (Social Security, PEBA retirement benefits, workers' compensation, sick leave, return-to-work earnings, etc.) should be reported to The Standard immediately, as they may be considered offsets.

Waiver of premiums

The SLTD premium waiver begins the first of the month after the end of the benefit waiting period, and premiums should continue until then.

The waiver ends when the employee returns to work. At that time, notify The Standard and complete the [SLTD Premium Waiver Form](#).

The Standard prepays FICA and Medicare

BLTD and SLTD benefits are subject to taxes, including FICA and Medicare.

- The employee share of these taxes is deducted before the benefit payments are issued.
- The Standard prepays the employer share and bills the employer quarterly for reimbursement of these amounts under the BLTD plan. You will receive a letter itemizing the charges. Follow the instructions outlined in the letter. If you receive such a letter and have any questions, call Cindy Bofinger at The Standard at 971.321.4653.
- Employee receives deductible income/offsets (PEBA retirement benefits, Social Security, workers' compensation benefits, sick leave or shared leave, etc.);
- Employee returns to work in any capacity;
- Employee needs help or assistance in returning to work;
- Employee dies; or
- Employee is terminated.

MoneyPlus

If on leave due to disability, the employee can continue their MoneyPlus accounts as explained on Page 62 under Unpaid leave or reduction in hours.

If the employee is eligible for disability retirement through PEBA, their options are explained in the **Retiree subscribers** chapter of this manual.

When you should call The Standard

Notify The Standard when you become aware of any of the following events concerning an employee receiving SLTD and/or BLTD benefits:

The image features a white background with two prominent blue geometric shapes. On the left, a horizontal blue bar with a diagonal cutout on its right side contains the text 'Claims and appeals'. To the right of this bar is a larger, dark blue trapezoidal shape that also has a diagonal cutout on its left side, creating a white gap between the two shapes. The overall design is clean and modern.

Claims and appeals

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Many of the claims and appeals procedures are outlined in the [Insurance Benefits Guide \(IBG\)](#). Refer to the appropriate benefit sections of the IBG for general claims and appeals information and procedures.

This section highlights specifics related to filing claims and appeals that are not included in the IBG and that you might need to know as a benefits administrator.

State Health Plan claims

Network providers file claims for subscribers. However, to receive benefits when a hospital or doctor does not file, subscribers can file a claim manually, as outlined in the IBG.

Tips for filing claims

The insured's name on the [State Health Plan Benefits Claim Form](#) should match the subscriber's name on file with PEBA.

Subscribers should allow about three weeks to receive an *Explanation of Benefits* (EOB) before calling BlueCross for assistance.

Claims should be filed as soon as possible, but **MUST** be filed no later than the end of the calendar year following the year in which expenses are incurred. Claims filed after that time will be denied.

The claim form cannot be used to make an address change. Subscribers can update their addresses online using MyBenefits.

State Health Plan claims for services outside the U.S.

Claims outside the U.S. are filed for subscribers through the BlueCross BlueShield Global® Core provider network. However, to receive benefits when a hospital or doctor does not file, subscribers can file the [BCBS Global Core International Claim Form](#) manually.

Coordination of benefits

State Health Plan benefits for health and prescription drug coverage are coordinated with other coverage that a subscriber, their covered spouse or their covered child(ren) may have. Refer to the IBG for the general rules about how to determine which plan is considered primary or secondary.

Prescription drug benefit

If the State Health Plan is the secondary payer for prescription drug benefits when coordination of benefits applies, the covered person should present the primary insurance card first.

The covered person would then file a manual claim using the [Prescription Drug Claim Form](#) for any benefits due as the secondary payer.

A person with a MoneyPlus debit card is advised not to use the card at the pharmacy when the State Health Plan is the secondary payer, because the manual claim must be filed to determine the amount of unreimbursed expense before filing a Medical Spending Account claim.

Claims for an active subscriber with Medicare

Medicare is the secondary payer under the active employer, unless the employee, spouse or child is enrolled in Medicare solely due to end-stage renal disease.

When an active employee, their spouse or their child(ren) is enrolled in Medicare, claims are filed with BlueCross first. Once the employee receives the *Explanation of Benefits* (EOB), they should send an itemized bill and a copy of the EOB to Medicare to be processed for secondary benefits.

If an employee is enrolled in Medicare solely due to end-stage renal disease, contact Medicare for additional information. After 30 months, Medicare becomes the primary payer for a subscriber with end-stage renal disease.

Claims for a retiree subscriber with Medicare

Medicare is the primary payer for a retiree who is eligible for Medicare. The State Health Plan (including the Medicare Supplemental Plan) coordinates claims payment as though the subscriber is enrolled in Medicare Part A and B, regardless of whether the subscriber is actually enrolled. Prior to Medicare eligibility, the Plan is the primary payer.

A retiree, who is not eligible for Medicare by their own employment record, but who might become eligible on a spouse's employment record, must enroll for Medicare when the spouse enrolls. If either refuses Medicare coverage, the Plan still coordinates claims payment as if they have both Part A and Part B benefits. If the Medicare-eligible subscriber is not covered by Part A and Part B, they will be required to pay the portion of their health care costs that Part A and Part B would have covered.

Accident questionnaires

For accident-related claims, BlueCross might need information about the event. BlueCross gathers this information through an accident questionnaire. Gathering this information is typically related to subrogation, when more than one party is involved in the accident. Subrogation is explained under *Helpful terms* in the [IBG](#).

Questionnaires are sent to subscribers when there is a claim filed for treatment of an injury or diagnosis established by BlueCross' staff of physicians as likely to be an accident or work-related.

Questionnaires are generated once a week. Subscribers can receive multiple questionnaires related to the same event, due to any of the following:

- BlueCross may not have received a response to the first questionnaire before a second one is sent. Additional questionnaires will be sent to the subscriber

each week until BlueCross receives a completed one.

- Subscribers might also receive more than one questionnaire if more than one covered person in the family receives treatment related to the same accident. A separate questionnaire is sent for each covered individual being treated for injuries related to the accident. The name of the patient is included at the top of the questionnaire.
- Once BlueCross receives a questionnaire response, it is valid for six months. If claims meeting the established accident-related criteria are reported more than six months after the original accident date, the subscriber will receive another questionnaire. This six-month cycle helps BlueCross identify any subsequent accidents that might have occurred.

If claims reported more than six months after the original accident are related to that event, the subscriber should simply check the update space and return the questionnaire to BlueCross. This will update the subscriber's file for another six months.

Other health/dental questionnaire

BlueCross sends this questionnaire to subscribers who cover dependents under the health and/or dental coverage to determine if the dependent has other primary coverage. Dependent claims can be suspended until the questionnaire is returned to BlueCross. Upon receipt of the questionnaire, it is valid for one year.

Mental health and substance use claims

Office visit services for psychological or neuropsychological testing and applied behavior analysis and all hospital inpatient, partial and intensive outpatient program admissions must receive prior authorization from Companion Benefit Alternatives (CBA).

Network claims

The provider files claims when the subscriber, their covered spouse or their covered child(ren) uses a provider that participates in the mental health and substance use provider network.

Out-of-network claims

The subscriber must complete and submit a claim form for out-of-network services. The claim form is the same for State Health Plan medical claims and mental health and substance use claims. The subscriber can file a claim manually as outlined in the IBG.

Dental Plus and Basic Dental claims

Most dental offices can file claims directly with BlueCross. However, to receive benefits when a dentist does not file directly, subscribers can file a [Dental Claim Form](#) manually as outlined in the IBG.

Tips for filing claims

The subscriber's name on the dental claim form should match the subscriber's name on file with PEBA.

A [Pretreatment Estimate](#) from BlueCross must be returned with the claim after the services are rendered. These estimates are valid for one year. Subscribers should allow about three weeks to receive an *Explanation of Benefits* (EOB) before calling BlueCross for assistance.

Claims should be filed as soon as possible but **MUST** be filed no later than 24 months following the date charges were incurred. Claims filed after that time will be denied.

The claim form cannot be used to make an address change. Subscribers can update their addresses online using MyBenefits.

State Vision Plan claims

Network claims

There are no claims to file when the subscriber uses a provider that participates in EyeMed's provider network.

EyeMed no longer requires prior authorization for medically necessary contact lenses. The provider is responsible for determining adherence to the criteria and submits a medically necessary contact lens claim form to EyeMed directly.

Out-of-network claims

The subscriber must complete and submit an [Out-of-Network Vision Services Claim Form](#) to be reimbursed for eligible expenses.

EyeMed will accept only itemized, paid receipts listing the services and the amount charged for each service. Handwritten receipts must be on the provider's letterhead.

Itemized receipts should be attached to the completed claim form and mailed to EyeMed's Out-of-Network Claims department at the address on the claim form's instructions page or follow instructions to submit claims online.

Claims must be submitted within 15 months of the date of service.

Denials and appeals

Because the Vision Plan is fully insured, subscribers cannot appeal EyeMed determinations to PEBA.

If a claims question cannot be resolved by EyeMed's Customer Care Center, the subscriber 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. EyeMed will work with the subscriber to resolve the issue within 30 days. If the subscriber is dissatisfied with EyeMed's decision, the subscriber can appeal

to an EyeMed appeals subcommittee. All appeals are resolved by EyeMed within 30 days of the date the subcommittee receives it.

Life insurance claims

Policy Number 200879

Submit the termination in EBS. The will cancel the life insurance coverage and prompt a file to be sent from PEBA to MetLife to initiate the claim process.

Submitting the claim

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 a retiree dies, the beneficiary, or the employer on their behalf, should notify MetLife of the death by calling 800.638.6420.

Notification

After MetLife receives the completed claimant statement and certified death certificate, either the claim will be approved, and payment will be made to the beneficiary, or the claim will be denied, and MetLife will send a notification of denial to the beneficiary.

Claims that are completed and submitted properly are typically processed within 10 business days, unless there are extenuating circumstances surrounding the death.

Allow at least 10 business days before checking the claim status if it is an uncomplicated claim. More complicated claims — accidents and homicides — could require an in-depth investigation. MetLife may also need to request additional medical information. Payment will be determined after the investigation is complete. If a beneficiary has a question about the status of a life insurance claim, they can call MetLife at 800.638.6420, then press 2.

Retirees

If the claim is for a deceased retiree, the beneficiary should call MetLife at 888.507.3767. The necessary claim form will be sent to the correct party for completion. MetLife will need to verify the retiree has continued the coverage into retirement.

Claims payments

MetLife will pay life insurance benefits to the beneficiary or beneficiaries as indicated on file with PEBA. *Exceptions* include:

- **Estate of the insured:** Benefits will be paid to the administrator or executor of the deceased's estate.
- **A minor:** Benefits will be paid to the court-appointed guardian for the minor and minor's estate.
- **An incompetent beneficiary:** Benefits will be paid to the guardian or other appointed representative for the beneficiary.

If applicable, a court certificate showing the appointment must be submitted. Do not delay submitting proof of death. Send it in, noting the court certificate of appointment is pending.

When the claim is approved, MetLife will send a payment notice to the beneficiary.

Assignment

MetLife is not responsible for the validity or tax consequences of any payment to a third party (called *assignment*). An assignment is the irrevocable, legal transfer of some or all of the *interest* (amount payable in the future) under a policy to a third party. The individual with the interest (e.g., the insured) makes the irrevocable assignment. The insured can assign certain rights, such as, but not limited to:

- The right to convert group coverage to individual coverage;
- The right to designate or change a beneficiary;
- The right to accelerate death benefits, if applicable; and

- The right to increase coverage, as applicable.

No assignment will be binding on MetLife until MetLife receives a completed [Absolute Assignment to Trust](#) form, records and acknowledges it. Assignments for collateral are not permitted (such as for a loan).

PEBA will maintain a copy of records of death claim payments.

Accidental death benefit

In the case of accidental death, notify PEBA, and PEBA will submit some information to initiate a life insurance claim to MetLife. The beneficiary 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 the beneficiary(ies). See the Life Insurance chapter of the *Insurance Benefits Guide* for descriptions of additional accidental death benefits.

Suicide

Suicide is a covered life claim; however, double-indemnity benefits are not payable. No Optional Life or Dependent Life-Spouse benefits are payable if death results from suicide within two years of the effective date.

If death occurs within two years of the effective date of an increase, the death benefit payable is limited to the amount of coverage prior to the increase.

Other benefits

Dismemberment benefits

If a claim is for dismemberment or loss of vision, the employer, employee and their physician must complete the [Accidental Death & Dismemberment Claim](#) form and submit it to MetLife. Dismemberment benefits are not available to retirees or dependent children.

Accelerated benefits option (Living benefit option)

When a physician diagnoses an employee or their covered dependent spouse as terminally ill with a life expectancy of no more than 12 months, the employee may request that MetLife pay up to 80% of their Optional Life or Dependent Life-Spouse benefit prior to death, up to \$400,000. The employer, employee and their physician must complete the [Accelerated Benefit Option](#) form and submit it to MetLife. When the ABO is used, a death certificate must be submitted to MetLife to obtain the remaining benefit. There is no need to complete an additional claim form.

If terminating employment, refer to the **Transfers and terminations** chapter for additional information and procedures.

Dependent Life

Policy Number 200879

Follow the claims procedures explained on Page 135.

If the spouse or child was the last eligible covered family member, and the level of coverage is affected by the spouse's or child's death, the employee has 31 days to complete the coverage change.

If coverage is not affected, to delete the spouse's or child's name the employee must still complete, sign and date an NOE.

Dependent Life pays double the amount for accidental death of a covered spouse, but not a covered child.

Dependent Life Accidental Death and Dismemberment

The procedures for filing accidental death and dismemberment claims for covered spouses are the same as for employees.

Denials and appeals (Optional Life and Dependent Life)

If a claim is denied, MetLife will notify the claimant in writing. The notice of denial states:

- The specific reason(s) for the denial;
- A reference to the plan provisions on which the denial is based; and
- An explanation of the review procedure.

The claimant may request an appeal in writing.

- Eligibility appeals should be sent to PEBA. For more information regarding the PEBA appeals process, see Page 139.
- All other appeals should be sent to MetLife.

Long term disability claims

Basic Long Term Disability

(BLTD Policy #627284-B)

Supplemental Long Term Disability

(Policy #621144-B)

Provide employees with the [Frequently asked questions about LTD coverage provided through The Standard](#) and the latest LTD Certificate(s) of Coverage(s). Both certificates of coverage, for BLTD and SLTD, are available on PEBA's website.

The FAQ document provides details on how to initiate a claim and what to expect once the claim has been submitted. Employees can initiate their disability claim(s) telephonically, online or by completing and submitting their portion of the [LTD Benefits Claim Form packet](#). Only one submission per disability is required and will be used for both BLTD and SLTD claims. Claims should be initiated as soon as the employee is absent from work for more than 31 days or when modified duties have exceeded 31 days. Employees may work part-time or have modified duties and still be eligible for benefits.

Once the employee initiates their disability claim(s) with The Standard, regardless of which submission method they use, The Standard will fax the *Attending Physician's Statement* to their treating physician. The primary benefits administrator for their agency (according to PEBA's records) will also receive an email from DoNotReplyCI@standard.com. That email is the benefits administrator's notification that one of their employees has initiated a disability claim and an employer form is required. The email will include a link to the secure site where the employer form can be completed and submitted online. Please follow the instructions in the email. If The Standard does not receive a response to its initial employer outreach email, it will make two more outreach attempts.

If the employee is not able to apply for benefits, you may initiate a claim on behalf of the employee by contacting The Standard.

Satisfactory written proof that the employee is disabled and entitled to BLTD and/or SLTD benefits must be provided. If using the paper claim form packet for submission, the claim form packet must be completed by the appropriate parties in its entirety. Detailed instructions are included on the first two pages of the packet.

Note the following if using the paper claim form packet:

- The employee completes the *Employee's Statement* in its entirety.
- The employee signs and dates the *Authorization to Obtain and Release Information*.
- The employee also signs and dates the *Authorization to Obtain Psychotherapy Notes*, if applicable.
- The employee should forward the *Employee's Statement* and both *Authorizations* to The Standard at the address on the form.
- The employee completes only Part A of the *Attending Physician's Statement* and

forwards it to their physician, who should complete Part B. The physician should forward the completed *Attending Physician's Statement* directly to The Standard at the address on the form.

- The employee should complete Section 1 of the *Employer's Statement* and forward it to their benefits administrator. You should then complete the *Statement* and forward it directly to The Standard at the address on the form.

Time limits for filing and substantiating claims

An employee should submit a completed packet to The Standard as soon as possible, but within 90 days after the end of the benefit waiting period (90 or 180 days, based on the chosen benefit waiting period). The Standard will review the *completed claim* upon receipt.

In situations where the employee is unable to obtain the information to submit a completed claim to The Standard within the time frame above, The Standard will accept completed claims up to one year after the 90-day period following the respective benefit waiting period.

If a completed claim is not filed within one year after the 90-day period following the waiting period, the employee's claim will be denied.

These time limits do not apply while the employee lacks legal capacity. In this situation, contact The Standard for additional information and instructions.

Documentation

If The Standard asks the employee to provide documentation to complete a claim packet, the employee must provide that documentation within 45 days of The Standard's request. Otherwise, the claim will be denied. The cost for providing the requested documentation is the employee's responsibility.

If The Standard asks a provider to provide documentation to complete a claim packet, the provider must provide that documentation within 45 days of The Standard's request. Otherwise, the claim may be denied.

Investigation of claim

Once The Standard receives a completed claim packet, The Standard will review the claim and gather any additional information necessary to make a determination on it.

The Standard continues to manage the employee's claim and may investigate the claim at any time for the duration of the claim.

At The Standard's expense, The Standard may have the employee examined at any time by specialists of The Standard's choice. The Standard may deny or suspend benefits if an employee fails to attend an examination or cooperate with the specialist.

If The Standard approves the employee for SLTD benefits, The Standard will notify PEBA, the employee and the employer of the approval.

- The employee's premiums are waived while SLTD benefits are payable.
- PEBA will process the waiver of premiums and generate a letter to the employer, requesting PEBA be notified immediately if the employee returns to work.

Denials and appeals

If the claim is denied, the decision is made within a reasonable period (in most cases, no more than 105 days) and communicated afterward. The notice of denial states:

- The specific reason(s) for the denial;
- A reference to the plan provisions on which the denial is based; and
- A description of additional information or material that may reverse the denial decision and why it is necessary.

How to request an appeal of a long term disability claim

The claimant can write to Standard Insurance Company, P.O. Box 2800, Portland, OR 97208, to request a review. The request must be made to The Standard within six months of receipt of the denial letter. The claimant should include any additional documentation to be considered.

The claimant will receive notification of The Standard's final decision within 90 days of the request, or within 120 days if special circumstances require an extension.

If The Standard reviews the claim and upholds the denial, the claimant will receive correspondence from the Administrative Review Unit at The Standard, including instructions for appealing the decision.

BLTD only: If The Standard upholds its decision on a claim

An appeal may be filed with PEBA within 90 days of the notice of denial.

If the denial is upheld by PEBA, the subscriber has 30 days from receipt of the denial letter from PEBA to seek judicial review as provided by S.C. Code Ann. §1-11-710 and 1-23-380.

Note: Because Supplemental Long Term Disability is fully insured by The Standard, SLTD decisions may not be appealed to PEBA.

Refer to the Disability subscribers section of this manual for additional information.

MoneyPlus claims and reimbursement

Medical Spending Account and Dependent Care Spending Account reimbursements

The subscriber files claims for reimbursement directly with ASIFlex.

ASIFlex offers several easy ways to submit claims for reimbursement. Employees can use any of these options throughout the year:

- ASIFlex website at www.asiflex.com/SCMoneyPlus;
- ASIFlex mobile app; or
- [MoneyPlus claim form](#).

If approved, reimbursement will be made within three business days of receipt. Reimbursement may be direct deposited into bank accounts within one day of processing a claim.

Employees can log in to their ASIFlex account to sign up for direct deposit, as well as email and text alerts. Employees can also opt to receive a mailed check.

There is no reimbursement minimum for direct deposit. The minimum check reimbursement is \$25, except for the last reimbursement, which brings an account balance to zero.

Special notes on Medical Spending Account reimbursements

Only eligible expenses may be claimed. Any medical expenses already covered by health, dental or vision insurance are not reimbursable.

Medical Spending Account (MSA) reimbursements are issued for the full amount of the claim, regardless of the employee's account balance, up to the unused portion of the elected annual deduction.

If not continuing an MSA after termination through COBRA, the employee has through the run-out

period to submit claims incurred during their period of coverage while they were an employee.

ASIFlex debit card reimbursements

The ASIFlex debit card may be used at:

- Medical service providers, such as physician and dental offices, hospitals, medical labs;
- Prescription drug mail-order websites, such as Express Scripts Pharmacy, the State Health Plan's mail-order prescription drug service; and
- Pharmacies and any other stores that use Inventory Information Approval Systems (IIAS).
 - Prescriptions and eligible over-the-counter items are coded and identified electronically by the debit card and other MSA card programs. Only the items that are IIAS coded can be purchased with the card.
Example: If you go to Walgreens, an IIAS user, and buy a prescription, contact lens solution and a magazine, the charge for the magazine will not process. It must be paid for separately.

People with an ASIFlex debit card should not use the card at a pharmacy if they have other coverage, because claims for both primary and secondary plans must be filed to determine the amount of *unreimbursed* expense before filing an MSA reimbursement.

Documentation

ASIFlex will receive claims information from other third-party vendors to auto-adjudicate as many card transactions as possible. Use of the card, however, is not paperless. Employees may be required to submit documentation to substantiate claims.

Requests for documentation are emailed and posted to an online secure message center. A participant has 52 days to respond. An initial notice is sent approximately five days after ASIFlex receives notice of transaction. A reminder notice is sent 21 days after initial notice. A deactivation notice is sent 21 days after reminder notice. Future

claim submissions are offset by any outstanding amount.

Card transactions that remain unsubstantiated by March 31 after the end of the plan year are taxable as income, and ASIFlex will send a report to employers listing all unsubstantiated card transactions. Refer to the Accounting, Billing and Reports section of this manual for additional information.

Special notes on Dependent Care Spending Account reimbursements

The dependent care provider may sign the MoneyPlus claim form where indicated in lieu of an itemized receipt.

There must be sufficient funds in the account balance to reimburse expenses. Payroll deductions from the employer are submitted to ASIFlex. If there is no payroll discrepancy, ASIFlex will post contributions to accounts within one business day of receipt or on the actual payroll date, whichever is later.

If an employee submits a reimbursement request before ASIFlex receives and posts the payroll deduction, the request is suspended and then paid within three business days after the payroll deduction posts.

A suspended request also results when an employee incurs expenses for more than the account balance. Payment for the balance is issued. Additional reimbursements are issued as the payroll deduction posts and the funds become available.

Health Savings Account reimbursements

There must be sufficient funds in the bank account balance to reimburse expenses. Payroll deductions from the employer are submitted to ASIFlex. If there is no payroll discrepancy, ASIFlex will send contributions to HSA Central to post to participants' accounts within one business day of receipt or on the actual payroll date, whichever is later.

Employees who enroll in a Health Savings Account (HSA) must set up a bank account with HSA Central to access their funds.

The participant is responsible for reimbursing themselves from their HSA by using their HSA debit card at the time of service or transferring funds from their HSA to their checking account online.

The participant is responsible for ensuring they reimburse themselves *only for eligible expenses*. The participant is responsible for retaining documentation and providing it to the IRS, if requested.

Refer to the **MoneyPlus and HSA payroll deductions** chapter for more information about payroll deductions.

Administrative or eligibility appeals

If an employee, retiree, survivor, spouse, former spouse or child(ren) is unable to enroll, disenroll or change their coverage, the subscriber has the right to a review.

Examples include, but are not limited to:

- Eligibility for incapacitated child coverage;
- Enrollment in MoneyPlus;
- A coverage change request outside of an open enrollment period;
- A coverage change request more than 31 days after a special eligibility situation occurs;
- Eligibility for nonfunded, partially-funded or funded retiree coverage;
- Extension of COBRA coverage; and
- Removal of the tobacco and e-cigarette use premium.

Retirees, survivors and COBRA subscribers of state agencies, public school districts or public higher education institutions can submit requests directly to PEBA, which serves as their benefits administrator.

Retirees, survivors or COBRA subscribers of optional employers can submit requests through the benefits office of their former employer, which serves as their benefits administrator.

Employees may request a review through their benefits administrator.

Request for Review process

Submit a Request for Review (RFR) through EBS under Manage Subscribers. A RFR describes the active subscriber's issue, explains the surrounding circumstances and includes any supporting documentation. Upon the employee's request, you must submit the RFR regardless of whether you support the subscriber's request.

If a mistake was made by the benefits office, such as misplacing or failing to submit documentation in a timely manner, select the reason as *Late - Employer or Correction - Employer* from the drop-down list of reasons. Include a summary of the change requested, explain the circumstances of the request and upload any supporting documentation. Subscriber negligence is not considered an employer delay or correction.

If no mistake was made by the benefits office, select the reason as *Late - Employee or Correction - Employee* from the drop-down list of reasons. Include a summary of the change requested, explain the circumstances of the request and upload any supporting documentation.

If the RFR is approved, the transaction will apply with the requested effective date, and the transaction will no longer appear on your RFR tab. Any premiums due must be paid; therefore, it is imperative the subscriber understands the possibility of retro premiums.

If the RFR is rejected, an explanation of what needs to be done to correct the error will be shown on the suspended transaction.

If it is denied, the status changes to *PEBA Denied* and the employee will receive an email if PEBA has a valid email address on file. View the RFR Denial and

denial reason, and save or print prior to your acknowledgement. Notify the employee and place a copy of the denial in the employee's file.

View a RFR training resource at peba.sc.gov/insurance-training.

If completing a request on the paper [Request for Review](#) form, complete the form in its entirety and mark the change reason as either a *BA clerical error or delay* or a *Subscriber request*. Explain the circumstances of the request and attach any supporting documentation.

- If making a change to coverage, you need to include an original NOE, completed and signed by you and the subscriber. The NOE must correct the error addressed on the form.
- Attach an NOE whenever an effective date correction is more than 90 days retroactive.
- If denied, PEBA will send you a denial that must be sent to the subscriber, notifying them they have 90 days to appeal to PEBA.

A Request for Review is not required for retroactive termination of a subscriber's file. If the retroactive termination exceeds 31 days, the employer is responsible for paying any premiums beyond the 31-day period, back to the date of termination.

If the request is approved due to an employer delay or error, the approval is effective retroactively, up to one year back to the actual effective date. Any premiums due must be paid. Changes cannot be made prospectively or for the date the request is made.

Example: A new employee was hired on March 1, 2024, but due to an employer delay, the enrollment is not submitted to PEBA until July 1, 2025. PEBA receives a Request for Review and enrollment to add the employee, effective July 1, 2025.

- The employee will be added effective July 1, 2024, one year retroactive from PEBA's receipt of the request, as the request was received more than one year after the hire

date of March 1, 2024. Premiums are due from July 1, 2024, forward.

Appeal process

If the subscriber disagrees with PEBA's decision, the subscriber may appeal in writing to PEBA within 90 days of the denied request. The subscriber should explain why they are appealing, attach any additional information and supporting documents and include a copy of the denial.

If the Request for Review was denied because of lack of documentation, the subscriber should include the previously missing documentation.

A benefits administrator, employer or health care provider may not appeal to PEBA on the subscriber's behalf. Only the subscriber, 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 may initiate an appeal through PEBA. A benefits administrator, employer or health care provider cannot be an authorized representative.

In most cases, the appeal should be sent to IAD@peba.sc.gov or:

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

If the appeal is urgent and relates to a pregnancy, newborn child or the prior authorization of a life-saving treatment or drug, the subscriber may send the appeal to urgentappeals@peba.sc.gov.

PEBA will review the request and make every effort to process the subscriber's appeal within 180 days of the date all the appeal information is received. However, this time may be extended if additional material is requested or the subscriber asks for an extension. PEBA will send the subscriber periodic updates on the status of the review. Once PEBA's

review of the appeal is complete, the subscriber will receive a written determination.

If the appeal is approved, PEBA will process the enrollment and notify the subscriber and their benefits administrator of any other needed documentation.

If the appeal is denied, PEBA will send the subscriber a detailed decision letter explaining the reason(s) for denial. The subscriber will then have 30 days to seek judicial review at the Administrative Law Court, as provided by Section 1-11-710 and 1-23-380 of the S.C. Code of Laws, as amended.

Appeals related to claims or authorization of benefits

If an employee, retiree, survivor, spouse, former spouse or child is seeking authorization of benefits or reimbursement for a claim, the subscriber has the right to a review.

Vision, Life Insurance and Supplemental Long Term Disability benefits are fully insured products and are not to be appealed to PEBA. Page 139 describes the appeals process for these fully insured products.

All other coverage issues related to claims or the authorization of benefits are appealed first to the applicable third-party claims administrator and then to PEBA. Examples include, but are not limited to:

- Prior authorization of medical, behavioral health, or dental services, and treatments or devices;
- Prior authorization of prescription medication;
- Reimbursement of MoneyPlus claims;
- Reimbursement of claims for medical, behavioral health or dental services, and treatments, or devices; and
- Payment for Basic Long Term Disability claims.

If a subscriber request for authorization of benefits or reimbursement for a claim from the appropriate third-party claims administrator is denied, then the

subscriber can appeal to the third-party claims administrator within:

- Three days for radiology prior authorization appeals;
- 31 days for MoneyPlus appeals; and
- Six months for other appeals.

If the third-party claims administrator denies the appeal, the subscriber can appeal to PEBA within 90 days.

Exceptions:

- **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, the subscriber may request a second-level medical review within 90 days of notice of the denial. The subscriber must include the following information in their 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 their claim or prior authorization request.

They may also request an expedited second-level medical review. If the subscriber would like for someone to appeal on their behalf, they may make this request to BlueCross, Medi-Call or CBA in writing. Note: medical providers cannot appeal on a subscriber's behalf.

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 the subscriber a written decision stating the specific reasons for its final decision.

- The pharmacy benefits manager, Express Scripts, may conduct one to three reviews, depending on the circumstances of the appeal. Once the appeals process is completed, Express Scripts will send a decision letter to the subscriber. If denied, the denial letter will describe the subscriber's appeal rights to PEBA. The subscriber will still have 90 days to appeal to PEBA.

Third-party claims administrators

- **BlueCross BlueShield of South Carolina** (health insurance claims)
StateSC.SouthCarolinaBlues.com
803.736.1576 or 800.868.2520
- **Medi-Call** (medical prior authorization)
803.699.3337 or 800.925.9724
- **Companion Benefit Alternatives** (behavioral health benefits prior authorization)
www.CompanionBenefitAlternatives.com
803.736.1576 or 800.868.2520
- **Evolent** (radiology prior authorization)
www.RadMD.com
866.500.7664
- **Express Scripts** (prescription medication)
Attn: Benefit Coverage Review Department
P.O. Box 66587
St. Louis, MO 63166-6587
- **BlueCross BlueShield of South Carolina** (dental claims)
Attn: State Dental Appeals
AX-B15
P.O. Box 100300
Columbia, SC 29202-3300
- **Standard Insurance Company** (Basic Long Term Disability)
P.O. Box 2800
Portland, OR 97208

- **ASIFlex** (MoneyPlus claims)
ASIFlex Appeals
Attn: S.C. MoneyPlus
P.O. Box 6044
Columbia, MO 65205-6044

Once the subscriber has received the denial letter from the third-party claims administrator with the 90-day appeal language, the subscriber can appeal to PEBA.

A benefits administrator, employer or health care provider may not appeal to PEBA on the subscriber's behalf. Only the subscriber, 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 may initiate an appeal through PEBA. A benefits administrator, employer or health care provider cannot be an authorized representative.

In most cases, the appeal should be sent to IAD@peba.sc.gov or:

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

If the appeal is urgent and relates to a pregnancy, newborn child or the prior authorization of a life-saving treatment or drug, the subscriber may send the appeal to urgentappeals@peba.sc.gov.

PEBA will review the request and make every effort to process the subscriber's appeal within 180 days of the date all the appeal information is received. However, this time may be extended if additional material is requested or if the subscriber asks for an extension. PEBA will send the subscriber periodic updates on the status of the review. Once PEBA's review of the appeal is complete, the subscriber will receive a written determination.

If the appeal is denied, PEBA will send the subscriber a detailed decision letter explaining the reason(s) for denial. The subscriber will then have

30 days to seek judicial review at the Administrative Law Court, as provided by Section 1-11-710 and 1-23-380 of the S.C. Code of Laws, as amended.



Accounting and billing

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This section includes information about the monthly billing statement and other accounting procedures. This is only a guide; it will not cover every situation. If you have questions, call your PEBA Insurance Finance account representative (indicated on your Billing Statement) at 803.734.1696 or 888.260.9430.

View information about accounting and enrollment reports in the **EBS reports** chapter.

General accounting rules

Employers are responsible for collecting all premiums and submitting them to PEBA. In relation to this responsibility, an employee authorizes their employer to collect their portion of the premiums for the coverage selected. The employer will be billed and is required to pay all outstanding premiums.

Collecting premiums for mid-month changes

Changes in status

For changes in status, effective *on or before the 15th of the month*, collect premiums for that entire month.

For changes in status, effective *after the 15th of the month*, start collecting premiums the first of the following month.

Death of employee/subscriber

If terminating coverage due to death of an employee or other subscriber *on or before the 15th of the month*, do not collect premiums for that month.

- Exception: If the employee or other subscriber dies *on the 15th of the month*, coverage will be terminated on the 16th of the month. Collect premiums for the entire month.

If terminating coverage due to death of an employee or other subscriber *after the 15th of the month*, collect premiums for that entire month.

Unpaid leave rules

For more information and policies regarding unpaid leave, refer to the **Active subscribers** chapter under unpaid leave or reduction in hours.

In an unpaid leave situation, be consistent and fair with notification and time allowances on premium payments owed by the employee.

If the employee does not pay the premiums, the employer can terminate the coverage for nonpayment of premiums, but only up to 31 days retroactive.

See *Submitting premiums for employees on unpaid leave* for your employer type.

Issuing credits

Not applicable to Comptroller General (CG) agencies

PEBA does not issue individual refunds. Instead, a credit is applied to the billing statement and the employer then refunds the subscriber.

- When a refund of tax-deferred premiums is issued to an employee, the employee's taxable salary should be adjusted for their W-2 records. It is not PEBA's responsibility to confirm this adjustment is made.

Retroactivity

When a coverage election is processed with an effective date prior to the current billing statement month, a charge or credit of premiums is considered retroactive.

Billing statements

On or before the first of each month, PEBA produces a billing statement in EBS (HAC610) for active subscribers. This PDF billing statement enables you to maintain the accounting records of each employee. If you verify the information on the billing statement and communicate with PEBA when there are questions about the information, the financial process for employees' benefits should work smoothly.

The billing statement includes employer contributions and employee premiums due for all insurance programs.

See the **EBS reports** chapter for more information about the billing statements in EBS.

Advance deposit billing statement

Not applicable to Comptroller General (CG) agencies

An advance deposit of at least one month's premium for employer contributions is due to PEBA each year. Payment is due to PEBA by July 15.

The advance deposit bill lists insurance programs for which the employer contributes to the monthly premium (State Health Plan, Basic Dental, Basic Life, Basic LTD) and the subscriber count enrolled in each of these programs at the end of June. The subscriber count is multiplied by the current employer rate to arrive at the deposit amount.

See the **EBS reports** chapter for more information.

Active billing file

All employers are responsible for reconciling their employer and employee records monthly. PEBA provides Active Billing Files (HAC450 or HAC460) in EBS.

See the **EBS reports** chapter for more information.

Submitting premium payments to PEBA

Not applicable to Comptroller General (CG) agencies

All balances are due to PEBA on the 10th of the month and must be paid as billed. If there is a keying error on the Coverage Processing pages of the bill, contact PEBA immediately. If payment is not remitted by the 10th, employers will risk suspension of claims payments for their employees.

- Do not adjust the billing statement.
- Do not delay the regular remittance of monthly premiums due to inability to collect payments from subscribers.

- Employers must pay no less than the current employer share of the premiums for their active employees.
- Do not submit individual checks from your employees. See *Submitting premiums for employees on unpaid leave* for your employer type.

Remit payments to PEBA through one of the three following options:

Online Bill Pay

Processing your payment online through EBS is easy and convenient.

To use this feature:

- Complete a new *EBS Designated Employee Confidentiality Agreement* form and mark Online Bill Pay.
- Log in to your EBS account and verify your email address in the lower right corner on the EBS homepage before submitting a payment. Select the *Update My Email Address* link if changes are needed.

After you complete these steps, you will be able to complete the following with Online Bill Pay:

- Schedule a payment;
- View the status of your account;
- View bill and payment history for the previous 12 months; and
- View billing statements for the previous 12 months.

Note: the minimum amount you may pay is your current balance.

Electronic Funds Transfer (EFT)

Electronic Funds Transfer, or automatic draft, gives PEBA authorization to automatically deduct the total amount due, per the monthly billing statement (HAC610), from the designated bank account. The amount will be drafted from the designated bank account on the 10th of the following month. If the 10th falls on a weekend or holiday, the draft will occur on the next business day.

To enroll in EFT payments, complete an *Authorization Agreement for Electronic Funds Transfer*. Submit this form with a voided check from the designated bank account. After PEBA receives the authorization, it will take about 31 days for the automatic draft to begin.

Check

Allow additional time for processing of paper checks. All checks should be made payable to PEBA. See more information about check payments for your employer type in the next section.

You must return a completed Remittance Advice form with every payment. See the **EBS reports** chapter for information about the Remittance Advice.

If you are submitting more than one check, list the amount of each check on the right side of the Remittance Advice. Verify the total check amounts equal the total amount due. Sign, date and provide a telephone number in the appropriate spaces.

Do not return any other section of the billing statement with your payment.

Mail your payment to the following address:

S.C. PEBA
Attn: Insurance Finance Department
P.O. Box 11661
Columbia, SC 29211

See also the premium checks quick reference on Page 231.

MoneyPlus and HSA payrolls and accounting

Each employer is responsible for reporting the actual amount of each payroll deduction every payroll cycle to ASIFlex. Refer to the **MoneyPlus and HSA payroll deductions** chapter for details about the ASIFlex employer portal, processing payroll deduction files, reviewing and responding to discrepancy reports, and more.

To post contributions to participant accounts, ASIFlex must receive the funding from each employer in a timely manner. Send actual funds via ACH to ASIFlex three business days prior to the actual pay date.

For optional employers

Review the *Requirements for Participation* and more information in the [Optional Employer Handbook](#).

Administrative fee

Optional employers must pay a \$3 administrative fee for each active employee, retiree, survivor and COBRA participant per month based on enrollment in health or dental coverage. Employers cannot pass this fee to active employees and COBRA participants. An employer may require retirees and survivors to pay this fee.

Experience rating health premiums

Optional employers are subject to experience rating of health insurance premiums. The experience rating load factor or a percentage amount is added to the optional employer's health premiums based on claims history. This factor is adjusted each year.

PEBA calculates the experience rating load factor of all optional employers annually. Employers will receive written notification of their load factor each March, and the factor will be applied in January of the following year to both the employer and employee premiums.

The employer may choose to absorb some or all of any increase in the employee share. However, an employer may **not** pass along any of the employer share of the increase to the employee. The employer is responsible for notifying its subscribers of any rate changes. Employer contributions and employee premiums might be different than those published in PEBA publications. Use the [fillable optional employer premium worksheet](#).

Rate changes due to experience rating are separate and are in addition to any annual, across-the-board

rate increases that are announced each fall for the upcoming plan year.

When optional employers initially join the State insurance benefits program, they are categorized by their number of covered lives (number of individuals insured under the program).

- **Small:** Fewer than 100 covered lives. Rated according to average claims experience of all the small employers.
- **Medium:** 100-500 covered lives. Once 24 months of claims are incurred for an employer, rated using a formula that gives 50% weight to the average claims experience of all medium employers combined and 50% weight to the claims experience of the individual employer.
- **Large:** More than 500 covered lives. Once 12 months of claims are incurred for an employer, rated solely on the claims experience of that employer.

See the [Optional Employer Handbook](#) for complete details about experience rating load factors. A [history of load factors](#) is also available.

View information about two reports that detail updated health insurance premiums in the **EBS reports** chapter.

- Active Rate with Load Factor (HTB527)
- Individual Rate with Load Factor (HTB528)

For optional employers and charter schools

PEBA designates charter schools as Track 1 if the school participates in the state insurance benefits program only and does not participate in the state retirement systems. Learn more in the [Charter School Handbook](#).

Retiree, COBRA and Survivor premiums

The employer continues to serve as the benefits administrator for these subscribers; therefore, the employer will receive the monthly Retiree, COBRA and Survivor bill (HRA610) in EBS.

The PDF billing statement is the same as that for active subscribers. Note that some programs are not listed, because they are not available to these subscribers. The \$3 administrative fee for each retiree, survivor and COBRA participant per month is included on the Account Summary pages.

Collect the premiums for covered retirees, COBRA and survivor subscribers and deposit their checks into your account. Their checks should be made payable to the employer, **not PEBA. Do not submit personal subscriber checks to PEBA.**

Subscriber questions regarding the premium amounts or billing will be directed to the employer.

Remit a single check for the total amount due shown on the Remittance Advice page of the individual and active group bills.

Retiree, COBRA and Survivor Roster

This monthly PDF- or CSV-formatted roster (HRA500) provides information on each retiree, COBRA and survivor subscriber's coverage, and the monthly employee premium for each program:

- State Health Plan;
- Basic Dental;
- Dental Plus;
- Vision; and
- Tobacco and e-cigarette use premium.

The roster is divided into sections based on subscriber type (18-month COBRA, 29-month COBRA, 36-month COBRA, Retiree-Regular, Retiree-25 Year, Survivor, etc.).

In each of the sections, names are printed in alphabetical order by last name, first name and middle initial, with the BIN listed in the next

column. This roster will not include Social Security numbers.

Submitting premiums for employees on unpaid leave

Premiums for employees on unpaid leave are included on the monthly billing statement (HAC610).

Collect the total monthly premium due for employees on unpaid leave. Personal checks must be made payable to the employer, **not** PEBA. Deposit the collected unpaid leave premiums into your employer account and include the premiums in your monthly payment. **Do not submit personal subscriber checks to PEBA.**

For school districts, public higher education institutions and charter schools

PEBA designates charter schools as Track 2 if the school participates in both the state retirement systems and the state insurance benefits program. Learn more in the [Charter School Handbook](#).

Retiree, COBRA and Survivor premiums

PEBA becomes the benefits administrator for these subscribers. The subscriber, not the employer, will receive a bill from PEBA.

Personal checks, payable to PEBA, must be submitted to PEBA with the bill. Retirees, who have their premiums deducted from their retirement checks or automatically drafted from a bank account, do not receive a bill.

Submitting premiums for employees on unpaid leave

Premiums for employees on unpaid leave are included on the monthly billing statement (HAC610).

Collect the total monthly premium due for employees on unpaid leave. Personal checks must be made payable to the employer, **not** PEBA. Deposit the collected unpaid leave premiums into your group account and include the premiums in your monthly payment. **Do not submit personal subscriber checks to PEBA.**

For Comptroller General (CG) agencies only

Retiree, COBRA and Survivor premiums

PEBA becomes the benefits administrator for these subscribers. The subscriber, not the CG agency, will receive a bill from PEBA.

Personal checks, payable to PEBA, must be submitted to PEBA with the bill. Retirees, who have their premiums deducted from their retirement checks or automatically drafted from a bank account, do not receive a bill.

Submitting premiums for employees on unpaid leave

Premiums for employees on unpaid leave are included on the monthly billing statement (HAC610).

Collect the total monthly premium due for employees on unpaid leave. Make sure the personal check(s) includes the employee's BIN. Submit the personal checks from the employees on unpaid leave, along with a [personal checks](#) form of the plans/coverage for each.

If you do not collect the monthly premium from a subscriber while they are in unpaid leave status, SCEIS will collect the total amount due from the first payroll check the subscriber receives once they are no longer in unpaid leave status. If you remit the monthly premiums, notify SCEIS that the payments have been sent to PEBA so they will not deduct the incorrect amount. SCEIS will continue to remit the

monthly employer premiums for the subscriber while they are in unpaid leave status.

See Page 146 for more information on unpaid leave rules.

Payroll reconciliation report

PEBA sends an enrollment file to SCEIS daily. SCEIS uses the information on the file (benefit, effective date, type of entry, coverage level and premium) to determine the premiums to be deducted on the next payroll. The reconciliation reports are a comparison of the enrollment files at PEBA and the SCEIS payroll deductions.

PEBA provides a monthly reconciliation (Employee-HAC402; Employer-HAC403) of monthly premiums to all CG agencies. The reconciliations identify when a billed amount is different than the deducted premium (employee) or SCEIS employer contribution. Research each difference and take proper action to correct any problem(s).

See the **EBS reports** chapter for more information.

SCEIS payroll process

SCEIS collects and remits to PEBA the employer and employee premiums based on the daily enrollment file. You may view your monthly billing statement (HAC610); however, do not remit payment for the monthly premiums. See *Billing Statement* and the **EBS reports** chapter for details.

Contact the SCEIS Help Desk with questions concerning which account the employer premiums are taken from or the funding source for the employer premiums.

If you discover an enrollment error on the billing statement, contact PEBA to resolve the error, which should correct the deduction. If the coverage is correct but the payroll deductions are not, contact the SCEIS Help Desk.

For a new hire or coverage change resulting in a large balance due, premiums may be collected over several pay periods. Contact the SCEIS Help Desk to

change the amount of the deduction and the number of pay periods.

Refunds are a reimbursement of overpaid insurance premiums to the employee, or to the employer in certain situations.

After February 1 of each year, SCEIS no longer collects or refunds for enrollment transactions with an effective date in the previous year. Employers should submit refund requests for premiums deducted in the previous year to PEBA. Balances from the previous year should be paid by collecting and remitting a personal check from the subscriber to PEBA.

SCEIS will not process a refund check for amounts less than \$1; therefore, an adjustment must be requested to zero out an employee's balance.

Unclaimed refund checks

If the U.S. Postal Service returns a refund check to your employer as undeliverable, the check, along with the envelope returned from the U.S. Postal Service stating it was unable to deliver the refund check, should be forwarded to PEBA. The overpayment of premiums will become a part of the Unclaimed Property maintained by the Office of the State Treasurer. Former employees can search by their name to locate any unclaimed funds due to them at treasurer.sc.gov.

Annual SLTD salary updates

Not applicable to Comptroller General (CG) agencies

All salaries must be reviewed and updated annually during open enrollment. You may begin entering the salaries in EBS on September 15, and the information is due to PEBA no later than October 31.

See the **Using the online system** chapter for more information.

Affordable Care Act (ACA)

The Patient Protection and Affordable Care Act, also known as the Affordable Care Act, is the health reform legislation signed into law in March 2010. Key provisions of the legislation include extending coverage to millions of uninsured Americans, implementing measures that will lower health care costs and eliminating industry practices that include denial of coverage due to preexisting conditions.

The ACA does not require businesses to provide health benefits to their workers, but applicable large employers may face penalties if they don't make affordable coverage available. The Employer Shared Responsibility Provision of the ACA penalizes employers who either do not offer coverage or do not offer coverage that meets minimum value and affordability standards.

As a participating employer in PEBA insurance benefits, you must offer coverage to all employees eligible to participate in the insurance benefits. The [Plan of Benefits](#) document has been amended to allow coverage for permanent full-time employees, as well as non-permanent full-time employees and variable-hour, part-time and seasonal employees.

PEBA offers "grandfathered health plans" under the ACA. As a grandfathered plan, PEBA will be able to minimize the increase in State Health Plan premiums while it assesses the future financial impact of the act. As permitted by the ACA, a grandfathered health plan can preserve certain basic health coverage that was already in effect when the law was enacted.

Being a grandfathered health plan means the plan may not include certain consumer protections of the ACA that apply to other plans, such as the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the ACA, such as the elimination of lifetime limits on benefits.

For ACA resources, including frequently asked questions and reporting requirements, go to peba.sc.gov/aca.

Nondiscrimination testing

To remain tax free under Internal Revenue Code sections 105, 125 and 129, the MoneyPlus plan must pass several nondiscrimination tests.

One of these tests, the 55% Average Benefits Test, requires that all eligible employees' gross compensation be collected. This test is vital in determining the MoneyPlus plan's compliance with IRS nondiscrimination rules.

PEBA and ASIFlex collaborate to perform this test twice each plan year.

This is for your information only. PEBA and/or ASIFlex will contact you directly if they need any information for the purpose of nondiscrimination testing.

Imputed income (taxable portion of Optional Life premiums)

Optional Life insurance coverage in excess of \$50,000 is considered imputed income (taxable) by the IRS when the premium for this coverage is paid through the MoneyPlus Pretax Group Insurance Premium feature. The imputed income is based on an employee's age and amount of Optional Life coverage in excess of \$50,000. It is added to the employee's salary and is subject to federal income tax and FICA. The taxable portion of the Optional Life coverage will always be the amount over \$50,000 of the total coverage, regardless of any employer contributions.

Imputed income rate table
(2025 tax year)

Age category	Rate per \$1,000 in coverage beyond \$50,000
Younger than 25	0.05
25-29	0.06
30-34	0.08
35-39	0.09
40-44	0.10
45-49	0.15
50-54	0.23
55-59	0.43
60-64	0.66
65-69	1.27
70 and older	2.06

Imputed income is calculated based on the IRS rate table above. The IRS may change these rates periodically. Each \$1,000 of Optional Life coverage beyond \$50,000 is multiplied by the monthly rate for the applicable age group.

Example: An employee, who elected \$180,000 in Optional Life coverage, turns age 40 in October 2024. His monthly Optional Life premium on \$180,000 in coverage is \$10.80, based on his age category the previous December 31.

His imputed income would be calculated like this:

1. $\$180,000 - \$50,000 = \$130,000$
2. $\$130,000 \div 1,000 = \130 (the per-thousand amount)
3. 130×0.10 (the rate for the age 40-44 category from the IRS rate table) = \$13.00

per month. This is the taxable monthly amount of imputed income.

This monthly amount may be multiplied by 12 to get an annual amount. The employer is responsible for reporting the imputed income amounts on employees' W-2 forms.

On a monthly basis, PEBA provides the Optional Life Taxable/Non-taxable Change File (HAC998), and prior to the new plan year, after open enrollment changes have been updated, PEBA will provide the OL Taxable/Non-taxable Premiums File (HAC999). Files include employees enrolled with Optional Life coverage over \$50,000. See the **EBS reports** chapter for more information.

At the end of the year, PEBA will provide the YTD Imputed Income Report (HAC996) so you can adjust the employees' W-2 forms accordingly. See the **EBS reports** chapter for more information.

Your employer may choose to deduct the taxable and non-taxable premium amounts separately each pay period. If your employer accounts for the taxable portion of the OL premiums for employees throughout the year on all payrolls, you will need to use only the YTD Imputed Income Report (HAC996) for comparison purposes.

Important reminders in calculating imputed income

Imputed income for employees who were enrolled only part of the year should be prorated.

Unlike calculating PEBA OL premiums, which are based on the employee's age category as of the *previous* December 31, imputed income is calculated by the IRS, based on the employee's age category as of December 31 of the *current* year.

Example: For the 2024 tax year, if an employee turns age 50 in September, their IRS-imputed income for 2024 is based on the rate for the 50-54 age category in the IRS rate table, even though their 2024 OL premium is based on the age 45-49 category.

Instead of one age category for OL premiums for those younger than 35, there are three age categories in the IRS rate table for those younger than 35:

- Younger than age 25;
- Ages 25-29; and
- Ages 30-34.

The last category in the IRS rate table is for those ages 70 and older, whereas the last age category for OL premiums is 80 and older.

Reclassification of outstanding MoneyPlus MSA debit card transactions

Reclassification report

By November 1 each year, ASIFlex will send benefits administrators a payback report listing any employees with outstanding debit card transactions from the previous plan year. This report shows each individual transaction (by SSN and name) and the total amount due. Employers will receive the report only if they have employees with outstanding transactions.

Employees who are on this report have received multiple notifications about the outstanding transaction(s), including a final notice sent by September 1 instructing them to provide documentation.

Reclassification


The unsubstantiated amounts must be reclassified as taxable income, and the employee's W-2 must be amended to reflect that amount.

Example: For the 2024 plan year, an employee has an outstanding card transaction of \$50. That employee has until March 31, 2025, to clear up the expense by:

- Submitting the necessary documentation to substantiate the claim;
- Filing a paper claim or claims that will offset the outstanding card transaction amount; or
- Writing a check made payable to the State of South Carolina and mailing it to ASIFlex, S.C. MoneyPlus, P.O. Box 6044, Columbia, MO 65205-6044. This check will repay their account for the outstanding card transaction amount.

If the outstanding transaction amount is not cleared up by one of these methods, the amount is taxable as income. Since this amount cannot be confirmed until after the end of the tax-reporting period (April 15, 2025), the amount will be reported for the 2025 tax year. In November 2025, ASIFlex will post a report on its employer portal that will include the employee's name and the amount to be added to their taxable income on their 2025 W-2, which will be issued to them in early 2026.

For CG agencies, ASIFlex will send a file to the Comptroller General's Office to include the unsubstantiated amounts on the employee's W-2. Your accountant/auditor can discuss the proper W-2 application.

The image features a white background with two prominent blue geometric shapes. On the left, a horizontal blue bar with a diagonal cutout on its right side contains the text. To the right of this bar is a larger, dark blue trapezoidal shape that also has a diagonal cutout on its left side, creating a white diagonal line between the two shapes.

MoneyPlus and HSA payroll deductions

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ASIFlex administers the MoneyPlus flexible spending accounts, as well as Health Savings Accounts (HSAs). HSA Central serves as the custodial bank for HSAs. Health Savings Accounts are no longer a part of MoneyPlus; however, employers will continue to submit payroll deductions for HSAs to ASIFlex. There are no changes to the payroll submission process with the new HSA contract.

Each employer is responsible for sending funds for flexible spending accounts and HSAs to ASIFlex and for timely reporting of payroll deductions to these accounts to ensure uninterrupted claim processing for employees. This chapter provides an overview of the process; describes your ongoing duties regarding when and how to report deductions; discusses how ASIFlex identifies and reports account discrepancies to you; and tells you how to respond to and resolve discrepancies.

Enrollment

Each year during open enrollment, employees elect to participate in, or reenroll in, the MoneyPlus programs for the following year. Employees can elect to contribute to an HSA throughout the year. Mid-year new hires can enroll within 31 days of employment. PEBA reports enrollment to ASIFlex daily, and accounts are established for each participant with the plan year election amount. During the plan year, employers will take pretax payroll deductions from each participant to fund the accounts.

As the claims administrator, ASIFlex establishes an expected payroll deduction amount for each participant, which is based on the participant's election and payroll cycle provided to PEBA. These expected amounts can be modified during the year within 31 days of a qualifying change in status event for flexible spending accounts.

HSA elections roll over from year to year unless a participant changes their election during open

enrollment. HSA contribution elections can be changed at any time for any reason, but not more frequently than monthly. Changes must be made through PEBA's enrollment process, and PEBA will provide the updated election amount and payroll cycle to ASIFlex.

Payroll deductions

Each employer is responsible for reporting the actual amount of each payroll deduction every payroll cycle to ASIFlex.² There are two ways an employer can report deductions to ASIFlex:

1. Use a common file format to transmit data; or,
2. Enter payroll deduction data through a secure ASIFlex employer portal.

Each employer will send the actual funds to ASIFlex via an ACH transaction. Although checks can be accepted for account funding, it is recommended that funds be sent to ASIFlex via ACH transaction, which is secure and fast. Sending a check may delay the process and ultimately impact timely claim reimbursements for participants. Contributions cannot be posted to participant accounts until funding is received.

The expected payroll deduction amounts will be compared to the payroll deduction file sent by the employer each payroll cycle by one of the two methods above. ASIFlex will determine if there are any discrepancies in the deduction information. If there are no discrepancies between the expected amounts and payroll deduction file, and the payroll deduction file matches the actual funding, the contributions are posted to participant accounts on the payroll date and no discrepancy report is produced.

If the total funding does not match the payroll deduction file, the entire process is stopped and ASIFlex will contact the employer by email (from scdata@asiflex.com) to request that the payroll

² Does not apply to employers whose payroll is submitted through the Comptroller General's Office.

deduction file and funding be reconciled in a timely manner so correct contributions can be posted to participant accounts by the payroll date.

If there are any individual account contributions that do not match the expected amounts, ASIFlex will produce a discrepancy report to identify the individual account discrepancies. The employer is then responsible for reviewing the discrepancy report and informing ASIFlex if the amounts have changed, if there is a new enrollee or if an account has terminated. The employer must also make eligibility and enrollment updates in EBS with PEBA, if needed.

ASIFlex will post the contributions to participant accounts provided funding is received and matches the payroll deduction file, even if there are individual account discrepancies. If the employer reports a \$100 contribution but sends funding of only \$25, this is reported to the employer as a discrepancy. If the employer reports a \$25 contribution but sends funding of \$100, the error is still reported to the employer as a discrepancy.

A flowchart of the process is on Page 166.

When to report payroll deductions

The reporting date is determined by each employer's pay cycle. The contributions must be posted to the participant accounts no later than the actual payroll date. Therefore, report deductions to ASIFlex at least three business days prior to the actual payroll date. Late payroll deduction files or funding can directly impact claim reimbursements and cause delays in reimbursements to participants.

How to report payroll deductions

Employers report payroll deduction data through ASIFlex's secure employer portal. ASIFlex provides secure login credentials to each employer. There are two ways to report payroll deductions to ASIFlex.

1. **Transmit via common file format** Use a common file format to upload the data file to the secure employer portal prior to each pay date. To receive the file format, email SCdata@asiflex.com.
2. **Enter payroll deduction data** Enter the payroll deduction data online through the secure employer portal. The online reporting includes a prepopulated template created by ASIFlex each pay cycle based on the elections in force at that time. Employers will not have to reenter the deduction data for each pay date.

Transmit via common file format

1. To access the portal, go to www.asiflex.com/SCMoneyPlus, select the Account Login tab, then select Employer Login.
2. Enter your user ID and password to sign in.
3. Select Upload File. Select Browse to locate and select your file to upload. Then, click Submit.

Manually enter payroll deduction data

1. To access the portal, go to www.asiflex.com/SCMoneyPlus, select the Account Login tab, then select Employer Login.
2. Enter your user ID and password to sign in.
3. Select Payroll Data Entry from the top menu.
4. Select the issue date and a location.
5. Review the current employee information details and contributions. If the deduction amount shown is correct and there are no changes, select Submit. To edit deductions for this payroll cycle, select Edit and modify the appropriate amount for each employee. If the change is beyond more than \$0.01 (either up or down), you must also add a comment to explain the reason for the change. Add this information in the last column, which is labeled Comment. Once you've made all changes, select Submit.

6. View the employee's current deduction amount.

After the payroll cycle has been processed, you cannot make edits.

How to submit funding

To post contributions to participant accounts, ASIFlex must receive the funding from each employer in a timely manner. Send actual funds via ACH to ASIFlex three business days prior to the actual pay date.

Funds should be sent to ASIFlex via ACH transaction to the designated bank accounts. Participant contributions and administrative fees must be sent in two separate transactions. **Include your employer group number on the memo/invoice line.** Below is the bank name and account number for each transaction.

Participant contributions

Bank name: Central Bank of Boone County
Routing number: 081500859
Account number: 128608478

Administrative fees

Bank name: Central Bank of Boone County
Routing number: 081500859
Account number: 128613463

If your employer requires you to complete a vendor form to send payment, use the information below.

Central Bank of Boone County
Attn: Government Affairs Division
P.O. Box 779
Columbia, MO 65102

If you must mail a check, make the check payable to ASIFlex, include your employer group number on the memo line of the check and use the mailing address below. Note that sending a check may cause a delay in contributions being posted to participants' accounts.

ASIFlex
Attn: Accounting Department
P.O. Box 6044
Columbia, MO 65205-6044

Physical address for delivery other than via USPS:

ASIFlex
Attn: Accounting Department
201 West Broadway, Suite 4C
Columbia, MO 65205

Processing the payroll deduction file

Once each employer submits its payroll deduction file and funds, ASIFlex will compare the payroll deduction file and funds. If funds do not match the file, the process stops and ASIFlex will contact the employer. If funds match the file, contributions will be posted to individual participant accounts. ASIFlex will then compare the expected deduction amounts to the actual contributions reported on the file and funding that is received. Contributions that do not match for individual participants will be identified as a discrepancy and reported to the employer for review and resolution.

ASIFlex will post contributions to each participant's account within one business day of receipt or on the actual payroll date, whichever is later. ASIFlex will send Health Savings Account (HSA) contributions to HSA Central to post to participants' accounts within three business days.

At any point, ASIFlex's record of each employee's year-to-date contributions should agree with the employer's year-to-date record of participant contributions. See Page 164 to learn about the ASI MoneyPlus Year-to-Date Contribution Report available in EBS.

Types of discrepancies

There are three types of discrepancies that can occur:

1. The contribution sent for a participant is different than the expected amount.
2. A record is missing on the payroll deduction file for a participant for whom ASIFlex expects to receive a contribution.
3. A record is received on the payroll deduction file for an employee for whom ASIFlex does not have enrollment information on file.

Financial discrepancies

Some discrepancies might only be financial in nature. This could be because of a keying error or because a participant is on unpaid leave. In these instances, the employer will respond directly to ASIFlex to resolve the discrepancy.

Enrollment and eligibility discrepancies

Some discrepancies might be due to an enrollment or eligibility change, which includes new hires, terminations and qualifying changes in status. In these instances, the employer will respond to ASIFlex to notify them of the reason for the discrepancy. The employer must also update enrollment information in EBS with PEBA. If the employer does not update information in EBS, the discrepancy will continue to appear in subsequent payroll cycles.

Discrepancy reports

If you transmitted data via common file format

A discrepancy report will be posted to the secure employer portal after the payroll deduction file is processed. The employer will receive an email (from scdata@asiflex.com) to indicate the discrepancy report has been posted to the portal and is ready for review. Each employer will need to download

and review the discrepancy report and provide resolution to ASIFlex in a timely manner so accounts can be updated by the actual payroll date. This discrepancy report can also be used as a communication tool to identify coverage changes and terminations, which need to be updated with PEBA.

If you manually entered payroll deduction data

The online reporting includes a pre-populated template for each pay cycle based on the elections ASIFlex receives from PEBA. This pre-populated information allows an employer to see if a discrepancy exists before the employer submits the information. As such, a separate discrepancy report will not be posted to the secure employer portal. If an edit is needed to the deductions, and the change is beyond more than \$0.01 (either up or down), you must also add a comment to explain the reason for the change. Add this information in the last column, which is labeled Comment. This comment provides a resolution to the discrepancy. Once you've made all changes, select Submit. This prepopulated information can also be used as a communication tool to identify coverage changes and terminations, which need to be updated with PEBA. The employer will be contacted separately if the funding ASIFlex receives does not match the deductions reported.

Responding to discrepancy reports

It is critical that each employer carefully reviews the discrepancies and responds to ASIFlex within two business days or before the payroll date. If the employer transmitted data via a common file, the preferred method of responding to a discrepancy report is to open the report from the employer portal and, if necessary, add a comment in the field next to the discrepancy. Then, save the file as the original file name, adding the payroll date to the end. Upload it to the employer portal. Employers may also send a secure email to ASIFlex at scdata@asiflex.com. Additionally, the employer

must make eligibility and enrollment updates in EBS with PEBA, if needed.

Unlike Medical Spending Accounts, Dependent Care Spending Accounts and Health Savings Accounts are not prefunded at the beginning of the year. Instead, they rely on reported and received funds for ASIFlex to make timely reimbursements to participants. If the payroll deduction file or funding is late, or if discrepancies are not resolved in a timely manner, reimbursements to participants could be delayed.

How to respond

There are four discrepancy messages that might appear on your discrepancy report:

1. Amount you sent not as expected.
2. No data expected.
3. No data sent for this employee.
4. EID/SSN not found.

For more information about types of discrepancies, refer to Page 160. Below are examples of the discrepancy messages and how to respond. Discrepancies will continue to appear in subsequent payroll cycles if the error still exists. Your previous comments will show on subsequent reports.

To resolve discrepancies and understand the status of participant accounts, you may also reference the Complete Balance Sheet Discrepancy Report (YTDEXP10), which is available on the employer portal, to compare year-to-date expected contributions with year-to-date actual contributions.

You can view a sample discrepancy report on Page 167. This sample report also includes comments in Column M that help explain what the discrepancy means.

Discrepancy message 1

Amount you sent not as expected

If ASIFlex receives a payroll deduction for a participant that is different from what was expected (i.e., a lesser or greater amount), there are two options:

- If the payroll deduction amount sent is correct, provide a reason for the change in the amount in Column M on the discrepancy report. If the participant had a qualifying status change and their election amount was changed, you must also update their election amount in EBS with PEBA.
- If the payroll deduction amount sent is incorrect, indicate this in Column M on the discrepancy report and correct the contribution on the next payroll deduction file. If the expected contribution amount is also incorrect, confirm the enrollment information on file with PEBA in EBS (i.e., annual election amount, number of payroll cycles) and submit any necessary updates in EBS to PEBA, because ASIFlex calculates the expected contribution amount from enrollment information it receives from PEBA.

Discrepancy message 2

No data expected

If ASIFlex receives a payroll deduction for a participant, but they do not expect it, there are two options:

- ASIFlex does not have the enrollment information on file for that participant for the specific account type (i.e., MSA, DCSA or HSA). However, ASIFlex has a record for this participant because they currently contribute to another account type or have contributed to an account in the past. Respond to the discrepancy in Column M by indicating the effective date of enrollment for this account type. You must also confirm the enrollment information on file with PEBA in EBS and submit any necessary updates. To expedite the process of resolving the discrepancy, email a screenshot of the enrollment in EBS to ASIFlex at sc@asiflex.com. Contact PEBA with questions about enrollment.
- If the payroll deduction was made in error, refund the amount on the next payroll

deduction file by entering a negative amount that offsets the deduction. To refund the amount on your next file, reduce the total amount of money you send to ASIFlex by the amount you are refunding, and enter a negative amount on your payroll deduction file. Confirm the funds you send match the data on the payroll deduction file.

Discrepancy message 3

No data sent for this employee

If ASIFlex was expecting to receive a contribution for a participant, but the participant is missing on the payroll deduction file, there are two options:

- If the payroll deduction should have been made, provide a reason for the missing contribution in Column M on the discrepancy report and include the missing deduction(s) on the next payroll file. A participant's account will be put on hold by ASIFlex after missing two consecutive payroll deductions. If an employee misses a contribution, contact ASIFlex to spread out the missed contribution over several pay periods, if necessary. You may also double the contribution amount on the next payroll cycle. If a participant's account is on hold, email ASIFlex at sc@asiflex.com to request the hold to be removed and MSA debit card reactivated after you send the missed payroll deductions to ASIFlex.
- If the participant had a change in eligibility or enrollment, provide a reason for the missing contribution in Column M on the discrepancy report and update their information in EBS with PEBA.

Discrepancy message 4

EID/SSN not found

If ASIFlex receives a payroll deduction for a participant, but they do not expect it, there are two options:

- ASIFlex has never received any enrollment information on file for the participant, current or previous. Respond to the discrepancy in Column M by indicating the effective date of enrollment. You must also confirm the enrollment information on file with PEBA in EBS and submit any necessary updates. To expedite the process of resolving the discrepancy, email a screenshot of the enrollment in EBS to ASIFlex at sc@asiflex.com. Contact PEBA with questions about enrollment.
- If the payroll deduction was made in error, refund the amount on the next payroll deduction file by entering a negative amount that offsets the deduction. To refund the amount on your next file, reduce the total amount of money you send to ASIFlex by the amount you are refunding, and enter a negative amount on your payroll deduction file. Confirm the funds you send match the data on the payroll deduction file.

Discrepancy message 5

No data sent - Account is suspended due to insufficient contributions

If ASIFlex was expecting to receive a contribution for a participant, but ASIFlex does not receive a payroll deduction for two consecutive payroll cycles, the participant's MSA will be placed in suspense. Investigate and respond appropriately. Once the discrepancy is resolved, ASIFlex will remove the hold on the participant's account. If a participant's account is in suspense, they do not have access to their funds and cannot use their ASIFlex Card.

You can also ignore a recurring discrepancy to which you have already responded if you know it will be resolved in future payroll cycles. Remember, your previous comments will show on subsequent reports if the same discrepancy exists.

Refunds and adjustments

Occasionally, refunds of payroll deductions must be issued because of an administrative error, enrollment error or other instances that are allowed by the IRS.

For flexible spending accounts (MSAs, DCSAs and Limited-use MSAs), process the refund through your employer/payroll center. Also, submit the refund to ASIFlex as a negative amount on your next payroll deduction file so ASIFlex can reconcile the participant's account. If the participant had a change in eligibility or enrollment, update their information in EBS with PEBA.

If a payroll deduction was sent to ASIFlex in error, HSA refunds are processed the same as flexible spending account refunds as long as ASIFlex has not sent the funds to Central Bank. Once funds are deposited into the account, ASIFlex cannot issue refunds, because the funds belong to the employee once deposited. If the participant had a change in eligibility or enrollment, update their information in EBS with PEBA.

If the employee changes their mind about participating in an HSA, they may stop contributing to their account and withdraw the funds from their HSA bank account with HSA Central according to IRS guidelines. The employee can change their HSA contributions only once a month (stop, increase or decrease contributions), and the change in contributions is made on a prospective basis. Retroactive changes are not allowed.

If you are unable to process a refund by including a negative amount on your payroll file, contact ASIFlex at sc@asiflex.com to initiate a manual refund.

Escalation path

If a discrepancy remains unresolved after you provided a response, email the Data Team at scdata@asiflex.com. If the Data Team does not reply, email Sarah Luebrecht at sc@asiflex.com.

Year-end adjustments

Refer to the *Complete Balance Sheet Discrepancy Report* (YTDEXP), which is available on the employer portal, to determine if you need to adjust MSA and DCSA participant accounts that are on track to overcontribute. Be sure to do this in a timely manner. It is recommended you make changes by late November each year so the correction can be made through payroll prior to the end of the year.

Transfer employees

When an employee transfers to your employer group from another employer group that participates in PEBA-administered insurance benefits, follow the process below:

1. Confirm the participant's year-to-date contributions from the previous employer on the ASI MoneyPlus Year-to-Date Contribution Report (HIS763NP) in EBS.
2. To determine the participant's new expected contribution amount:
 - Confirm the participant's annual election amount in EBS.
 - Subtract the year-to-date contributions from the annual election.
 - Divide by the number of payrolls remaining in the plan year based on your employer group's payroll cycle.
3. Send ASIFlex's Data Team an email to scdata@asiflex.com with the subject line "Transfer participant's new expected amount." Do not use the message feature in the portal. Include the following details in the email:
 - Participant's name;
 - Last four digits of the participant's Social Security number;
 - Your employer's group number;
 - Name of prior employer;
 - New expected amount; and
 - Your payroll cycle.

The first time you send a payroll deduction for the transfer employee, a “no data expected” discrepancy might appear on your discrepancy report due to the timing of the deduction and receiving enrollment information from PEBA. If this occurs, indicate the reason in Column M on the discrepancy report (Transfer, new expected amount \$xxxx.xx).

If you are the losing employer, remember to remove the employee who transferred from your subsequent payroll deduction files.

Special handling for participant accounts with carryover funds only

MoneyPlus MSAs include a provision that allows participants to carry over up to \$660 of unused funds into the next plan year. If a participant doesn't reenroll in an MSA for the following year, they can still use any carryover funds in the new year until the funds are exhausted as long as they remain eligible to participate in MoneyPlus. The monthly administrative fee will be deducted from the participant's account during the next plan year.

Available reports

There are several reports employers have access to either via the ASIFlex employer portal or EBS. The reports are described below.

Complete Balance Sheet Discrepancy Report (YTDEXP)

Report available on employer portal

ASIFlex produces this report monthly only if there are discrepancies for individual participants. This report shows the difference between the actual contribution ASIFlex has received year-to-date as of the last payroll cycle and the expected amount based on the annual election amount for each participant. The per-pay columns (Columns G, K and O) show the amount ASIFlex expects for that participant per payroll cycle.

The year-to-date received and year-to-date expected amounts for HSAs are shown in Columns C and E, respectively. The difference in these two amounts is shown in Column F. The year-to-date received and year-to-date expected amounts for MSAs are shown in Columns H and I, respectively. The difference in these two amounts is shown in Column J. The year-to-date received and year-to-date expected amounts for DCSAs are shown in Columns L and M, respectively. The difference in these two amounts is shown in Column N.

If the amounts in Columns F, J and N are negative, the participant will be short in meeting their annual election. If these amounts are positive, the participant is on track to exceed their annual election amount.

If the amounts in Columns F, J and N are off by more than the amount ASIFlex expects to receive in one payroll cycle, contact the Data Team at scdata@asiflex.com. If the amounts are off by one payroll cycle or less, adjust the participant's contribution on the next payroll deduction file.

ASI MoneyPlus Year-to-Date Contribution Report (HIS763NP)

Report available in EBS

PEBA produces this report daily. It shows the annual election amounts and year-to-date contributions for MSA, DCSA and HSA participants. Use this report to verify the contribution amounts ASIFlex has received for its participants. Employees who transfer employers will also appear on this report once PEBA processes their enrollment.

MoneyPlus Enrollment Data (HIS761NP)

Report available in EBS

PEBA produces this report monthly. This report shows employees' annual MoneyPlus elections for MSAs, DCSAs and HSAs. Use this report to verify the enrollment information PEBA has on file. Employees

enrolled in multiple MoneyPlus accounts will appear multiple times.

MoneyPlus Pretax Feature (HIS912NP)

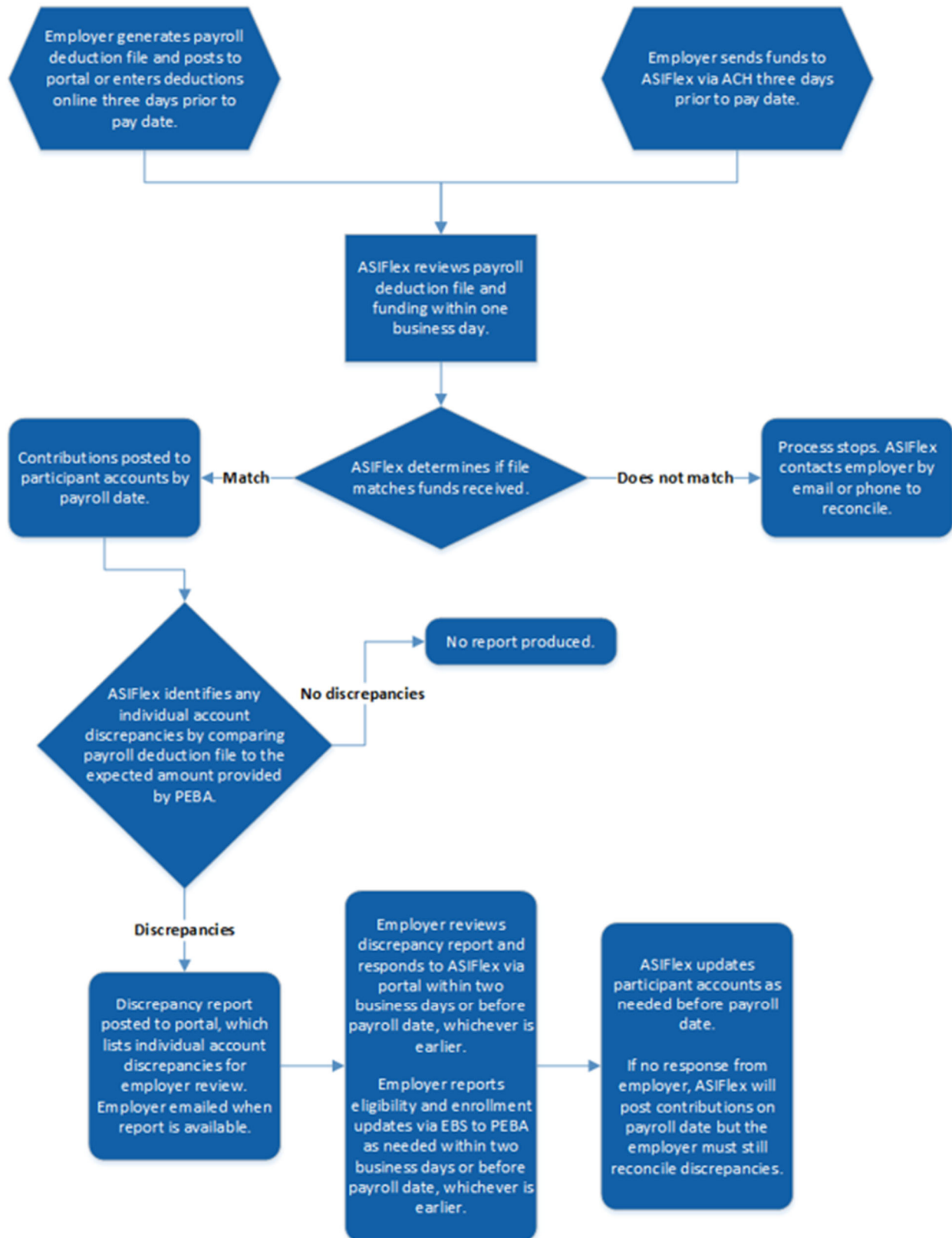
Report available on EBS

PEBA produces this report monthly. This report shows employees who participate in the Pretax Group Insurance Premium feature, as well as employees who have opted out of the pretax feature. Use this report to determine which employees have elected to have their premiums deducted before or after taxes. Premiums for health, dental, vision and up to \$50,000 of Optional Life coverage, as well as the tobacco-use premium, should be deducted pretax for employees who have elected to participate in the pretax feature.

ASIFlex account manager team

Role	Contact
Day-to-day Assistant Account Manager	Sarah Luebrecht 573.777.5633 888.602.4132, ext. 5633 SC@asiflex.com
Account Manager	Gordon Sherard 573.239-9692 gsherard@asiflex.com
Backup account manager team	888.602.4132
Data Team Lead (payroll deduction file processing)	Jason House SCdata@asiflex.com

Payroll process



Discrepancy report examples

IMPORTANT! To respond to your discrepancy report, add comments in Column M, such as the enrollment date, LWOP with date or new expected amount. Save the file as the original file name, adding the payroll date to the end. Upload it to the employer portal. If you have a question regarding a discrepancy or the posting of funds, email the Data Team at scdata@asiflex.com. **Do not use the message feature in the portal.**

1/06/20 FSA PR issue 1/05/20 442-3035 (800) 659-3035 ASI

Soc-Sec-Num	Employee Name	Pay Cyc	<-Employee ID->	Loc	Dept	Agency	OrgID	Sent	Expected			What could this discrepancy mean?
999999999	LAST, FIRST	26		10	SC	X	0	\$20.88	\$41.66	MSA	Amount you sent not as expected	If the payroll deduction amount sent is correct, provide a reason for the change in the amount in Column M on the discrepancy report. If the participant had a qualifying status change and his election amount was changed, you must also update his election amount in EBS with PEBA.
888888888	LAST, FIRST	24		10	SC	X	0	\$150.00	\$75.00	HSA	Amount you sent not as expected	If the payroll deduction amount sent is incorrect, indicate this in Column M on the discrepancy report and correct the contribution on the next payroll deduction file. If the expected contribution amount is also incorrect, you should confirm the enrollment information on file with PEBA in EBS (i.e., annual election amount, number of payroll cycles) and submit any necessary updates in EBS to PEBA, because ASIFlex calculates the expected contribution amount from enrollment information it receives from PEBA.
777777777	LAST, FIRST	24		10	SC	X	0	\$110.42	\$0.00	DCSA	No data expected	ASIFlex does not have the enrollment information on file for that participant for the specific account type (i.e., MSA, DCSA or HSA). However, ASIFlex has a record for this participant because he currently contributes to another account type or has contributed to an account in the past. Respond to the discrepancy in Column M by indicating the effective date of enrollment for this account type. You must also confirm the enrollment information on file with PEBA in EBS and submit any necessary updates. To expedite the process of resolving the discrepancy, email a screenshot of the enrollment in EBS to Mo Willoh at sc@asiflex.com . You should contact PEBA with questions about enrollment.
666666666	LAST, FIRST	26		10	SC	X	0	\$41.67	\$0.00	MSA	No data expected	If the payroll deduction was made in error, refund the amount on the next payroll deduction file by entering a negative amount that offsets the deduction. To refund the amount on your next file, reduce the total amount of money you send to ASIFlex by the amount you are refunding, and you should enter a negative amount on your payroll deduction file. You should confirm the funds you send match the data on the payroll deduction file.

Soc-Sec-Num	Employee Name	Pay Cyc	<-Employee ID->	Loc	Dept	Agency	OrgID	Sent	Expected			What could this discrepancy mean?
55555555	LAST, FIRST	24		10	SC	X	0	\$0.00	\$300.00	HSA	No data sent for this employee	If the payroll deduction should have been made, provide a reason for the missing contribution in Column M on the discrepancy report and include the missing deduction(s) on the next payroll file. A participant's account will be put on hold by ASIFlex after missing two consecutive payroll deductions. If an employee misses a contribution, contact ASIFlex to spread out the missed contribution over several pay periods, if necessary. You may also double the contribution amount on the next payroll cycle. If a participant's account is on hold, email ASIFlex at sc@asiflex.com to request the hold to be removed and MSA debit card reactivated after you send the missed payroll deductions to ASIFlex.
44444444	LAST, FIRST	26		10	SC	X	0	\$0.00	\$126.83	DCSA	No data sent for this employee	If the participant had a change in eligibility or enrollment, provide a reason for the missing contribution in Column M on the discrepancy report and update his information in EBS with PEBA.
33333333	LAST, FIRST	26		10	SC	X	0	\$200.00	\$0.00	MSA	EID/SSN not found	ASIFlex has never received any enrollment information on file for that participant, current or previous. Respond to the discrepancy in Column M by indicating the effective date of enrollment. You must also confirm the enrollment information on file with PEBA in EBS and submit any necessary updates. To expedite the process of resolving the discrepancy, email a screenshot of the enrollment in EBS to Mo Willloh at sc@asiflex.com. You should contact PEBA with questions about enrollment.
22222222	LAST, FIRST	24		10	SC	X	0	\$152.07	\$0.00	HSA	EID/SSN not found	If the payroll deduction was made in error, refund the amount on the next payroll deduction file by entering a negative amount that offsets the deduction. To refund the amount on your next file, reduce the total amount of money you send to ASI Flex by the amount you are refunding, and you should enter a negative amount on your payroll deduction file. You should confirm the funds you send match the data on the payroll deduction file.
11111111	LAST, FIRST	24		10	SC	X	0	\$0.00	\$62.50	MSA	No data sent - Account is suspended due to insufficient contributions	ASIFlex has not received contributions for two consecutive payroll cycles, Consequently, the participant's account has been placed in suspense, and the participant no longer has access to his funds. Investigate the reason for missed contributions and respond in Column M on the discrepancy report what action you will take on the next payroll cycle. For example, you will make up the missed contributions, you will recalculate the expected amount or the employee is on leave without pay. Once the discrepancy is resolved, excluding LWOP, ASIFlex will remove the hold on the participant's account.

The image features a white background with two prominent blue geometric shapes. On the left, a horizontal blue bar with a diagonal cutout on its right side contains the text 'EBS reports'. To the right of this bar is a larger, dark blue trapezoidal shape that also has a diagonal cutout on its left side, creating a white triangular gap between the two shapes.

EBS reports

EBS reports

Contents

- [Accounting reports](#) 171
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- [Comptroller General \(CG\) agencies only](#) 189
- [Optional employers only](#) 194

PEBA provides several reports in EBS. Below are details about the format, availability and information for reports. Screenshots of reports are only examples and might not reflect the report in its entirety.

Common subscriber status codes:

- A1 - Active enrollment/currently enrolled
- TT - Transfer
- T4 - Subscriber refused or did not elect coverage
- T5 - Subscriber left employment, reduction in force, no longer eligible
- TH - Reduction in hours (in stability period)
- T6 - Leave without pay (LWOP)
- T7 - Regular retirement (service or age)
- T1 - Subscriber/dependent deceased

Common subscriber types:

- AR - Active employee
- RR - Regular Retiree
- RS/SRR - Survivor

Categories and health/dental plans:

- Enrollee - 1
- Enrollee/Spouse - 2
- Enrollee/Child(ren) - 3
- Full Family - 4
- Child(ren) only - 5
- Standard - BB
- Savings - BD
- Tricare - TC
- Medicare Supplement - BC
- Dental Plus - DP
- Basic Dental – DD

Accounting reports

EBS User Recertification (EBS950)

Frequency: Annual

Format: PDF

Authorizing agents must review and certify EBS users and users’ access each year. This report lists users who have not been certified.

EMPLOYEES NEEDING EBS ACCESS RECERTIFICATION		
GROUP ID:		AUTHORIZING AGENT:
***** SUBSCRIBER ***** NAME	***** EBS ***** ACCESS	
-----	-----	

Supplemental Long Term Disability Roster (HAC436)

Frequency: Annual

Format: PDF and .csv

Active subscriber roster for SLTD benefits. Roster indicates if an age group change is applicable.

ACTIVE SUBSCRIBER ROSTER FOR SUPPLEMENTAL LONG TERM DISABILITY
AS OF

GROUP ID: _____

GROUP NAME: _____ '*** indicates age group change.

NAME	BIN	EFFECTIVE DATE	PLAN	AGE RANGE	RATE	PREMIUM	SEMI-MONTH PREMIUM
-----	-----	-----	-----	-----	-----	-----	-----

Last Name	First Name	MI	Bin	SSN	SLTD Eff Date	Plan	Age Range	SLTD Rate	Premium	Semi-Month Premium
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Active Billing File (HAC450/460)

Frequency: Monthly

Format: .txt

Provided to assist employers with reconciling their employer and employee records monthly. Files include demographic and coverage information for subscribers, their dependents and beneficiaries.

The 460 version is four files, while the 450 version is two larger files that contain the same information but are formatted to use with CSI payroll software. HAC450 is available for all employers unless the HAC460 is requested. Contact your accounting representative if you wish to change to HAC460.

- Subscriber Data SD (HAC450/460).
- Dependent Data DD (HAC450/460).
- Beneficiary Data BD (HAC460).
- Other Insurance Data OD (HAC460).

Subscriber Premium Data (HAC470)

Frequency: Daily

Format: .csv and .txt

A daily snapshot of all benefits and premiums for subscribers.

CSV format

- SSN, last name, first name, middle initial.
- For each benefit:
 - Active (A) or terminated (T) status.
 - Category or coverage level of enrollee only (1); enrollee/spouse (2); enrollee/children (3); or full family (4).
 - Monthly employee premium.
 - Effective date of coverage.
- Health plan - Hlth:
 - Standard Plan (BB).
 - Savings Plan (BD).
 - TRICARE (TC).
- Basic Dental - Dntl.
- Dental Plus - Dntp.
- Dependent Life-Child - DL.
- Basic Life - SL (employer contribution).
- Basic LTD - LTD (employer contribution).
- Optional Life - OL (coverage amount).
- Dependent Life-Spouse - OLS (coverage amount).
- Vision - Visn.
- Tobacco premium - Tob.
- Flex benefits indicator.
- Subscriber date of birth.
- MSA annual amount.
- DCA annual amount.
- HSA annual amount.
- Dependent information.
- Supplemental long term disability - SLTD (plan level).

SSN	Last Name	First Name	MI	Hlth Status	Hlth Plan/Cat	Hlth Premium	Hlth Eff Date	Dntl Status	Dntl Plan/Cat	Dntl Premium	Dntl Eff Date	Dntp Status	Dntp Plan/Cat	Dntp Premium	Dntp Eff Date	DL Status	DL Plan/Cat	DL Premium	DL Eff Date	SL Status	SL Plan/Cat	SL Premium	SL Eff Date
-----	-----------	------------	----	-------------	---------------	--------------	---------------	-------------	---------------	--------------	---------------	-------------	---------------	--------------	---------------	-----------	-------------	------------	-------------	-----------	-------------	------------	-------------

LTD Status	LTD Plan/Cat	LTD Eff Date	OL Status	OL Plan/Lvl	OL Premium	OL Eff Date	OLS Status	OLS Plan/Lvl	OLS Premium	OLS Eff Date	Visn Status	Visn Plan/Lvl	Visn Premium	Visn Eff Date	Tob Status	Tob Premium	Tob Eff Date	SLTD Status	SLTD Plan/Lvl	SLTD Premium	SLTD Eff Date
------------	--------------	--------------	-----------	-------------	------------	-------------	------------	--------------	-------------	--------------	-------------	---------------	--------------	---------------	------------	-------------	--------------	-------------	---------------	--------------	---------------

FLEX Benefits	Subscriber	MSA	DCA	HSA
Ind	DateOfBirth	Ann Amt	Ann Amt	Ann Amt

Active Subscriber Roster (HAC500)

Frequency: Monthly

Format: PDF and .csv

Provides coverage information for each subscriber, as well as the monthly employer contribution and employee premium for insurance programs. Use this roster to update and/or verify records. Contact PEBA if there is a discrepancy. Employers can access up to five previous months' reports.

CSV format

- SSN, last name, first name, employee status.
- For each program:
 - Active (A) or terminated (T) status for each benefit.
 - Category or coverage level of enrollee only (1); enrollee/spouse (2); enrollee/children (3); or full family (4).
 - Monthly employer contribution and employee premium.
- Health plan:
 - Standard Plan (BB).
 - Savings Plan (BD).
 - TRICARE (TC).
- Basic Dental.
- Dental Plus.
- Vision.
- Tobacco-use premium.
- Basic Life (employer contribution).
- Basic LTD (employer contribution).
- Optional Life (age group 1-8 and coverage amount).
- Dependent Life-Spouse (age group 1-8 and coverage amount).
- Dependent Life-Child.
- SLTD (age group 1-6).

ssn	last_name	first_name	subscriber_indicator	health_status	health_plan	health_category	health_er_rate	health_ee_rate	dental_status	dental_category	dental_er_rate	dental_ee_rate
dental_plus_status	dental_plus_ee_rate	vision_status	vision_category	vision_ee_rate	tobacco_status	tobacco_ee_rate	bl_status	bl_er_rate	ltd_status	ltd_er_rate		
ol_status	ol_age_group	ol_coverage_level	ol_ee_rate	dls_status	dls_age_group	dls_coverage_level	dls_ee_rate	dlc_status	dlc_ee_rate	sld_status	sld_age_group	sld_ee_rate

The PDF format lists the subscriber BIN, not the SSN, and is in alphabetical order by the subscriber's last name. It also does not include individual employee coverage for Basic Life and Basic Long Term Disability but totals the employer contribution on the final page.

ACTIVE SUBSCRIBER ROSTER FOR									
GROUP ID:		GROUP NAME:							
FULL TIME EMPLOYEES									
PROGRAM	PLAN/CAT	ER	EE	PROGRAM	PLAN/CAT	ER	EE	PROGRAM	PLAN/CAT

ACTIVE SUBSCRIBER ROSTER TOTALS FOR						
GROUP ID:		GROUP NAME:				
TOTAL FOR ALL EMPLOYEES						
INSURANCE PLAN	TOTAL SUBSCR	TOTAL ER PREMIUMS	TOTAL EE PREMIUMS	INSURANCE PLAN	TOTAL SUBSCR	TOTAL EE PREMIUMS

Optional Life & Dependent Life-Spouse Age Group Changes (HAC502)

Frequency: Annually, if applicable

Format: PDF

Provided prior to the new plan year. Lists subscribers who are enrolled in Optional Life and/or Dependent Life-Spouse and who will have a premium adjustment effective in the new plan year, beginning January 1, due to a change in age group.

Displays the date of birth, coverage amount and new premium amount, effective January 1. Subscribers are listed in alphabetical order by last name.

```

OPTIONAL LIFE/DEP LIFE SPOUSE AGE GROUP CHANGES
*****
** EFFECTIVE **
*****
DISCLAIMER: Effective January 1,2018, premiums for Dependent Life Spouse Coverage are based on spouse's age. This report
includes the spouses who will have a change in their age bracket.
GROUP ID:
-- OPTIONAL LIFE --          ----- DEP LIFE SPOUSE -----
BIN NUMBER  SUBSCRIBER NAME  DOB  COV AMT  NEW PREM  NEW SEMI  SP DOB  COV AMT  NEW PREM  NEW SEMI
  
```

SLTD Age Group Changes (HAC515)

Frequency: Annually, if applicable

Format: PDF

Provided prior to the new plan year. Lists subscribers who are enrolled in SLTD and who will have a premium adjustment effective in the new plan year, beginning January 1, due to a change in age group.

Displays date of birth and SLTD benefit waiting period. Subscribers are listed in alphabetical order by last name. Employee premiums are not included.

```

SUPPLEMENTAL LONG TERM DISABILITY AGE GROUP CHANGES
*****
*** EFFECTIVE ***
*****
GROUP ID:
--- SUPPLEMENTAL LTD ---
BIN NUMBER  SUBSCRIBER NAME  DATE OF BIRTH  BENEFIT WAITING PERIOD
  
```

Optional and Dependent Life Roster (HAC516)

Frequency: Annually

Format: PDF and .csv

Provided prior to the new plan year. Includes Optional Life, Dependent Life-Spouse and/or Dependent Life-Child subscribers. Includes age bracket, coverage amount and premium for each program, effective in the new plan year, beginning January 1. An asterisk indicates if a change in age bracket is applicable for the new plan year.

Bin	SSN	Last Name	First Name	MI	Age Bracket	OL Coverage	OL Premium	OL Semi-Monthly	Dep Age	DL/Spouse Coverage	DL/Spouse Premium	DL/Spouse Semi-Monthly	DL/Child Coverage	DL/Child Premium
-----	-----	-----------	------------	----	-------------	-------------	------------	-----------------	---------	--------------------	-------------------	------------------------	-------------------	------------------

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OPTIONAL AND DEPENDENT LIFE ROSTER
FOR BILLING
GROUP ID:
GROUP NAME:
BIN NUMBER  NAME  AGE BRACKET  OPTIONAL LIFE COVERAGE PREMIUM SEMI-MTHLY  DEP AGE  DEPENDENT LIFE / SPOUSE COVERAGE PREM SEMI-MTHLY  DL/CHIL PREMIUM
  
```


Subscribers in SLTD Waiver Status (HAC555)

Frequency: Monthly, if applicable

Format: PDF

Includes employees in a premium waiver status for SLTD. See Page 126.

SUBSCRIBERS IN WAIVER STATUS AS OF						
GROUP ID:	GROUP NAME:					
BIN	NAME	EFF DATE OF WAIVER	AGE	OPTIONAL LIFE COV	LIFE PREM	SUPPLEMENTAL LTD PLAN PREM

Bills – Advance Deposit (HAC576)

Not applicable to Comptroller General (CG) agencies

Frequency: Annually, in June


Format: PDF

An advance deposit of at least one month’s premium for employer contributions is due to PEBA each year. At the beginning of the fiscal year in July, PEBA bills employers for the advance deposit. Payment is due to PEBA by July 15. You can also view the advance deposit bill in EBS through Online Bill Pay. Conveniently pay online in EBS.

The advance deposit bill lists insurance programs for which the employer contributes to the monthly premium (State Health Plan, Basic Dental, Basic Life, BLTD) and the subscriber count enrolled in each of these programs at the end of June. The subscriber count is multiplied by the current employer rate to calculate the deposit amount.

A one-month deposit will be credited to the June billing statement, which could result in a balance due or overpayment. A more than one-month deposit is credited to your account immediately.

EMPLOYER SHARE ADVANCE DEPOSIT BILLING STATEMENT FISCAL YEAR				
GROUP ID :	GROUP NAME:			
FULL TIME				
BENEFIT	CATEGORY	SUBSCRIBER COUNT	EMPLOYER RATE	DEPOSIT AMOUNT

EMPLOYER SHARE ADVANCE DEPOSIT BILLING STATEMENT FISCAL YEAR	
GROUP NAME:	
GROUP ID :	
ACCT REP :	
TOTAL ONE-MONTH DEPOSIT	CHECK AMOUNT
MORE THAN ONE-MONTH DEPOSIT	_____
Payment is due by July 15th. Remittance is payable to PEBA INSURANCE FINANCE. Remittance Advice must be completed and submitted with payment. If payment is by IDT, return two copies of remittance advice. One-month deposit will be credited to the June Billing Statement. More than one-month deposit will be credited to your group account immediately.	
Signature: _____	
Date: _____	
Telephone#: _____	
	

Bills – Active Subscribers (HAC610)

Frequency: Monthly

Format: PDF

On or before the first of each month, PEBA produces a billing statement for active subscribers. This PDF billing statement enables you to maintain the accounting records of each employee. If you verify the information on the billing statement and communicate with PEBA when there are questions about the information, the financial process for employees' benefits works smoothly. Employers can access up to five previous months' bills.

The billing statement includes employer contributions and employee premiums due for all insurance programs.

Group Address page

This page contains the group number, employer name and address, and the billing contact person PEBA will contact if there are any questions. The billing contact person should be the individual responsible for remitting payment for insurance premiums. If there is a change, your authorizing agent should update the primary Billing Contact in EBS under Contacts.

The middle of the page lists your account representative, phone number and PEBA Insurance Finance's return address.

At the bottom of the page, there is a key to assist with the Coverage Processing section of the billing statement.

PLAN	DESCRIPTION	CATEGORY
BB	- STANDARD	01 - SUBSCRIBER ONLY
BD	- SAVINGS	02 - SUBSCRIBER/SPOUSE
TC	- TRICARE	03 - SUBSCRIBER/CHILDREN
DD	- DENTAL	04 - FULL FAMILY
DP	- DENTAL PLUS	05 - CHILD ONLY
LTD	- LONG TERM DISABILITY	
BL	- BASIC LIFE	
OL	- OPTIONAL LIFE	
DLS	- DEPENDENT LIFE SPOUSE	
DLC	- DEPENDENT LIFE CHILD	
SLTD	- SUPPLEMENTAL LONG TERM DISABILITY	
VC	- VISION CARE	
TS	- TOBACCO SURCHARGE	

Account Summary pages

These pages summarize the prior month's activity, ending with the net premium outstanding from the prior month and the billing for the current month, including any retroactivity.

The Employer Share for health, dental, Basic Life and BLTD is rolled into one total. Separate totals are provided for the Employee Share for health, Basic Dental, Dental Plus, Optional Life, Dependent Life-Spouse, Dependent Life-Child, SLTD, State Vision Plan, and the tobacco-use premium. A grand total is provided (total employer plus employee shares).

GROUP BILLING STATEMENT						
GROUP NAME:				BILLING MONTH:		
GROUP ID :				ACCOUNT SUMMARY		
	EMPLOYER SHARE	EMPLOYEE SHARE				
	HEALTH	DENTAL	DENTAL PLUS	OPTIONAL LIFE	DLS	

GROUP BILLING STATEMENT					
GROUP NAME:				BILLING MONTH:	
GROUP ID :					
ACCOUNT SUMMARY					
EMPLOYEE SHARE					
DLC	SLTD	VISION CARE	TOBACCO SURCHARGE	TOTAL	

Beginning Balance lists the Total Net Balance due from the prior month’s billing statement.

Payment Transactions lists all payments received since the completion of the prior month’s billing statement, including SCEIS payroll deductions (CG agencies only) and returned payments.

Accounting Transactions lists all refunds, canceled refunds and accounting adjustments processed since the prior month’s billing statement. There are two types of accounting adjustments: subscriber and employer account.

- A subscriber adjustment is processed to correct the effective date of a coverage change. A group account adjustment is processed to correct a payment posted incorrectly.
- If an adjustment is processed for a subscriber, the BIN will be listed on the Account Summary page and an Adjustment form will be sent to the employer. This form will show the amount and explain why the subscriber’s account was adjusted.

The Net Premium Outstanding is the total of the Beginning Balance less the Total Payments, plus or minus the Total Adjustments.

The Current Month Billing details are on the Billing Summary pages.

The Retro Summary details are on the Billing Summary and Coverage Processing pages.

The \$3/subscriber Administrative Fee is included for optional employers only.

Total Net Balance is the total of the Net Premium Outstanding, Current Month Billing and Retro Summary.

BEGINNING BALANCE			
PAYMENT TRANSACTIONS			
DATE	BIN	NAME	TYPE
			Payment
TOTAL PAYMENTS			
ACCOUNTING TRANSACTIONS			
DATE	BIN	NAME	TYPE
TOTAL ADJUSTMENTS			
NET PREMIUM OUTSTANDING			
CURRENT MONTH BILLING			
RETRO SUMMARY			
TOTAL NET BALANCE			

Billing Summary pages

These pages show a breakdown of the current month’s bill for each program by employee type (full-time; part-time; non-permanent full-time; variable hour).

The summary itemizes the current month premiums, retroactive premiums and total due, for the employer share and the employee share, of each program. The current month's total number of subscribers enrolled in each of the programs is also included.

BILLING SUMMARY							
INSURANCE PROGRAM	SUBSCRIBER COUNT	EMPLOYER SHARE			EMPLOYEE SHARE		
		CURRENT MONTH	RETRO	TOTAL	CURRENT MONTH	RETRO	TOTAL

Coverage Processing pages

These pages provide a detailed list of enrollments, changes and terminations processed since the completion of the last month's bill. These changes are listed in alphabetical order by the subscriber's last name, with the information displayed only for the program(s) affected by the transaction. If no transactions are processed, this section of the billing statement is not included.

Review each subscriber listed against any transaction processed to confirm it was processed correctly. If there is a discrepancy, contact PEBA.

The first column lists the subscriber's name with the BIN and the date of birth displayed across the page on the same row.

The second column shows which program is affected by the coverage processing entry. View the key on the Group Address page for program help.

The third column lists which plan and coverage level the subscriber elected. The alpha and numeric characters for the various plans are in the key on the Group Address page.

The fourth column shows the effective date.

The next two columns display the employer and employee retroactive premiums and the current rate. The purpose of the current rate is to assist you in reconciling the bill.

The last column (Action) indicates the reason for the transaction.

The grand total for all retroactivity can be found after the last employee listed in the Coverage Processing pages. Retroactivity amounts are also listed on the Account Summary and Billing Summary pages.

COVERAGE PROCESSING							
PROGRAM	PLAN/CATEGORY	EFFECTIVE DATE	EMPLOYER		EMPLOYEE		ACTION
			RETRO	CURR RATE	RETRO	CURR RATE	

Remittance Advice page

This final page of the billing statement includes the total amount due for the current month. This amount is also at the bottom of the Account Summary page.

Conveniently pay online in EBS, or if sending payment by check, return the completed Remittance Advice page with payment to PEBA. See Submitting premium payments to PEBA for detailed instructions.


GROUP BILLING STATEMENT

GROUP NAME:
 GROUP ID : BILLING MONTH:
 ACCT REP :

	REMITTANCE ADVICE	CHECK AMOUNTS
Employer Share		_____
Health		_____
Dental	If you are submitting more than one check, please list each amount in the spaces provided. The total of the checks should equal to the Total Amount Due.	_____
Dental Plus		_____
Optional Life		_____
Dependant Life Spouse		_____
Dependant Life Child		_____
Supplemental Long Term Disability		_____
Vision Care		_____
Tobacco Surcharge		_____
Total Amount Due		_____

Payment is due by the 10th of the month.
 Remittance is payable to PEBA INSURANCE FINANCE.
 Remittance Advice must be completed and submitted with payment.

Signature: _____
 Date: _____
 Telephone#: _____



YTD Imputed Income (HAC996)

Frequency: Annually
Format: .csv

Includes employees with Optional Life coverage more than \$50,000, which is considered imputed income and taxable by the IRS when the premium is paid through the MoneyPlus Pretax Group Insurance Premium feature. Use this information to adjust employees' W-2 forms. See Imputed Income on Pages 152 and 153.

SSN	Last Name	First Name	YTD Imputed Income
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OL Taxable/Non-taxable Change File (HAC998)

Frequency: Monthly
Format: .csv

Includes new hires and changes to Optional Life coverage due to special eligibility events when Optional Life coverage is more than \$50,000. See Imputed Income on Pages 152 and 153.

SSN	Last Name	DOB	OL Total Coverage	Coverage > 50K	Status	PEBA OL Monthly Premium	IRS Age Bracket	IRS Rate Factor	IRS Rate Calculated	Monthly Taxable Amount (Imputed Income)	Monthly Non-Taxable Amount	Pre-Tax Indicator
-----	-----------	-----	-------------------	----------------	--------	-------------------------	-----------------	-----------------	---------------------	---	----------------------------	-------------------

OL Taxable/Non-taxable Premiums File (HAC999)

Frequency: Annually
Format: .csv

Provided prior to the new plan year. Includes employees with Optional Life coverage more than \$50,000. See Imputed Income on Pages 152 and 153.

SSN	Last Name	DOB	OL Total Coverage	Coverage > 50K	Status	PEBA OL Monthly Premium	IRS Age Bracket	IRS Rate Factor	IRS Rate Calculated	Monthly Taxable Amount (Imputed Income)	Monthly Non-Taxable Amount	Pre-Tax Indicator
-----	-----------	-----	-------------------	----------------	--------	-------------------------	-----------------	-----------------	---------------------	---	----------------------------	-------------------

Enrollment reports

View under Enroll. Reports in EBS.

MyBenefits New Hires (HAC475)

Frequency: Weekly

Format: .csv

Summarizes MyBenefits enrollment new hire elections. The report includes an indicator if a new hire does not make their online elections within 31 days of hire, and thus defaults to no insurance coverage. Learn more about submitting online enrollments at peba.sc.gov/insurance-training.

CSV format

- SSN, BIN, last name, first name, middle initial.
- For each program:
 - Active (A) or refused (T4) status.
 - Category of enrollee only (1); enrollee/spouse (2); enrollee/children (3); or full family (4).
 - Effective date of coverage.
- Health plan:
 - Standard Plan (BB).
 - Savings Plan (BD).
 - TRICARE (TC).
- Basic Dental.
- Dental Plus.
- Dependent Life-Child.
- Basic Life.
- Basic LTD.
- Optional Life (coverage amount).
- Dependent Life-Spouse (coverage amount).
- Vision.
- Tobacco-use premium.
- SLTD (plan level).
- MSA (annual election amount).
- HSA (annual election amount).
- DCSA (annual election amount).
- Pay periods.
- Pretax premium feature (Y or N).
- MSA-Limited indicator (if Y, see MSA annual election amount).
- Default refusal indicator (Y, if defaulted to no election within 31 days of hire).
- Transaction Type (Enroll).
- Trans Created Method (NOELECT, if defaulted to no election within 31 days of hire).

					Hlth	Hlth	Hlth	Dntl	Dntl	Dntl	Dntp	Dntp	Dntp
SSN	BIN	Last Name	First Name	MI	Status	Plan/Cat	Eff Date	Status	Plan/Cat	Eff Date	Status	Plan/Cat	Eff Date

DL	DL	DL	SL	SL	LTD	LTD	OL	OL	OL	OLS	OLS	OLS
Status	Plan/Cat	Eff Date	Status	Eff Date	Status	Eff Date	Status	Plan/Lvl	Eff Date	Status	Plan/Lvl	Eff Date

Visn	Visn	Visn	Tob	Tob	SLTD	SLTD	SLTD	MSA	MSA	MSA	MSA
Status	Plan/Cat	Eff Date	Status	Eff Date	Status	Plan/Lvl	Eff Date	STATUS	Eff Date	End Date	AMT

HSA	HSA	HSA	HSA	DCA	DCA	DCA	DCA	Pay	Flex	FLEX	MSA	Default	Transaction	Trans Created
STATUS	Eff Date	End Date	AMT	STATUS	Eff Date	End Date	AMT	Period	IND	Eff Date	Limited	Refusal	Type	Method

Weekly EBS Report of Member BINs (HIS17546)

Frequency: Weekly

Format: .txt

Includes employee name, SSN and BIN in alphabetical order by last name.

Rejected Paper Notice of Election Transactions (HIS312)

Frequency: Daily, if applicable

Format: PDF and .csv

Includes rejected paper NOE transactions with explanation. A weekly email is also sent to the primary benefits administrator when a rejection report is available.

SOUTH CAROLINA PUBLIC EMPLOYEE BENEFIT AUTHORITY										HIS312NP	
INSURANCE BENEFITS										PAGE	
Rejected Paper Notice of Election Transactions As Of											
GROUP:											
SSN	BIN	SUBSCRIBER NAME			TRANS DATE	REJECTION REASON					
XXX-XX-											

SSN	BIN	SUBSCRIBER NAME	TRANS DATE	REJECTION REASON
-----	-----	-----------------	------------	------------------

Statement of Health Request Report (HIS314)

Frequency: Weekly, if applicable

Format: PDF

PDF report lists all life insurance *Statement of Health* requests submitted the previous week. Employers can access up to four previous weeks' reports in EBS. Learn more about the electronic *Statement of Health* process at peba.sc.gov/insurance-training.

SOUTH CAROLINA PUBLIC EMPLOYEE BENEFIT AUTHORITY										HIS314NP	
INSURANCE BENEFITS										PAGE 1	
Statement of Health - Extract Report											
GROUP:											
EXTRACT DATE:											
TRANS DATE	SSN	BIN	NAME	SUBSCRIBER			REQ AMNT	EMAIL	DEPENDENT		REQ AMNT

Dependent Turning 19/25/26 Within 90 Days (HIS501)

Frequency: Monthly, if applicable

Format: PDF

Report and letter (HIS600) provide advance notice to an employee within 90 days of when a child turns age 19 or 25 (for Dependent Life-Child) and age 26 (for all other coverage). Employers can access up to five previous months' reports.

Report includes subscriber name, dependent name and date of birth, dependent coverage and letter type. Report also indicates subscribers with coverage level changes due to dependent terminations.

- Provide the letter (HIS600) to the employee and necessary COBRA information.

If the child is incapacitated, the subscriber and dependent's physician must complete the *Incapacitated Child Certification* and forward to PEBA for review and a determination. See Page 116 for more details.

Also see Dependent Turning 19/25/26 Within 90 Days Letters (HIS600).

DEPENDENTS TURNING 19 WITHIN 90 DAYS (ON OR BEFORE)						LETTER TYPE	
SUBSCRIBER TYPE ACTIVE - REGULAR (AR)		GROUP ID:				'T19' - TURN 19 LTR	
						'O19' - OVER 19 LTR	
						' ' - LTR SENT	
***** BIN	S U B S C R I B E R N A M E	*****	D E P E N D E N T N A M E		*****	LETTER T Y P E	
-----	-----	-----	-----	-----	-----	-----	-----

DEPENDENTS TURNING 25/26 WITHIN 90 DAYS (ON OR BEFORE)						LETTER TYPE	
SUBSCRIBER TYPE ACTIVE - REGULAR (AR)		GROUP ID:				'T25/T26' - TURN 25/26 LT	
						' ' - LTR SENT	
						TERMINATED	
						'O25/O26' - OVER 25/26	
***** BIN	S U B S C R I B E R N A M E	*****	D E P E N D E N T N A M E		*****	LETTER T Y P E	
-----	-----	-----	-----	-----	-----	-----	-----

SUBSCRIBERS WITH COVERAGE LEVEL CHANGES DUE TO DEPENDENT TERMINATIONS						
SUBSCRIBER TYPE ACTIVE - REGULAR (AR)		GROUP ID:				
***** BIN	L A S T N A M E	Old/New Hlth Rates EMPL EMPR	Old/New Dntl Rates EMPL EMPR	Old/New DL Rates EMPL	Old/New DP Rates EMPL	Old/New VC Rates EMPL
-----	-----	-----	-----	-----	-----	-----

Temporary Coverage on Adoptions Ending Within 90 Days (with letters) (HIS507)

Frequency: As needed

PEBA will give advance notice to an employee who has added a child to their coverage and is waiting for completion of the one-year final adoption.

PEBA will send a letter to employees who failed to furnish the needed final placement agreement at the end of the one-year temporary placement.

- Send an NOE for corrections if the child is still eligible. Attach a copy of the final adoption/placement agreement to the employee's letter and return them to PEBA for processing.

If the child is no longer eligible, provide a copy of the denial for placement letter from the agency and the NOE to delete the child. Notify payroll of any necessary adjustments.

Terminated Subscriber Listing (HIS512)

Frequency: Monthly, if applicable

Format: PDF

Report lists subscribers who are terminated from the current month's billing. Includes terminated coverage(s) and effective date(s). Employers can access up to five previous months' reports.

- Make sure the proper notification is sent to each listed employee.
- If the termination is in error, submit a corrected Active NOE or submit a Reinstatement in EBS immediately to reinstate the employee's benefits or correct an incorrectly keyed late entrant date.
- Refer to the key (reminder) at the bottom of the report for proper notification.

**** TERMINATED SUBSCRIBER LISTING ****														
REPORT MONTH:														
SUBSCRIBER TYPE: ACTIVE - REGULAR (AR)														
EMPLOYER GROUP:														
		COVERAGE										EFF DATE	COVERAGE	EFF DATE
SOCIAL SECURITY NUMBER	EMPLOYEE NAME	H	D	DP	DL	DLS	SL	LTD	LTC	STLD		OL		

Subscribers with Incorrect Coverage Level (HIS518)

Frequency: Monthly, if applicable

Format: PDF

Letters to subscribers who, according to PEBA records, are enrolled in an incorrect coverage level.

Dear Subscriber:

According to our records, you have this level of coverage, but no eligible dependents:

PLAN	COVERAGE LEVEL	EFFECTIVE DATE
Dependent Life/Child(ren)	Child(ren) only	

Since there are no eligible dependents, you may be paying higher premiums for a level of coverage that you do not need. To reduce your level of coverage, you must complete a Notice of Election form, removing all ineligible dependents from your coverage, within 31 days of the date of their ineligibility.

For additional information and assistance, please contact your benefits office or call us at 803-734-0678 (Greater Columbia area) or at 888-260-9430 (toll-free outside the Columbia area).

Dependent Age 1 and Older with No SSN (HIS534)

Frequency: Monthly, if applicable

Format: PDF

Report of subscribers with eligible spouses or children on file without Social Security numbers. Report includes subscriber name, dependent name, relationship type, date of birth and age. The spouse or child(ren) will be listed on this report each month until an SSN is provided.

REPORT OF DEPENDENTS AGE 6 MONTHS OR MORE WITH NO SSN							
EMPLOYER GROUP ID:							
---	SUBSCRIBER	-----	DEPENDENT	-----	REL ELIG	DOB	YRS/MON
TYPE	SSN	NAME	NAME				

Subscriber/Dependent Roster (HIS539)

Frequency: Monthly

Format: PDF and.csv

Provides coverage information for each subscriber and any dependents. Employers can access up to five previous months' reports.

CSV format

- Last name, first name, middle initial, last four of SSN, BIN.
- For each program:
 - Category of enrollee only (1); enrollee/spouse (2); enrollee/children (3); or full family (4).
- Health plan:
 - Standard Plan (STD).
 - Savings Plan (SAV).
- Basic Dental.
- Dental Plus.
- Vision.
- Dependent Life-Child.
- Optional Life (coverage amount).
- Dependent Life-Spouse (coverage amount).
- SLTD (waiting period).
- Tobacco-use premium.
- Dependent information, coverage, date of birth, relationship to subscriber (for up to 15 dependents).

Subscriber					Hlth	Dntl	Dntp	Visn						Tobc
Last Name	First Name	MI	SSN	Bin	Plan/Cat	Cat	Cat	Cat	DL/CH	OL	DL/SP	SLTD	User	

Dependent 1					Hlth	Dntl	Dntp	Visn					
Last Name	First Name	MI	SSN	Plan/Cat	Cat	Cat	Cat	DL/CH	OL	DL/SP	Dep 1 DOB	Dependent 1 Relation	

Dependent information repeated up to 15 dependents on this report.

The final page of the PDF includes total number of subscribers and dependents for each program.

*** ACTIVE SUBSCRIBER LISTING ***													
GROUP:					HLTH	DNTL	DNTP	VISN					TOBC
NAME		SSN	PLAN/CAT	CAT	CAT	CAT	DL/CH	OL	DL/SP	SLTD	USER	DEP DOB	DEPENDENT RELATION

SUBSCRIBER LISTING TOTALS		
INSURANCE PLAN	TOTAL SUBSCRIBERS	TOTAL DEPENDENTS
HEALTH STANDARD PLAN		
HEALTH SAVINGS PLAN		
BLUECHOICE		
CIGNA		
STATE DENTAL PLAN		
DENTAL PLUS		
DEPENDENT LIFE		
OPTIONAL LIFE		
OPTIONAL LIFE SPOUSE		
VISION		
SUPPLEMENTAL LONG TERM DISABILITY		
TOBACCO USER		

Dependent Turning 19/25/26 Within 90 Days Letters (HIS600)

Frequency: Monthly, if applicable

Format: PDF

Letters to accompany dependent turning 19/25/26 within 90 days (HIS501). Employers can access up to five previous months' reports.

According to our records, this dependent is turning 19 and is enrolled in Dependent Life-Child coverage. Eligibility for Dependent Life-Child insurance ends at age 19 unless the child is certified as a full-time student or an incapacitated child. Dependent children with proof of full-time student status may be covered until age 25.

If your child is not a full-time student or incapacitated child, please notify your benefits administrator to remove the dependent from Dependent Life coverage, and your payroll deductions will be adjusted, as needed.

If you do nothing, your dependent will remain on coverage until age 25. MetLife will require eligibility documentation before any claims will be paid. This includes documentation certifying the child was a full-time student enrolled in high school, trade, vocational or technical school, or college or university (not correspondence courses).

If your child is incapable of self-sustaining employment because of mental illness, intellectual disability or physical disability, and is principally dependent (more than 50 percent) on you for support and maintenance, you must submit an Incapacitated Child Certification Form within 31 days of your child's 19th birthday. If your dependent is approved for coverage as an incapacitated child, your dependent's eligibility will continue.

Remember, MetLife will require eligibility documentation before any claims will be paid.

If you have any questions, please call us at 803-737-6800 (Greater Columbia area) or at 888-260-9430 (toll-free outside the Columbia area).

According to our records, the dependent listed below will turn age 25 within the next 90 days:

Eligibility for Dependent Life-Child insurance as a full-time student ends at age 25, unless your dependent is approved by PEBA Insurance Benefits to continue coverage as an incapacitated child. Therefore, your dependent will be dropped from your Dependent Life Child coverage on the first of the month after your dependent turns 25. If this dependent is incapacitated, contact us immediately at 803-737-6800 (Greater Columbia area) or at 888-260-9430 (toll-free outside the Columbia area).

If you have any questions, please call us.

According to our records, this child will turn age 26 within the next 90 days and no longer be eligible for coverage.

Your child will be dropped from your coverage on the first of the month after he turns 26. Accordingly claims incurred by your child after that will not be paid.

As required, eligibility ends at age 26 unless your child is approved by PEBA Insurance Benefits to continue coverage as an incapacitated child. If your child is incapable of self-sustaining employment because of mental illness, intellectual disability or physical disability, and is principally dependent (more than 50 percent) on you for support and maintenance, you must submit an Incapacitated Child Certification Form within 31 days of your child's 26th birthday. This form is available on the PEBA Insurance Benefits website, www.peba.sc.gov.

If your child is not approved for coverage past age 26, coverage may be continued under COBRA for a maximum of 36 months, if we receive a completed COBRA Notice of Election (NOE) form within 60 days of the loss of coverage and premium payment within 45 days of receipt of the NOE. Please be sure to provide information about your child in the Enrollee Info section of the COBRA NOE. Your child's COBRA coverage will not be effective until the first premium is paid. Please contact your benefits office to make any changes as a result of this child's removal from your coverage and for additional information on COBRA coverage for your dependent.

If you have any questions, please contact your benefits administrator or call PEBA at 803-737-6800 (Greater Columbia area) or at 888-260-9430 (toll-free outside the Columbia area).

OE Suspense Transactions to be Purged (HIS759)

Frequency: Annually, if applicable

Format: PDF

Lists subscribers for whom an open enrollment transaction was initiated by the subscriber; however, due to the reason listed, the open enrollment transaction will be purged. The open enrollment changes will not be applied for the new plan year.

SOUTH CAROLINA PUBLIC EMPLOYEE BENEFIT AUTHORITY INSURANCE BENEFITS					HIS759NP PAGE 1
OE SUSPENSE TRANSACTIONS PURGED					
GROUP ID:					
BIN	SUBSCRIBER NAME	TRANSACTION DATE	TRANSACTION ID	SUSPENSE REASON	
-----	-----	-----	-----	-----	

MoneyPlus Enrollment Data (HIS761)

Frequency: Weekly

Format: .csv

Employees' annual MoneyPlus elections for MSAs, DCSAs and HSAs. Employees who are enrolled in multiple MoneyPlus accounts will appear multiple times.

Ssn	Bin	First Name	Last Name	Addr1	Addr2	City	St	Zip Code	Group Id	Money Plus Coverage	Annual Amt	Pay Period	Pretax
-----	-----	------------	-----------	-------	-------	------	----	----------	----------	---------------------	------------	------------	--------

MoneyPlus YTD Contribution Report (HIS763)

Frequency: Weekly

Format: PDF and .csv

Report of year-to-date contributions for MSA and DCSA accounts as reported by ASIFlex. Includes previous employer group number, if applicable, for a subscriber transferring between employers.

SOUTH CAROLINA PUBLIC EMPLOYEE BENEFIT AUTHORITY INSURANCE BENEFITS										HIS763NP PAGE 1
ASI YTD CONTRIBUTIONS FOR MSA/DCA										
GROUP ID:										
BIN	SUBSCRIBER NAME	MSA ANN AMT	MSA YTD CONTRIB	MSA YTD REIMBURSE	DCA ANN AMT	DCA YTD CONTRIB	DCA YTD REIMBURSE	HSA ANN AMT	HSA YTD AMT	PREV GROUP

MoneyPlus Pretax Feature (HIS912)

Frequency: Weekly

Format: PDF and .csv

Active subscribers with Pretax indicator of Y or N.

Last Name	First Name	MI	Bin	SSN	PreTax
-----------	------------	----	-----	-----	--------

MONEY PLUS PRETAX FEATURE AS OF			
GROUP ID:			
GROUP NAME:			
NAME	BIN	SSN	PRETAX

Dependents Terminated from Dependent Life-Child (HIS991)

Frequency: Monthly, if applicable

Format: PDF

This report shows dependents who have terminated from Dependent Life-Child coverage.

Automated Subscriber Coverage Changes Report (HRA615)

Frequency: Monthly, if applicable

Format: PDF

Lists subscribers for whom a coverage change occurred. The reason is listed.

SOUTH CAROLINA PUBLIC EMPLOYEE BENEFIT AUTHORITY INSURANCE BENEFITS										HRA615NP PAGE 1
AUTOMATED SUBSCRIBER COVERAGE CHANGES EFFECTIVE										
GROUP ID: GROUP NAME:										
NAME	BIN	HEALTH		DENTAL		DENTAL PLUS			REASON	
		CURRENT PLN/CAT	PREVIOUS PLN/CAT	CURRENT PREM	PREVIOUS PREM	CURRENT PLN/CAT	PREVIOUS PLN/CAT	CURRENT PREM	PREVIOUS PREM	

1095-C NMSN File (HT1095CN)

Frequency: Annually, if applicable

Format: .txt

This report is for groups with employees for whom they received a National Medical Support Notice (NMSN). Do not list the child's Social Security number on the Form 1095-C they issue.

1095-B File (HTB1095B)

Frequency: Annually

Format: .txt

View the [ACA reporting requirements FAQs](#) for more information.

An employer subject only to Code Section 6055 will report the necessary information for an employee on Form 1095-B. In Part IV of the 1095-B, non-ALEs must report about their employees (and their dependents) who are covered by the Plan for the purposes of satisfying their reporting obligations under Code Section 6055. To facilitate the employer's reporting requirement, PEBA provides this report in late December, refreshing each Friday prior to the deadline for mailing the forms, which contains this information. View the [file layout](#) for more information.

1095-C File (HTB1095C)

Frequency: Annually

Format: .txt

View the [ACA reporting requirements FAQs](#) for more information.

An employer subject to Code Section 6055 and Code Section 6056 will report the necessary information for an employee on Form 1095-C. In Part III of the 1095-C, ALEs must report about their employees and their dependents who are covered by the Plan for the purposes of satisfying their reporting obligations under Code Section 6055. To facilitate the employer's reporting requirement, PEBA provides this report in late December, refreshing each Friday prior to the deadline for mailing the forms, which contains this information. View the [file layout](#) for more information.

Health Subscriber and/or Spouse's TEFRA/DEFRA Letter

Tax Equity and Fiscal Responsibility Act/Deficit Reduction Act

Frequency: Monthly, if applicable

PEBA mails this letter to employees and spouses 90 days prior to their 65th birthday. The letter details their insurance options once they become eligible for Medicare at age 65.

Letters are mailed the first of each month to the subscriber and/or their spouse. Retain a copy for your files.

Comptroller General (CG) agencies only

Payroll Reconciliation Report

Frequency: Monthly

Format: PDF (Accounting Reports)

PEBA sends an enrollment file to SCEIS daily. SCEIS uses the information in the file (benefit, effective date, type of entry, coverage level and premium) to determine the premiums to be deducted on the next payroll. The reconciliation reports are a comparison of the enrollment files at PEBA and the SCEIS payroll deductions.

PEBA provides a monthly reconciliation (Employee-HAC402; Employer-HAC403) of monthly premiums to all CG agencies. The reconciliation for the previous month is forwarded to the agency with the current month's billing statement.

The employee reconciliation report (HAC402) lists the subscriber(s) who is being billed a different amount than the deducted premium, in the following page order.

- State Health Plan and the TRICARE Supplement Plan;
- Basic Dental;
- Dental Plus;
- Optional Life;
- Dependent Life-Child;
- Dependent Life-Spouse;
- SLTD;
- State Vision Plan; and
- Tobacco-use premium.

EMPLOYEE RECONCILIATION INSURANCE MASTER VS SCEIS PAYROLL DEDUCTIONS FOR:						
GROUP ID/NAME: TYPE OF INSURANCE:						
BIN	INSURANCE MASTER NAME	PREMIUM	BIN	SCEIS DEDUCTION NAME	PREMIUM	DIFFERENCE
SUMMARY						
INSURANCE MASTER TOTALS PREMIUM AMOUNT		SCEIS MASTERS TOTALS AMOUNT DEDUCTED			DIFFERENCE TOTALS AMOUNT	

The Employer Reconciliation Report (HAC403) lists the subscriber(s) for which the employer is billed a different amount than the SCEIS employer contribution, in the following page order.

- State Health Plan and the TRICARE Supplement Plan (\$ per coverage level);
- Basic Dental;
- Basic LTD; and
- Basic Life.

EMPLOYER RECONCILIATION INSURANCE MASTER VS SCEIS PAYROLL DEDUCTIONS FOR:						
GROUP ID/NAME: TYPE OF INSURANCE:						
BIN	INSURANCE MASTER NAME	PREMIUM	BIN	SCEIS DEDUCTION NAME	PREMIUM	DIFFERENCE

SUMMARY		
INSURANCE MASTER TOTALS PREMIUM AMOUNT	SCEIS MASTERS TOTALS AMOUNT DEDUCTED	DIFFERENCE TOTALS AMOUNT

Insurance Master is the premium amount per PEBA’s enrollment records. SCEIS Deduction is the premium amount that is payroll deducted. The final column is the difference between the two amounts. A summary for each program is included.

Research each difference and take proper action to correct any problem(s).

Accumulator Reports

Frequency: Monthly

Format: PDF (Accounting Reports; six months of historical reports available)

Employee (HAC581)

This report identifies the payroll or enrollment discrepancies that need to be resolved before the next billing statement. Balance, retro billed, reconciliation amount, checks remitted, refunds/canceled refunds, canceled warrants, emergency payroll, adjustments, returned checks and employee balance summarized, as well as individual subscriber amounts for each program, are included on the report in the following order:

- State Health Plan and the TRICARE Supplement Plan;
- Basic Dental;
- Dental Plus;
- State Vision Plan;
- Optional Life;
- Dependent Life-Spouse;
- Dependent Life-Child;
- SLTD; and
- Tobacco-use premiums.

Benefit: Group:		Employee Accumulator For: June			
Subscriber	Beginning Balance from March	April	May	June	
Balance Forward					
Retro Billed					
Reconciliation Amount					
Checks Remitted					
Refunds / Cancelled Refunds					
Cancelled Warrants					
Emergency Payroll					
Adjustments					
Returned Checks					
Employee Balance					

Subscriber	Beginning Balance from March	April	May	June
Balance				

The report is created using the monthly amount billed and payroll deducted; refunds and billing adjustments processed; and personal checks remitted during the month. If the amount billed is the same as the amount payroll deducted, the subscriber will not appear on this report. A minus sign by the amount indicates a credit.

The top section of the report is a calculation using the total amount of premiums billed, payroll deductions, refunds, personal checks and billing adjustments to determine the employee balance. The net of the amounts shown for each subscriber equals the employee balance. The employee balance also matches the Net Premium Outstanding amount on the Account Summary pages of the billing statement.

The subscriber column lists the employee's benefits identification number (BIN) and name. The report is in alphabetical order based on last name.

The amounts shown in the column for the most current month need your attention. A zero balance in the current month column means the discrepancy was resolved and no action is necessary. Zero balances will remain on the report through the end of the fiscal year and will be deleted once a new year begins. The report displays four consecutive months to help identify in which month the discrepancy occurred. Amounts not resolved carry forward to the next month. If the amount carried forward remains the same, it was a one-time error. If the amount changes each month, the error is continuing and should take priority to resolve.

You might need to refer to the reconciliation report, billing statement, the balance screen and subscriber inquiry in EBS and the NOE in your research.

There are some situations in which the discrepancy cannot be avoided due to the timing of when the enrollment is processed and the SCEIS payroll schedule. For example, if a March 1 termination is processed on February 25, SCEIS cannot stop the deduction for the March 1 payroll, which results in a refund due.

In reviewing the report, you may see that balances appear in one month but do not carry forward to the next month. These are examples of a timing issue, and the balances were resolved by a refund, payroll deduction or enrollment transaction. A balance that appears one month and the same balance carries forward is an example of a one-time error. To resolve the discrepancy, determine if there was an enrollment processed (i.e., termination, new hire or coverage change). If the coverage is not correct in EBS, contact PEBA. If the enrollment is correct, review the payroll deductions to determine if the appropriate premiums were collected. If deductions are not correct, open a SCEIS ticket. SCEIS should automatically refund overpayments or collect amounts owed; however, that does not always occur. Therefore, review this report monthly.

It's important to note that after February 1 of each year, SCEIS will no longer collect or refund for enrollment transactions with an effective date in the previous year. The refund request for premiums deducted in the previous year should be submitted to PEBA, and balances should be paid by collecting and remitting a personal check from the subscriber to PEBA.

Employer (HAC582)

This report identifies the payroll or enrollment discrepancies for the employer premiums for health, dental, life insurance and long term disability insurance. The discrepancies on the employer accumulator will automatically be resolved in May of each year when the net amount of the employer under- or overpayments will be billed or refunded to the group. If there is a balance due, an IDT will be billed in SCEIS. If the group is due a refund, the group will enter an IDT document in SCEIS for PEBA to process.

Balance, retro billed, reconciliation amount, checks remitted, refunds/canceled refunds, canceled warrants, emergency payroll, adjustments, returned checks and employee balance summarized, as well as individual subscriber amounts for each program, are included on the report in the following order:

- State Health Plan;
- Basic Dental;
- Basic LTD; and
- Basic Life.

Benefit: Group:		Employer Accumulator For: June			
Subscriber	Beginning Balance from March	April	May	June	
Balance Forward					
Retro Billed					
Reconciliation Amount					
Checks Remitted					
Refunds / Cancelled Refunds					
Cancelled Warrants					
Emergency Payroll					
Adjustments					
Returned Checks					
Employer Balance					

Subscriber	Beginning Balance from March	April	May	June
Employer - BALANCE				
Balance				

Subscriber Balance Report (HAC583)

Frequency: Monthly

Format: Excel (Accounting Reports; six months of historical reports available)

This report shows the balances (under- or overpayments) also listed on the Accumulator Report, but in a different format. This report displays the subscriber’s name and the employee balance for each benefit, as well as the employer balance for health, dental, life insurance and long term disability insurance.

BIN	Name	Health	Dental	Dental+	Vision	OL	DLS	DLC	SLTD	TS	ER Health	ER Dental	ER LTD	ER BL	Total
-----	------	--------	--------	---------	--------	----	-----	-----	------	----	-----------	-----------	--------	-------	-------

1095 Clean-up for SCEIS (HIS17981)

Frequency: Annually

Format: PDF (Enrollment Report)

To comply with Affordable Care Act (ACA) requirements, the S.C. Comptroller General’s Office and SCEIS provided information that was included on your employees’ 2024 Form 1095-C to the IRS. The IRS notified SCEIS that some of the information did not match their files. To determine a match, the IRS looks only at the first four letters of the last name and the SSN.

This report contains the mismatched information, if applicable, and includes the employee’s information first, then the individual whose information did not match the IRS’ files. Verify the information with your employee and use the guide below to make corrections. If the employee no longer works for you, use the information you have on file to verify the report.

Mismatched information	What to do
Correct dependent’s name, SSN or DOB	Correct on report
Correct employee’s SSN	Correct on report
Correct employee’s name – misspelled	Correct on report
Correct employee’s name – different name	Submit an NOE to PEBA and correct on report

1095 CLEAN UP FOR SCEIS								
EMP SSN	EMP NAME	EMP STAT	SSN	TYPE	LAST NAME	FIRST NAME	DOB	VERIFIED
Return to Public Employee Benefit Authority, Attn: Denise Hunter, 202 Arbor Lake Drive, Columbia, SC 29223 or EMAIL: dhunter@peba.sc.gov								

Optional employers only

Retiree, COBRA and Survivor Subscriber/Dependent Roster (HIS587)

Frequency: Monthly

Format: PDF and .csv (Enrollment Report)

Provides coverage information for each retiree, COBRA and survivor subscriber with dependents. Dependent coverage, date of birth and relationship are included. Employers can access up to five previous months' reports.

SOUTH CAROLINA PUBLIC EMPLOYEE BENEFIT AUTHORITY INSURANCE BENEFITS										HIS587NP PAGE 1
GROUP:										
NAME	SSN	HLTH PLAN/CAT	DNTL CAT	DNTP CAT	VISN CAT	TOBC USER	DEP DOB	DEPENDENT RELATION		

Retiree, COBRA and Survivor Roster (HRA500)

Frequency: Monthly

Format: PDF and .csv (Accounting Report)

Employers can access up to five previous months' reports. Provides coverage information for each retiree, COBRA and survivor subscriber, as well as the monthly employee premium for the following PEBA insurance programs:

- State Health Plan;
- Basic Dental;
- Dental Plus;
- Vision; and
- Tobacco-use premium.

Subscriber type on the CSV format is identified as:

C18	18 month COBRA	RR	Retiree - Regular	SRR	Survivor
C29	29 month COBRA	R05	Retiree - 5/10 year		
C36	36 month COBRA	R25	Retiree - 25 year		

ssn	last_name	first_name	subscriber_type	health_status	health_plan	health_category	rate_scheme	health_er_rate	health_ee_rate	
dental_status	dental_category	dental_er_rate	dental_ee_rate	dental_plus_status	dental_plus_ee_rate	vision_status	vision_category	vision_ee_rate	tobacco_status	tobacco_ee_rate

The PDF format is divided into sections based on subscriber type (18-month COBRA, 29-month COBRA, 36-month COBRA, Retiree-Regular, Retiree-25 Year, Survivor, etc.). In each of the sections, names are printed in alphabetical order by last name, first name and middle initial, with the BIN listed in the next column. This roster will not include the Social Security number.

Bills – Retiree, COBRA and Survivor (HRA610)

Frequency: Monthly

Format: PDF (Accounting Report)

The optional employer continues to serve as the benefits administrator for these subscribers; therefore, you will receive the monthly Retiree, COBRA and Survivor bill, in addition to the Active Subscribers bill (HAC610). Employers can access up to five previous months' bills.

The PDF billing statement is the same as that for active subscribers. Note that some programs are not listed, because they are not available to these subscribers. The \$3 administrative fee for each retiree, survivor and COBRA participant per month is included on the Account Summary pages.

Collect the premiums for covered retirees, COBRA and survivor subscribers, and deposit their checks into your account. Their checks should be made payable to the employer, not PEBA. **Do not submit personal subscriber checks to PEBA.**

Remit a single check for the total amount due shown on the Remittance Advice page of the individual and active group bills.

C18	18 month COBRA	RR	Retiree - Regular	SRR	Survivor
C29	29 month COBRA	R05	Retiree - 5/10 year		
C36	36 month COBRA	R25	Retiree - 25 year		

Active Rate with Load Factor (HTB527)

Frequency: Annually, if applicable

Format: PDF

Provides monthly health employer contributions and employee premiums per plan (Standard Plan and Savings Plan) and coverage level, including the load factor. If the load factor is 1.000, the report will not post in EBS. Use the published rates from PEBA. View more information about load factors in the [Optional Employer Handbook](#).

INSURANCE RATES FOR:							
SUBSCRIBER TYPE: HEALTH PLAN:			RATE SCHEME:				
		CURRENT		PREVIOUS1		PREVIOUS2	
EFF DATE	LOAD FACTOR	EMPLOYEE	EMPLOYER	EMPLOYEE	EMPLOYER	EMPLOYEE	EMPLOYER
CATEGORY							
SUBSCRIBER							
SUBS/SPOUSE							
SUBS/CHILD							
FAMILY							

Individual Rate with Load Factor (HTB528)

Frequency: Annually, if applicable

Format: PDF

Provides monthly health employer contributions and employee premiums per subscriber type and coverage level (detailed below), including the load factor. If the load factor is 1.000, the report will not post in EBS. Use the published rates from PEBA. View more information about load factors in the [Optional Employer Handbook](#).

Note: This report references the Standard Plan for Medicare-eligible members, not the Carve-out Plan.

INSURANCE RATES FOR:						
SUBSCRIBER TYPE: HEALTH PLAN:			RATE SCHEME:			
EFF DATE LOAD FACTOR	CURRENT		PREVIOUS1		PREVIOUS2	
	EMPLOYEE	EMPLOYER	EMPLOYEE	EMPLOYER	EMPLOYEE	EMPLOYER
CATEGORY	-----		-----		-----	
SUBSCRIBER						
SUBS/SPOUSE						
SUBS/CHILD						
FAMILY						

Subscriber type: 18-month COBRA

- Standard, Medicare Supp, Savings

Subscriber type: 29-month COBRA

- Standard, Medicare Supp, Savings

Subscriber type: 36-month COBRA

- Standard, Medicare Supp, Savings

Subscriber type: Retiree 15/25

- Subscriber and Spouse have Medicare
 - Standard, Medicare Supp
- Subscriber and Spouse not eligible for Medicare
 - Standard, Savings, TRICARE
- Subscriber has Medicare; Spouse not eligible for Medicare
 - Standard, Medicare Supp
- Subscriber not eligible for Medicare; Spouse has Medicare
 - Standard, Medicare Supp, Savings
- Child(ren) only eligible for Medicare
 - Standard, Medicare Supp, Savings

Subscriber type: Retiree – Buy-in/5-10 year/25 year

- Subscriber and Spouse have Medicare
 - Standard, Medicare Supp
- Subscriber and Spouse not eligible for Medicare
 - Standard, Savings, TRICARE

- Subscriber has Medicare; Spouse not eligible for Medicare
 - Standard, Medicare Supp
- Subscriber not eligible for Medicare; Spouse has Medicare
 - Standard, Medicare Supp, Savings
- Child(ren) only eligible for Medicare
 - Standard, Medicare Supp, Savings

Subscriber type: Retiree – regular

- Subscriber and Spouse have Medicare
 - Standard, Medicare Supp
- Subscriber and Spouse not eligible for Medicare
 - Standard, Savings, TRICARE
- Subscriber has Medicare; Spouse not eligible for Medicare
 - Standard, Medicare Supp
- Subscriber not eligible for Medicare; Spouse has Medicare
 - Standard, Medicare Supp, Savings
- Child(ren) only eligible for Medicare
 - Standard, Medicare Supp, Savings

Subscriber type: Survivor – partially funded

- Spouse and child(ren) have Medicare
 - Standard, Medicare Supp
- Spouse and child(ren) not eligible for Medicare
 - Standard, Savings, TRICARE
- Spouse has Medicare; child(ren) not eligible for Medicare
 - Standard, Medicare Supp, Savings
- Spouse not eligible for Medicare; child(ren) has Medicare
 - Standard, Medicare Supp, Savings

Subscriber type: Survivor – funded

- Spouse and child(ren) have Medicare
 - Standard, Medicare Supp
- Spouse and child(ren) not eligible for Medicare
 - Standard, Savings, TRICARE
- Spouse has Medicare; child(ren) not eligible for Medicare
 - Standard, Medicare Supp, Savings
- Spouse not eligible for Medicare; child(ren) has Medicare
 - Standard, Medicare Supp, Savings

Subscriber type: Survivor – regular

- Spouse and child(ren) have Medicare
 - Standard, Medicare Supp
- Spouse and child(ren) not eligible for Medicare
 - Standard, Savings, TRICARE
- Spouse has Medicare; child(ren) not eligible for Medicare
 - Standard, Medicare Supp, Savings
- Spouse not eligible for Medicare; child(ren) has Medicare

- Standard, Medicare Supp, Savings

Subscriber type: Survivor – regular

- Medicare



Reference

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Acronyms used in this manual

Acronym	Explanation
AD&D	Accidental Death & Dismemberment
BA	Benefits administrator
BlueCross	BlueCross BlueShield of South Carolina
BIN	Benefits ID number (subscriber identification number in lieu of SSN)
BLTD	Basic Long Term Disability
CBA	Companion Benefit Alternatives
CG	Comptroller General
COBRA	Consolidated Omnibus Budget Reconciliation Act
DCSA	Dependent Care Spending Account (MoneyPlus)
DHHS	Department of Health and Human Services (Medicaid)
DSS	Department of Social Services
EBS	Employee Benefits Services
ERISA	Employee Retirement Income Security Act of 1974
FSA	Flexible Spending Account (MoneyPlus)
FMLA	Family and Medical Leave Act of 1993
GEA	Government Employees Association, sponsor of the TRICARE Supplement Plan
HIPAA	Health Insurance Portability and Accountability Act of 1996
HMO	Health Maintenance Organization
HSA	Health Savings Account

Acronym	Explanation
IBG	<i>Insurance Benefits Guide</i>
LTC	Long term care
LTD	Long term disability
MSA	Medical Spending Account (MoneyPlus)
NOE	<i>Notice of Election</i>
PEBA	Public Employee Benefit Authority
PCP	Primary care physician
PPACA (ACA)	Patient Protection and Affordable Care Act of 2010
RETRO	Retroactivity
SCEIS	South Carolina Enterprise Information System
SLTD	Supplemental long-term disability
SOC	Summary of change
SOE	Summary of enrollment
SOI	Summary of intent
SSN	Social Security number
STARS	Statewide Accounting and Reporting System
SVP	State Vision Plan
URT	Unrequested refund transfer
USERRA	Uniformed Services Employment and Reemployment Rights Act of 1994

County codes

Code	County	Code	County
1	Abbeville	25	Hampton
2	Aiken	26	Horry
3	Allendale	27	Jasper
4	Anderson	28	Kershaw
5	Bamberg	29	Lancaster
6	Barnwell	30	Laurens
7	Beaufort	31	Lee
8	Berkeley	32	Lexington
9	Calhoun	33	McCormick
10	Charleston	34	Marion
11	Cherokee	35	Marlboro
12	Chester	36	Newberry
13	Chesterfield	37	Oconee
14	Clarendon	38	Orangeburg
15	Colleton	39	Pickens
16	Darlington	40	Richland
17	Dillon	41	Saluda
18	Dorchester	42	Spartanburg
19	Edgefield	43	Sumter
20	Fairfield	44	Union
21	Florence	45	Williamsburg
22	Georgetown	46	York
23	Greenville	99	Out-of-state
24	Greenwood		

Quick reference charts

Active NOE quick reference

Use EBS when permissible. EBS includes edits that can prevent errors and rejections. Instructions for the [Active Notice of Election](#) form are on Page 3 of the form. This chart includes specific details for additions and changes. Each column in the table represents a unique event.

NOE section	New hire	Open enrollment	Marriage	Divorce/separation
ACTION	Select: New Hire/Election. Type of Change: Enrollment.	Select: Change. Type of Change: Enrollment.	Select: Change. Type of Change: Other (Specify Marriage and Date of Change Event). Must provide documentation.	Select: Change. Type of Change: Other (Specify Divorce and Date of Change Event). Must provide documentation.
BA USE ONLY	Effective Date; Group ID#; Group Name; if 20-hour employee; Pay periods per year.	Effective Date; Group ID#; Group Name; Pay periods per year.	Effective Date; Group ID#; Group Name; Pay periods per year.	Effective Date; Group ID#; Group Name; Pay periods per year.
ENROLLEE INFO	#1-19	#1-5	#1-5; #8-17	#1-5; #8-17
COVERAGE	#20-26	#20-22, 23-24, 26, if applicable.	#20-24, 26 if changing coverage level.	#20-24, 26 if changing coverage level.
MONEYPLUS Pretax Premiums	Refuse or Enroll.	Complete if changing election.	Complete if changing election.	Complete if changing election.
MONEYPLUS Elections	Complete if enrolling.	Complete if reenrolling or enrolling.	Complete if changing election.	Complete if changing election.
EMPLOYEE INITIALS	Initial and date.	Initial and date.	Initial and date.	Initial and date.
MEDICARE	Complete all, if applicable.	Complete all, if applicable.	Complete all, if applicable.	Complete all, if applicable.

For beneficiaries and dependents:

Do not list “spouse” or “child.” List relationship as wife, husband, daughter, son.

For beneficiaries:

An estate or trust has no relationship.

BENEFICIARIES	Complete all.	Employee option to change; complete all, if applicable.	Employee option to change; complete all, if applicable.	Employee option to change; complete all, if applicable.
DEPENDENTS	Complete all, if applicable.	Complete all, if applicable.	Add; complete all, listing dependents to add.	Delete; listing dependents to delete.
CERTIFICATION & AUTHORIZATION	#31-32	#31-32	#31-32	#31-32

NOE section	Ineligible child/coverage change	Last ineligible child/coverage change	Returning student	Dependent Life-Spouse coverage with medical approval
TYPE OF CHANGE	Select: Change. Type of Change: Other (Specify ineligible child and give reason).	Select: Change. Type of Change: Other (Specify ineligible child and give reason).	Select: Change. Type of Change: Other (Specify returning student). Must provide documentation.	Select: Change. Type of Change: Other (Specify Dependent Life and increase with medical approval). Must provide approval from MetLife.
BA USE ONLY	Effective Date; Group ID#; Group Name.	Effective Date; Group ID#; Group Name.	Effective Date; Group ID#; Group Name.	Effective Date; Group ID#; Group Name.
ENROLLEE INFO	#1-5	#1-5	#1-5	#1-5
COVERAGE	#20-22 and 26 if decreasing coverage level.	#20-22 and 26 if decreasing coverage level.	#20-22 and 26 if decreasing coverage level.	#23
MONEYPLUS Pretax Premiums	Complete if changing election.	Complete if changing election.	Complete if changing election.	N/A
MEDICARE	Complete all, if applicable.	Complete all, if applicable.	Complete all, if applicable.	Complete all, if applicable.

For beneficiaries and dependents:

Do not list “spouse” or “child.” List relationship as wife, husband, daughter, son.

For beneficiaries:

An estate or trust has no relationship.

BENEFICIARIES	Employee option to change; complete all, if applicable.	Employee option to change; complete all, if applicable.	Employee option to change; complete all, if applicable.	Employee option to change; complete all, if applicable.
DEPENDENTS	Delete; list child to delete.	Delete; list child to delete.	Add; complete all, listing child to add.	Add; listing spouse.
CERTIFICATION & AUTHORIZATION	#31-32	#31-32	#31-32	#31-32

NOE section	Optional Life add/increase	Optional Life add/increase with medical approval	Optional Life decrease/refuse	Dependent Life add/increase with medical approval	SLTD add/decrease waiting period with medical approval
TYPE OF CHANGE	Select: Change. Type of Change: Other (Specify OL add or increase and give reason).	Select: Change. Type of Change: Other (Specify OL add or increase with medical approval). Must provide approval from MetLife.	Select: Change. Type of Change: Other (Specify OL decrease or refuse and give reason for change if on Pretax Feature).	Select: Change. Type of Change: Other (Specify DL add or increase with medical approval). Must provide approval from MetLife.	Select: Change. Type of Change: Other (Specify: SLTD add or wait period). Must provide approval from The Standard.
BA USE ONLY	Effective Date; Group ID#; Group Name.	Effective Date; Group ID#; Group Name.	Effective Date; Group ID#; Group Name.	Group ID#; Group Name.	Group ID#; Group Name.
ENROLLEE INFO	#1-5; 18	#1-5; 18	#1-5	#1-5; 18	#1-5, 18
COVERAGE	#24 (enter new amount).	#24 (enter new amount).	#24 (enter new amount or refuse).	#22 for child(ren), #23 (enter new amount).	#25
MONEYPLUS Pretax premiums	Complete if changing election.	Complete if changing election by choosing either yes or refuse.	Complete if changing election.	N/A	N/A
MEDICARE	Complete all, if applicable.	Complete all, if applicable.	Complete all, if applicable.	Complete all, if applicable.	Complete all, if applicable.

For beneficiaries:

Do not list "spouse" or "child." List relationship as wife, husband, daughter, son.
An estate or trust has no relationship.

BENEFICIARIES	Employee option to change; complete all, if applicable.	Employee option to change; complete all, if applicable.	Employee option to change; complete all, if applicable.	Employee option to change; complete all, if applicable.	Employee option to change; complete all, if applicable.
DEPENDENTS	N/A	N/A	N/A	N/A? #30	N/A
CERTIFICATION & AUTHORIZATION	#31-32	#31-32	#31-32	#31-32	#31-32

Special eligibility situations quick reference

This information describes changes subscribers can make when a special eligibility situation occurs. Unless otherwise noted, all changes must be made within 31 days of the event. Additionally, refer to the Life event checklists at peba.sc.gov/publications.

Event	This person/these people (select one)	Can do one or more of these actions (select as many as apply)	Effective date	Documentation required
Birth of child	<input type="checkbox"/> Employee alone <input type="checkbox"/> Employee and newborn child <input type="checkbox"/> Employee and existing child(ren) <input type="checkbox"/> Employee and spouse <input type="checkbox"/> Employee, spouse, existing child(ren) and newborn child	<input type="checkbox"/> Enroll in health (if employee already enrolled in health, may change plans if adding spouse or child to health) <input type="checkbox"/> Enroll in dental <input type="checkbox"/> Enroll in State Vision <input type="checkbox"/> Enroll in Dependent Life-Child <input type="checkbox"/> Enroll in or increase Dependent Life-Spouse (\$10,000 or \$20,000 without medical evidence; more than \$20,000 with medical evidence) <input type="checkbox"/> Enroll in or increase Optional Life (up to \$50,000 without medical evidence; more than \$50,000 with medical evidence) <input type="checkbox"/> Review changes available with MSA/DCSA	Health, dental and vision: Date of birth Optional Life and Dependent Life-Spouse: For amounts available without medical evidence, the first of the month after request. For amounts requiring medical evidence, first of month following date of approval. Dependent Life-Child: Date of birth	Long-form birth certificate of child and if adding spouse, marriage license or Page 1 of latest federal tax return.
Notes				
<p>A. Note about premiums: If the employee is enrolled in the MoneyPlus Pretax Group Insurance Premium feature, premiums can be paid pretax beginning the first of the month following the date of the request.</p> <p>B. Cannot drop any coverage; can only change or add coverage.</p> <p>C. For Optional Life, if employee is not actively at work on the expected effective date, then the effective date will be the date when the employee returns to work. For Dependent Life, if dependent, other than a newborn, is confined to a hospital or elsewhere on the expected effective date, then the effective date will be deferred until the spouse or child is discharged from the hospital or no longer confined.</p>				

Event	This person/these people <i>(select one)</i>	Can do one or more of these actions <i>(select as many as apply)</i>	Effective date	Documentation required
Adoption of child (or placement for adoption)	<input type="checkbox"/> Employee alone <input type="checkbox"/> Employee and newly adopted child <input type="checkbox"/> Employee and existing child(ren) <input type="checkbox"/> Employee and spouse <input type="checkbox"/> Employee, spouse, existing child(ren) and newly adopted child	<input type="checkbox"/> Enroll in health (if employee already enrolled in health, may change plans if adding spouse or child to health) <input type="checkbox"/> Enroll in dental <input type="checkbox"/> Enroll in State Vision <input type="checkbox"/> Enroll in Dependent Life-Child <input type="checkbox"/> Enroll in or increase Dependent Life-Spouse (\$10,000 or \$20,000 without medical evidence; more than \$20,000 with medical evidence) <input type="checkbox"/> Enroll in or increase Optional Life (up to \$50,000 without medical evidence; more than \$50,000 with medical evidence) <input type="checkbox"/> Review changes available with MSA/DCSA	<p>Health, dental and vision: Date of adoption or placement for adoption unless baby is adopted or placed for adoption within 31 days of birth — then date of birth.</p> <p>Optional Life and Dependent Life-Spouse: For amounts available without medical evidence, the date of request. For amounts requiring medical evidence, first of month following date of approval.</p> <p>Dependent Life-Child: Date of birth for newborns. First of the month after date of request for other children.</p>	<p>Long-form birth certificate listing the subscriber as the parent; legal adoption documentation from court, verifying adoption completed; or letter of placement from adoption agency, attorney, or DSS verifying adoption in progress</p> <p>and</p> <p>if adding spouse, marriage license or Page 1 of latest federal tax return.</p>
Notes				
<p>A. Note about premiums: If the employee is enrolled in the MoneyPlus Pretax Group Insurance Premium feature, premiums can be paid pretax beginning the first of the month following the date of the request.</p> <p>B. Cannot drop any coverage; can only change or add coverage.</p> <p>C. For Optional Life, if employee is not actively at work on the expected effective date, then the effective date will be the date when the employee returns to work. For Dependent Life, if dependent, other than a newborn, is confined to a hospital or elsewhere on the expected effective date, then the effective date will be deferred until the spouse or child is discharged from the hospital or no longer confined.</p>				

Event	This person/these people <i>(select one)</i>	Can do one or more of these actions <i>(select as many as apply)</i>	Effective date	Documentation required
Placement of foster child (with court order)	<input type="checkbox"/> Employee alone <input type="checkbox"/> Employee and new foster child <input type="checkbox"/> Employee and existing child(ren) <input type="checkbox"/> Employee and spouse <input type="checkbox"/> Employee, spouse, existing child(ren) and new foster child	<input type="checkbox"/> Enroll in health (if employee already enrolled in health, may change plans if adding spouse or new foster child to health) <input type="checkbox"/> Enroll in dental <input type="checkbox"/> Enroll in State Vision <input type="checkbox"/> Review changes available with MSA/DCSA	Health, dental and vision Date of placement (usually date of court order).	Court order placing child in foster care with the employee and if adding spouse, marriage license or Page 1 of latest federal tax return.
<i>If you have gained legal custody of your foster child, see Gains custody of child</i>	Notes			
	A. Note about premiums: If the employee is enrolled in the MoneyPlus Pretax Group Insurance Premium feature, premiums must be paid post-tax for retroactive coverage back to the date of gaining custody or guardianship. Premiums can be paid pretax beginning the first of the month following the date of the request. B. Cannot drop any coverage; can only change or add coverage.			

Event	This person/these people <i>(select one)</i>	Can do one or more of these actions <i>(select as many as apply)</i>	Effective date	Documentation required
Gains custody of child (with court order)	<input type="checkbox"/> Employee alone <input type="checkbox"/> Employee and child for whom they gained legal custody <input type="checkbox"/> Employee and existing child(ren) <input type="checkbox"/> Employee and spouse <input type="checkbox"/> Employee, spouse, existing child(ren) and child for whom they gained legal custody	<input type="checkbox"/> Enroll in health (if employee already enrolled in health, may change plans if adding spouse or child to health) <input type="checkbox"/> Enroll in dental <input type="checkbox"/> Enroll in State Vision <input type="checkbox"/> Review changes available with MSA/DCSA	Health, dental and vision Date of court order	Court order granting custody of the child to employee and if adding spouse, marriage license or Page 1 of latest federal tax return.
Notes				
<p>A. Note about premiums: If the employee is enrolled in the MoneyPlus Pretax Group Insurance Premium feature, premiums must be paid post-tax for retroactive coverage back to the date of gaining custody or guardianship. Premiums can be paid pretax beginning the first of the month following the date of the request.</p> <p>B. Cannot drop any coverage; can only change or add coverage.</p> <p>C. For Dependent Life, if dependent, other than a newborn, is confined to a hospital or elsewhere on the expected effective date, then the effective date will be deferred until the spouse or child is discharged from the hospital or no longer confined.</p>				

Event	This person/these people <i>(select one)</i>	Can do one or more of these actions <i>(select as many as apply)</i>	Effective date	Documentation required
Marriage	<input type="checkbox"/> Employee alone <input type="checkbox"/> Employee and any new stepchild <input type="checkbox"/> Employee and existing child(ren) <input type="checkbox"/> Employee and spouse <input type="checkbox"/> Employee, spouse, existing child(ren) and any new stepchild	<input type="checkbox"/> Enroll in health (if employee already enrolled in health, may change plans if adding spouse or stepchild to health) <input type="checkbox"/> Enroll in dental <input type="checkbox"/> Enroll in State Vision <input type="checkbox"/> Enroll in Dependent Life-Spouse (\$10,000 or \$20,000 without medical evidence; more than \$20,000 with medical evidence) <input type="checkbox"/> Enroll in Dependent Life-Child <input type="checkbox"/> Enroll in or increase Optional Life (up to \$50,000 without medical evidence; more than \$50,000 with medical evidence) <input type="checkbox"/> Review changes available with MSA/DCSA	<p>Health, dental and vision: Date of marriage</p> <p>Optional Life and Dependent Life-Spouse: For amounts available without medical evidence, the first of the month after request. For amounts requiring medical evidence, first of month following date of approval.</p> <p>Dependent Life-Child: First of the month after date of request.</p>	<p>Marriage license</p> <p>and</p> <p>if adding stepchild(ren), also need long-form birth certificates for each child.</p>
Notes				
<p>A. Note about premiums: If the employee is enrolled in the MoneyPlus Pretax Group Insurance Premium feature, premiums must be paid post-tax for retroactive coverage back to the date of marriage. Premiums can be paid pretax beginning the first of the month following the date of the request.</p> <p>B. Cannot drop any coverage; can only change or add coverage.</p> <p>C. For Optional Life, if employee is not actively at work on the expected effective date, then the effective date will be the date when the employee returns to work. For Dependent Life, if dependent, other than a newborn, is confined to a hospital or elsewhere on the expected effective date, then the effective date will be deferred until the spouse or child is discharged from the hospital or no longer confined.</p>				

Event	This person/these people <i>(select one)</i>	Can do one or more of these actions <i>(select as many as apply)</i>	Effective date	Documentation required
Divorce	<input type="checkbox"/> Former spouse and any former stepchild(ren)	<input type="checkbox"/> The employee must drop former spouse and stepchild(ren) from health, dental and vision. <input type="checkbox"/> Must drop Dependent Life for former spouse or stepchild(ren), even if court ordered to continue. <input type="checkbox"/> If divorce decree requires the employee to continue coverage for former spouse, former spouse can enroll in own coverage using the Former Spouse NOE .	<p>Health, dental and vision: First of month following divorce</p> <p>Dependent Life: Last day of month in which divorce is final</p> <p>Exception to 31-day rule: If dropping ineligible spouse or stepchild(ren) and PEBA is notified more than 31 days after divorce, first of month following notification.</p>	First page of divorce decree and judge's signature page
	<input type="checkbox"/> Employee	<input type="checkbox"/> Enroll in or increase Optional Life up to \$50,000 without medical evidence <input type="checkbox"/> Cancel or decrease Optional Life <input type="checkbox"/> Review changes available with MSA	<p>Optional Life: If employee is actively at work, the date of request. If not actively at work, the date when the employee returns to work.</p>	
Notes				
<p>A. Cannot drop health, dental or vision coverage for themselves or any dependents who remain eligible for coverage.</p> <p>B. For Optional Life, if employee is not actively at work on the expected effective date, then the effective date will be the date when the employee returns to work.</p>				

Event	This person	Can do one or more of these actions <i>(select as many as apply)</i>	Effective date	Documentation required
Spouse gains eligibility for coverage with a PEBA-participating employer	Spouse who gained eligibility for coverage with a PEBA-participating employer	The employee must drop all coverage for spouse who gained coverage with a PEBA-participating employer including, Dependent Life insurance.	Effective date of eligibility for coverage with a PEBA-participating employer	No documentation required if spouse's enrollment has been submitted to PEBA
Child gains eligibility for coverage with a PEBA-participating employer	Child who gained eligibility for coverage with a PEBA-participating employer	<input type="checkbox"/> The employee must drop all coverage for child who gained coverage with a PEBA-participating employer if the child is enrolling in their own PEBA-sponsored coverage. <input type="checkbox"/> Dependent Life-Child: A child who refuses coverage to remain on their parent's plan is ineligible for Dependent Life-Child coverage.	Effective date of gain of eligibility for coverage with a PEBA-participating employer	No documentation required if child's enrollment has been submitted to PEBA
Notes				
<p>A. Note about dependent child eligibility: A parent may cover a child who is eligible for state benefits because the child works for an employer that participates in PEBA insurance benefits until the child turns age 26. The child may be covered under their parents' health, dental and vision coverage, and may be subject to additional coverage exclusions under the State Health Plan.</p>				

Event	This person/these people <i>(select one)</i>	Can do one or more of these actions <i>(select as many as apply)</i>	Effective date	Documentation required
Employee loses other health coverage (includes Medicare)	If employee is not already enrolled in PEBA's health coverage: <input type="checkbox"/> Employee <input type="checkbox"/> Employee and spouse <input type="checkbox"/> Employee and children <input type="checkbox"/> Employee, spouse and children	<input type="checkbox"/> Enroll in health <input type="checkbox"/> Enroll in dental <input type="checkbox"/> Enroll in State Vision	Health, dental and vision: Date of loss of health coverage	Verifiable confirmation from prior employer (letter, email, etc.) stating employee lost health coverage and date of loss
	If employee is already enrolled in PEBA health coverage: Not eligible to change elections.	Not eligible to change elections.		and long-form birth certificate if adding child; marriage license or Page 1 of latest federal tax return if adding spouse.
Notes				
<p>A. Note about premiums: If the employee is enrolled in the MoneyPlus Pretax Group Insurance Premium feature, premiums must be paid post-tax for retroactive coverage back to the date of loss of coverage. Premiums can be paid pretax beginning the first of the month following the date of the request.</p> <p>B. Letter does NOT have to state employee lost dental or vision to add dental or vision.</p> <p>C. Letter does not have to state spouse or child(ren) lost coverage to add them.</p> <p>D. Cannot drop any coverage but can add coverage.</p>				

Event	This person/these people <i>(select one)</i>	Can do one or more of these actions <i>(select as many as apply)</i>	Effective date	Documentation required
Spouse or child loses other health coverage (includes Medicare)	<input type="checkbox"/> Employee and spouse/child who lost health coverage	<input type="checkbox"/> Enroll in health (if employee already enrolled in health, may change plans if adding spouse or child to health) <input type="checkbox"/> Enroll in dental <input type="checkbox"/> Enroll in State Vision	Health, dental and vision: Date of loss of health coverage	Verifiable confirmation from prior employer (letter, email, etc.) stating spouse/child(ren) lost health coverage and date of loss and long-form birth certificate if adding child(ren); marriage license or Page 1 of latest federal tax return if adding spouse.
Notes				
<p>A. Note about premiums: If the employee is enrolled in the MoneyPlus Pretax Group Insurance Premium feature, premiums must be paid post-tax for retroactive coverage back to the date of loss of coverage. Premiums can be paid pretax beginning the first of the month following the date of the request.</p> <p>B. Letter does NOT have to say spouse/child(ren) lost dental or vision to add dental or vision.</p> <p>C. Employee cannot make changes to coverage unless they add spouse/child(ren) who lost health coverage.</p> <p>D. Cannot drop any coverage but can add coverage.</p> <p>E. If the spouse/child(ren) lost coverage through PEBA and is then added to the employee's Dependent Life coverage, the effective date is the date of the loss or the first of the month following date of request, whichever is later.</p>				

Event	This person/these people (<i>select one</i>)	Can do one or more of these actions (<i>select as many as apply</i>)	Effective date	Documentation required
Employee loses other dental coverage only (not health)	<input type="checkbox"/> Employee	<input type="checkbox"/> Enroll in dental	Dental: Date of loss of dental coverage	Verifiable confirmation from prior employer (letter, email, etc.) stating employee lost dental coverage and date of loss.
Employee loses other vision coverage only (not health)	<input type="checkbox"/> Employee	<input type="checkbox"/> Enroll in State Vision	Vision: Date of loss of vision coverage	Verifiable confirmation from prior employer (letter, email, etc.) stating employee lost vision coverage and date of loss.
Spouse or child loses other dental coverage only (not health)	<input type="checkbox"/> Employee and spouse/child who lost dental coverage	<input type="checkbox"/> Enroll in dental	Dental: Date of loss of dental coverage	Verifiable confirmation from prior employer (letter, email, etc.) stating spouse/child lost dental coverage and date of loss.

Notes

- A. Note about premiums: If the employee is enrolled in the MoneyPlus Pretax Group Insurance Premium feature, premiums must be paid post-tax for retroactive coverage back to the date of loss of coverage. Premiums can be paid pretax beginning the first of the month following the date of the request.
- B. If spouse/child(ren) not covered by employee for health, vision or life, dependent documentation is required. See the [Supporting Documentation for Insurance Enrollments](#) flyer.

Event	This person/these people <i>(select one)</i>	Can do one or more of these actions <i>(select as many as apply)</i>	Effective date	Documentation required
Spouse or child loses other vision coverage only (not health)	<input type="checkbox"/> Employee and spouse/child who lost vision coverage	<input type="checkbox"/> Enroll in State Vision	Vision: Date of loss of vision coverage	Verifiable confirmation from prior employer (letter, email, etc.) stating spouse/child(ren) lost vision coverage and date of loss.
Notes				
<p>A. Note about premiums: If the employee is enrolled in the MoneyPlus Pretax Group Insurance Premium feature, premiums must be paid post-tax for retroactive coverage back to the date of loss of coverage. Premiums can be paid pretax beginning the first of the month following the date of the request.</p> <p>B. If spouse/child(ren) not covered by employee for health, vision or life, dependent documentation is required. See the Supporting Documentation for Insurance Enrollments flyer.</p>				
Employee gains other health, dental or vision coverage	<input type="checkbox"/> Employee	<input type="checkbox"/> Drop coverage gained	Health, dental, vision: First of the month following gain of coverage or the first of the month if coverage is gained on the first of the month. Medical Spending Account: Change must be consistent with change reason.	Verifiable confirmation from prior employer (letter, email, etc.) stating subscriber gained coverage and date of gain.
Notes				
<p>A. Dependents enrolled in the same coverage must also be dropped.</p> <p>B. If subscriber drops Dental Plus, cannot remain enrolled in Basic Dental.</p>				

Event	This person/these people <i>(select one)</i>	Can do one or more of these actions <i>(select as many as apply)</i>	Effective date	Documentation required
Spouse/child gains other health, dental or vision coverage	<input type="checkbox"/> Spouse/child who gained other coverage	<input type="checkbox"/> Drop coverage gained	Health, dental, vision: First of the month following gain of coverage or the first of the month if coverage is gained on the first of the month. Medical Spending Account: Change must be consistent with change reason.	Verifiable confirmation from prior employer (letter, email, etc.) stating spouse/child(ren) gained coverage and date of gain.
Notes				
A. If subscriber drops Dental Plus, cannot remain enrolled in Basic Dental. B. Only the spouse/child(ren) listed on gain of coverage letter may drop.				
Employee gains Medicaid or CHIP coverage	<input type="checkbox"/> Employee	<input type="checkbox"/> Drop health <input type="checkbox"/> Drop dental <input type="checkbox"/> Drop vision <input type="checkbox"/> Decrease MSA (cannot be lower than amount contributed or reimbursed, whichever is greater)	Health, dental, vision: Exception to 31-day rule: Employee has 60 days from the date notified by Medicaid of gain of coverage to drop health, dental and/or vision. <ul style="list-style-type: none"> • If notified by Medicaid within 60 days of gain of coverage, date of gain of Medicaid. • If notified by Medicaid more than 60 days after gain of coverage, first of month following request. (See Note B below.) 	Copy of Medicaid approval letter.
Notes				
A. Spouse or child(ren) enrolled in the same coverage will also be dropped. B. If the employee contacts PEBA later than 60 days after they were notified by Medicaid, no change can be made due to gain of Medicaid.				

Event	This person/these people <i>(select one)</i>	Can do one or more of these actions <i>(select as many as apply)</i>	Effective date	Documentation required
Spouse/child gains Medicaid or CHIP coverage	<input type="checkbox"/> Spouse/child who gained Medicaid or CHIP coverage	<input type="checkbox"/> Drop health <input type="checkbox"/> Drop dental <input type="checkbox"/> Drop vision <input type="checkbox"/> Decrease MSA (cannot be lower than amount contributed or reimbursed, whichever is greater)	Same as above	Copy of Medicaid approval letter.
Notes A. Only the spouse/child(ren) listed on gain of coverage letter can drop. B. If the employee contacts PEBA later than 60 days after dependent was notified by Medicaid, no change can be made due to gain of Medicaid.				

Event	This person/these people <i>(select one)</i>	Can do one or more of these actions <i>(select as many as apply)</i>	Effective date	Documentation required
Employee loses Medicaid or CHIP coverage	If employee is not already enrolled in PEBA's health coverage: <input type="checkbox"/> Employee <input type="checkbox"/> Employee and spouse <input type="checkbox"/> Employee and children <input type="checkbox"/> Employee, spouse and children	<input type="checkbox"/> Enroll in health <input type="checkbox"/> Enroll in dental <input type="checkbox"/> Enroll in State Vision	Health, dental and vision: Exception to 31-day rule: <ul style="list-style-type: none"> Employee has 60 days from the date notified by Medicaid of loss of coverage to enroll. If notified by Medicaid within 60 days, date of loss of Medicaid. If notified by Medicaid more than 60 days after loss, first of month following request. (See Note D below.) 	Copy of Medicaid loss letter and Long-form birth certificate if adding child(ren); marriage license or Page 1 of latest federal tax return if adding spouse.
	If employee is already enrolled in PEBA health coverage: Not eligible to change elections	Not eligible to change elections		
Notes				
<p>A. Note about premiums: If the employee is enrolled in the MoneyPlus Pretax Group Insurance Premium feature, premiums must be paid post-tax for retroactive coverage back to the date of loss of coverage. Premiums can be paid pretax beginning the first of the month following the date of the request.</p> <p>B. Letter does not have to state spouse or child(ren) lost coverage to add them.</p> <p>C. Cannot drop any coverage but can add coverage.</p> <p>D. If the employee contacts PEBA later than 60 days after they were notified by Medicaid, no change is allowed.</p>				
Spouse/child loses Medicaid or CHIP coverage	<input type="checkbox"/> Employee and spouse/child who lost health coverage	<input type="checkbox"/> Enroll in health (if employee already enrolled in health, may change plans if adding spouse or child to health) <input type="checkbox"/> Enroll in dental <input type="checkbox"/> Enroll in State Vision	Same as above	Copy of Medicaid loss letter and long-form birth certificate if adding child(ren); marriage license or Page 1 of latest federal tax return if adding spouse.
Notes				
<p>A. Can add only the employee with the spouse/child(ren) who lost Medicaid.</p> <p>B. Cannot drop any coverage but can add coverage.</p>				

Event	This person/these people (<i>select one</i>)	Can do one or more of these actions (<i>select as many as apply</i>)	Effective date	Documentation required
Employee gains premium assistance through Medicaid or CHIP	If employee is not already enrolled in PEBA's health coverage: <input type="checkbox"/> Employee	<input type="checkbox"/> Enroll in health <input type="checkbox"/> Enroll in dental <input type="checkbox"/> Enroll in State Vision	Health, dental and vision: Exception to 31-day rule: Employee has 60 days from the date notified of gain of Medicaid premium assistance to enroll.	Copy of Medicaid approval letter
	If employee is already enrolled in PEBA health coverage: Not eligible to change elections	Not eligible to change elections	<ul style="list-style-type: none"> • If notified by Medicaid within 60 days, date of gain of assistance. • If notified by Medicaid more than 60 days after gain, first of month following request. <p><i>If enrolled in MoneyPlus Pretax Premium feature, premiums must be paid post-tax for retroactive coverage back to the date of loss. Premiums can be paid through the Pretax Premium feature beginning first of the month following date of request.</i></p>	
Notes				
A. Cannot drop any coverage but can add coverage. B. If the employee contacts PEBA later than 60 days after they were notified by Medicaid, no change can be made due to gain of Medicaid premium assistance.				
Spouse/child gains premium assistance through Medicaid or CHIP	<input type="checkbox"/> Employee and spouse/child who gained Medicaid or CHIP premium assistance	<input type="checkbox"/> Enroll in health (if employee already enrolled in health, may change plans if adding spouse or child to health) <input type="checkbox"/> Enroll in dental <input type="checkbox"/> Enroll in State Vision	Same as above	Copy of Medicaid approval letter and Long-form birth certificate if adding child(ren); marriage license or Page 1 of latest tax return if adding spouse
Notes				
A. Can add only the employee with the spouse/child(ren) who receives Medicaid gain letter. B. Cannot drop any coverage but can add coverage.				

Event	This person/these people <i>(select one)</i>	Can do one or more of these actions <i>(select as many as apply)</i>	Effective date	Documentation required
Employee loses premium assistance through Medicaid or CHIP	<input type="checkbox"/> Employee	<input type="checkbox"/> Drop health <input type="checkbox"/> Drop dental <input type="checkbox"/> Drop vision	Health, dental and vision: Exception to 31-day rule: Employee has 60 days from the date notified of loss of Medicaid premium assistance to enroll. <ul style="list-style-type: none"> • If notified by Medicaid within 60 days, date of loss. • If notified by Medicaid more than 60 days after gain, first of month following request. 	Copy of Medicaid loss letter
	Notes A. If the employee drops coverage, spouse or child(ren) enrolled in the same coverage will also be dropped. B. If the employee contacts PEBA later than 60 days after they were notified by Medicaid, no change can be made due to loss of Medicaid premium assistance.			
Spouse/child loses premium assistance through Medicaid or CHIP	<input type="checkbox"/> Spouse/child who lost Medicaid or CHIP premium assistance	<input type="checkbox"/> Drop health <input type="checkbox"/> Drop dental <input type="checkbox"/> Drop vision	Same as above	Copy of Medicaid loss letter
	Notes A. Only the spouse/child(ren) listed on loss of premium assistance letter can drop. B. If the employee contacts PEBA later than 60 days after they were notified by Medicaid, no change can be made due to loss of Medicaid premium assistance.			

Event	This person/these people <i>(select one)</i>	Can do one or more of these actions <i>(select as many as apply)</i>	Effective date	Documentation required
Marital separation <i>Requires a signed, filed court order from a jurisdiction that recognizes legal separation as a distinct legal status. As of the date of this publication, South Carolina does not.</i>	<input type="checkbox"/> Employee's separated spouse	<input type="checkbox"/> Drop health, dental and vision	First of the month following date of notification.	Decree of Separate Maintenance or other order filed with court from a jurisdiction that recognizes legal separation as a distinct legal status
	<input type="checkbox"/> Employee	<input type="checkbox"/> Enroll in or increase Optional Life up to \$50,000 <input type="checkbox"/> Cancel or decrease Optional Life	Optional Life: if employee is actively at work, the date of request. If not actively at work, the date when the employee returns to work.	
Notes				
A. Must notify within 31 days of court order or no election change can be made. B. If dropping a separated spouse, this is an all-or-nothing election change for all the benefits listed in Column 3. The employee cannot choose among the options. C. For Optional Life, if employee is not actively at work on the expected effective date, then the effective date will be the date when the employee returns to work.				

Effective date quick reference

Type of action	Effective date
New hire	<ul style="list-style-type: none"> • If the employee begins active employment on the first day of the month, coverage begins on that day (on the 1st of the month). • If the employee begins active employment on the first working day of the month (first day that is not a Saturday, Sunday or observed holiday), but not on the first day of the month (for example, they begin on the 2nd or 3rd of the month), then the employee may choose when coverage begins: <ul style="list-style-type: none"> ○ The first day of that month, OR ○ The first day of the following month. • If the employee begins active employment after the first working day of the month (after the first day that is not a Saturday, Sunday or observed holiday), coverage will begin the first day of the following month.
Birth	Health, dental and vision, and Dependent Life-Child: Date of birth.
Adoption	Health, dental and vision: Date of adoption or placement for adoption, within 31 days of birth — then date of birth.
Foster care/guardianship	Health, dental and vision: Date of placement (usually date of court order).
Marriage	Health, dental and vision: Date of marriage.
Separation	Health, dental and vision: First of the month following date of notification.
Divorce	Health, dental and vision: First of month following divorce. Dependent Life: Last day of month in which divorce is final.
Employee loss of coverage	Health, dental and vision: Date of loss of coverage.
Spouse/child loss of coverage	Health, dental and vision: Date of loss of coverage.
Employee gain of coverage	Health, dental, vision: First of the month following gain of coverage or the first of the month if coverage is gained on the first of the month.
Spouse/child gain of coverage	Health, dental and vision: First of the month following gain of coverage or the first of the month if coverage is gained on the first of the month.

Type of action	Effective date
Employee gain of Medicaid or CHIP coverage or loss of premium assistance	Health, dental and vision: Exception to 31-day rule: <ul style="list-style-type: none"> • Employee has 60 days from the date notified by Medicaid of loss of coverage to enroll. • If notified by Medicaid within 60 days, date of loss of Medicaid. If notified by Medicaid more than 60 days after loss, first of month following request.
Spouse/child gain of Medicaid or CHIP coverage or loss of premium assistance	
Employee loss of Medicaid or CHIP coverage or gain of premium assistance	Health, dental and vision: Exception to 31-day rule: <ul style="list-style-type: none"> • Employee has 60 days from the date notified of gain of Medicaid premium assistance to enroll. • If notified by Medicaid within 60 days, date of gain of assistance. If notified by Medicaid more than 60 days after gain, first of month following request.
Spouse/child loss of Medicaid of CHIP coverage or gain of premium assistance	
Spouse/child of Foreign National Employee	Date of arrival in the U.S. to add; first of the month following departure from the U.S. to drop.
Late entrant (health) <i>(no medical evidence of good health)</i>	January 1 following open enrollment.
Ineligible spouse or child	First of the month after becoming ineligible.
Returning student	First of the month after becoming eligible.
Death (health, dental, vision, SLTD)	One day after date of death.
Death (Optional Life)	Date of death.
Social Security number	N/A
Name	N/A
Address	N/A
Beneficiary changes (all plans)	Date of the signature on the NOE.
Optional Life increase throughout the year (not on MoneyPlus)	First of the month after approval of medical evidence. Deferred effective date provision applies.
Optional Life decrease or cancellation (not on MoneyPlus)	First of the month after request.
Optional Life increase due to special eligibility situation	See the Special eligibility situations quick reference charts.
Optional Life decrease or cancellation for MoneyPlus participants	See the Special eligibility situations quick reference charts.
Optional Life increase due to annual enrollment	Following January 1 for amount available without medical evidence, or first of month after approval of medical evidence if it is required for amount requested, whichever is later. Deferred effective date provision applies.
Optional Life decrease or cancellation due to annual enrollment	Following January 1.

Type of action	Effective date
Dependent Life-Spouse enrollment or increase throughout the year (when medical approval is required)	First of the month after approval. Deferred effective date provision applies.
Dependent Life-Spouse enrollment or increase due to special eligibility situation	See the Special eligibility situations quick reference charts.
Dependent Life-Child enrollment throughout the year	Date of birth for newborns. First of the month after date of request for other children. Deferred effective date provision applies to children other than newborns.
Retirement (service)	First of the month after retirement eligibility has been established.
Retirement (disability)	First of the month following the date on the approval letter from PEBA Retirement Benefits (disability retirement).

Documentation quick reference

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.

Type of action	Documentation required
Administrative error	Statement explaining error and circumstances on a Request for Review, with any supporting documentation attached.
Adoption/placement for adoption	Copy of a birth certificate listing the subscriber as the parent; or a copy of legal adoption documentation from the court, verifying the completed adoption; or a letter of placement from an attorney, adoption agency or DSS, verifying the adoption in progress.
Divorce Decree or Court Order to Insure Ex-spouse	Copy of the entire divorce decree or court order. Document must stipulate the programs under which the spouse or child(ren) must be covered. Note: Former stepchildren are not eligible and cannot be covered, even if it is specified in the court order.
Custody or Guardianship of Child(ren)	Copy of court order or other legal documentation from a placement agency or DSS, granting custody or guardianship of a child/foster child to the subscriber. The documentation must verify the subscriber has guardianship responsibility for the child(ren) and not merely financial responsibility.
Death in the line of duty	Verification of death while on duty.
Dependent Life (adding or increasing when medical evidence is required)	Copy of approval from MetLife.
Divorce Decree (drop spouse)	Copy of the first page of the divorce decree and the page with the judge's signature. (See also <i>Divorce Decree or Court Order to Insure Ex-Spouse above.</i>)
Divorce or annulment of married child (to add child) (For Dependent Life only)	Copy of divorce decree or documentation of annulment, along with proof of eligibility as a full-time student or incapacitated child, if child is age 19 or older.
Enrolling a child	Copy of the long-form birth certificate showing the subscriber as the parent.

Type of action	Documentation required
Enrolling a spouse	Copy of marriage license or Page 1 of latest federal tax return if filing jointly.
Enrolling a stepchild	Copy of the long-form birth certificate showing name of natural parent plus proof natural parent and subscriber are married.
Foreign national	Copy of entry stamp/departure stamp from visa.
Gain Medicare coverage	Copy of Medicare card.
Gain/Loss Medicaid coverage	Letter from the Department of Health and Human Services, confirming Medicaid approval and effective date, or confirming Medicaid coverage is ending and the effective date.
Gain/Loss other coverage	Copy of creditable coverage letter or verifiable confirmation from prior employer (letter, email, etc.) that includes: Date coverage gained/lost, individuals who gained/lost coverage, type(s) of coverage gained/lost and reason for gain/loss.
Incapacitation	Incapacitated Child Certification Form , completed by both the subscriber and the child's physician. For Dependent Life only, if child is ages 19-24, must also include letter from educational institution, confirming withdrawal from school as a full-time student.
Medicare correction	Copy of Medicare card.
Medicare due to disability	Copy of Medicare card.
Military activation	Copy of military orders.
Military — return from duty	Copy of military discharge papers.
Name change	Copy of driver's license, Social Security card, order of name change or vital records certificate.
Optional Life (adding or increasing when medical evidence is required)	Copy of approval from MetLife.
Retirement — Disability	Copy of approval letter from the S.C. Retirement Systems.
Retirement — Service	Copy of signed Employment Verification Record form.
Separation (to drop spouse)	Copy of a court order, signed by a judge. The court order must state that the divorce is in progress. <i>Separation is not recognized as a legal status in South Carolina, and therefore is not a special eligibly situation in which a subscriber can make changes to their coverage. If the subscriber has a court order from a jurisdiction that recognizes legal separation as a legal status, PEBA will honor that order and allow the subscriber to drop coverage as a result of a special eligibly situation.</i>
SSN Correction	Copy of Social Security card.
Student Certification	Statement on letterhead, from the educational institution, stating student is full time and dates of enrollment.
Supplemental Long Term Disability (adding/increasing when medical evidence is required)	Copy of the approval from The Standard.

Active Termination Form quick reference

Submit terminations through EBS when permissible.

Employee information	Action	Dates/coverage	Certification
#1-7	NOT ELIGIBLE	Enter dates and mark all plans in which enrolled.	Sign and date.
#1-7	TRANSFER TO: enter new group ID # and group name	Enter dates and mark all plans in which enrolled.	Sign and date.
#1-7	MILITARY LEAVE	Enter dates and mark all plans in which enrolled.	Sign and date.
#1-7	NONPAYMENT	Enter dates and mark all plans in which enrolled.	Sign and date.
#1-7	REDUCTION IN HOURS	Enter dates and mark all plans in which enrolled.	Sign and date.
#1-7	SERVICE RETIREMENT: must meet criteria for PEBA Retirement Benefits and retiree insurance	Enter dates and mark all plans in which enrolled.	Select COBRA and Retiree. Sign and date.
#1-7	DISABILITY: approved for BLTD/SLTD and/or PEBA Retirement Benefits disability	Enter dates and mark all plans affected by termination (OL can be continued). Do not terminate OL if in waiver; complete OL waiver form.	Select COBRA and Retiree. Sign and date.
#1-7	DECEASED: enter date of death	Enter dates and mark all plans in which enrolled.	Sign and date.

Affordable Care Act (ACA) glossary

New full-time employee (Permanent or Nonpermanent)	A newly hired employee who was determined by the employer, as of the date of hire, to be full-time and eligible for benefits.
New variable-hour, part-time or seasonal employee	A newly hired employee who is not expected to be credited an average of 30 hours per week for the entire measurement period, as of the date of hire. Therefore, the employer cannot reasonably determine their eligibility for benefits as of the date of hire.
Ongoing employee	Any employee who has worked with an employer for an entire Standard Measurement Period.
Plan year	January 1 to December 31.
Applies to new variable-hour, part-time and seasonal employees	
Initial Measurement Period	Begins the first of the month after the date of hire and ends 12 months later. Review the employee's hours over the Initial Measurement Period to determine future eligibility for benefits.
Initial Administrative Period	Begins the day after the initial measurement period ends and ends the last day of the same month. The employer uses this time to review the employee's hours over the initial measurement period, and, if the employee is eligible, offers benefits to the employee the first of the following month.
Initial Stability Period	Begins the day after the Initial Administrative Period ends and lasts 12 months. This is the period an employee cannot lose eligibility for benefits regardless of the number of hours they work. If the employee is deemed eligible for coverage during the Initial Administrative Period, they remain eligible for 12 months as long as they remain employed by the employer.
Applies to all ongoing employees	
Standard Measurement Period	Begins on October 4 and ends 12 months later, on October 3. The employer will review the employee's hours over the Standard Measurement Period to determine eligibility for the upcoming plan year.
Administrative Period	Begins on October 3 and ends December 31. This is the period an employer and the plan have to identify and enroll eligible individuals in coverage. Employers must offer coverage to eligible employees during the plan's open enrollment period, which ends October 31. PEBA uses the remainder of the Administrative Period to process enrollments to ensure employees have access to coverage at the beginning of the Stability Period.
Stability Period	Begins on January 1 and ends 12 months later, on December 31. This is the period an ongoing employee cannot lose eligibility for benefits regardless of the number of hours they work. If the employee is deemed eligible for coverage during the Administrative Period, they remain eligible for the entire plan year as long as they remain employed with the employer.

For more information on the ACA, including frequently asked questions, go to peba.sc.gov/aca.

Quick reference calendar for determining eligibility

This chart helps determine eligibility for new variable-hour, part-time and seasonal employees. After an employee has been employed for a full Standard Measurement Period, they become an ongoing employee, and their hours should be reviewed during the open enrollment period (with all other ongoing employees) to determine their eligibility for benefits in the next plan year.

Month employee began work	Initial Measurement Period (12 months)	Administrative Period	Initial Stability Period (12 months)
	<i>Begins the 1st of the month after the date of hire. During this period, an employer would measure the employee's hours.</i>	<i>Immediately follows the Initial Measurement Period. Review the hours worked during the Initial Measurement Period. If the employee averages 30 hours or more per week, they are eligible for benefits.</i>	<i>Immediately follows the Administrative Period. If the employee is deemed eligible for benefits during the Administrative Period, this is the period the employee remains eligible for benefits regardless of the number of hours worked.</i>
January	Feb. 1-Jan. 31	Feb. 1-28	March 1-Feb. 28
February	March 1-Feb. 28	March 1-31	April 1-March 31
March	April 1-March 31	April 1-30	May 1-April 30
April	May 1-April 30	May 1-31	June 1-May 31
May	June 1-May 31	June 1-30	July 1-June 30
June	July 1-June 30	July 1-31	Aug. 1-July 31
July	Aug. 1-July 31	Aug. 1-31	Sept. 1-Aug. 31
August	Sept. 1-Aug. 31	Sept. 1-30	Oct. 1-Sept. 30
September	Oct. 1-Sept. 30	Oct. 1-31	Nov. 1-Oct. 31
October	Nov. 1-Oct. 31	Nov. 1-30	Dec. 1-Nov. 30
November	Dec. 1-Nov. 30	Dec. 1-31	Jan. 1-Dec. 31
December	Jan. 1-Dec. 31	Jan. 1-31	Feb. 1-Jan. 31

Quick reference for unpaid leave or reduction in hours

This information describes how eligibility for insurance benefits is affected when an employee goes on an employer-approved leave of absence not associated with military leave or FMLA.

Employee's status	When unpaid leave (or reduction of hours) begins	Premium information	Employee's options	When employee returns from unpaid leave (or hours are increased)
Ongoing Employee (in a stability period) or variable-hour, part-time and seasonal employee (in an Initial Stability Period)	<p>Eligibility for health, dental and vision continues through the end of the stability period.</p> <p>Send the employee the Your Insurance Benefits When Your Hours are Reduced form.</p>	<p>Employee pays employee's share; employer pays employer's share. If employee fails to pay within the grace period, employer can submit termination to PEBA to terminate coverage. Employee is not eligible for COBRA.</p>	<p>Employee may choose to voluntarily drop coverage to enroll in the Marketplace. If employee elects to drop coverage for this reason, submit termination in EBS, choose Reduction in Hours.</p>	<p>If employee continued coverage while on unpaid leave, no action required.* If employee voluntarily dropped coverage to enroll in Marketplace (or if coverage was terminated due to nonpayment), employee can enroll within 31 days of special eligibility situation or during open enrollment (if eligible). *If SLTD or life insurance was terminated, employee may enroll with medical evidence.</p>
New variable-hour, part-time or seasonal employee (Not in a stability period)	Employee's eligibility has not yet been established.	N/A	N/A	<p>If employee returns to work with same employer as a variable-hour, part-time or seasonal employee:</p> <p>Less than a 13-week break (26 weeks if academic employer), the initial measurement period continues.</p> <p>13-week break or more (26-week break or more if academic employer), the initial measurement period begins the first of the month following return to work.</p>
New full-time employee (Employee is not in a stability period nor on FMLA nor on military leave)	<p>Eligibility for active benefits ends first of the month following employee's last day of paid work or first of the month following their reduction of hours.</p> <p>Employer sends employee the Your Insurance Benefits When Your Hours are Reduced form.</p> <p>Employer submits termination to PEBA and sends the 18-month COBRA notice to employee.</p>	Refer to COBRA rates	Employee and covered dependents may continue coverage through COBRA for up to 18 months (COBRA qualifying event is reduction of hours). Submit termination in EBS, choose Left Employment.	Eligibility for active benefits begins the first of the month following the employee's return to work or resumption of working 30 hours per week.

Premium checks quick reference

Type of employer	Submitting insurance checks to PEBA Insurance Finance		
	Active employee	Unpaid leave	Retiree/COBRA/Survivor
Optional employer	Single check from employer of all active premiums, as billed by PEBA Insurance Finance.	Single check from employer; include with active group, as billed. Do not send personal employee checks to PEBA Insurance Finance.	Include all premiums for these subscribers in the single check for active employees. Do not send personal employee checks to PEBA Insurance Finance.
School districts and public higher education institutions	Single check from employer of all active premiums, as billed by PEBA Insurance Finance.	Single check from employer; include with active group, as billed. Do not send personal employee checks to PEBA Insurance Finance.	PEBA Insurance Finance bills subscribers. Subscribers submit personal checks to PEBA Insurance Finance or have premiums deducted from PEBA retirement benefits annuity payment or other account.
CG agency	Employee and employer premiums are payroll-deducted by SCEIS and sent directly to PEBA Insurance Finance.	Submit personal employee checks, payable to PEBA Insurance Finance.	PEBA Insurance Finance bills subscribers. Subscribers submit personal checks to PEBA Insurance Finance or have premiums deducted from PEBA retirement benefits annuity payment or other account.

Employer checklists

Comprehensive PEBA employer checklists for life events are available at peba.sc.gov/publications.

- [Enrolling a new hire.](#)
- [Adding a dependent due to marriage.](#)
- [Adding a dependent due to birth.](#)
- [Adding a dependent due to adoption.](#)
- [Dropping a dependent due to divorce.](#)
- [Leaving employment before retirement eligibility.](#)
- [Service retirement.](#)
- [Disability retirement.](#)
- [Death of a covered employee.](#)
- [Death of a covered dependent.](#)

Coverage termination processes

Termination of employment due to resignation, RIF, dismissal

Effective date is the first of the month after the last day worked.

- Submit termination to PEBA immediately. Do not delay!
 - EBS termination: Left Employment.
 - [Active Termination Form](#): Not eligible (T5).
- Offer the employee and their spouse and/or children COBRA enrollment information by letter.
- Refer to the *COBRA subscribers* section of this manual for additional information.

ASIFlex will send the Medical Spending Account COBRA qualifying event letter to the employee if they qualify for COBRA continuation. The employee can continue a Medical Spending Account for the rest of the year on an **after-tax basis** through COBRA by electing coverage and paying monthly amounts in a timely manner.

If the terminating employee's spouse is a covered employee or retiree, the terminating employee can be added to the spouse's coverage and other eligible programs within 31 days. If enrolled within 31 days:

- The employee can convert Basic Life, Optional Life, Dependent Life-Spouse and/or Dependent Life-Child coverage.
- The employee can convert SLTD coverage if they meet the criteria.
- If eligible, the employee can continue to contribute to a Health Savings Account directly through HSA Central.

Termination of employment with transfer to another PEBA-participating employer

- Submit termination to PEBA immediately. Do not delay!
 - EBS termination: Transfer.
 - [Active Termination Form](#): Transfer (TT).

Include the group name and number to which the employee is transferring.

- Offer the employee and their spouse and/or children COBRA enrollment information by letter.
- Refer to the **COBRA subscribers** section of this manual for additional information.

Refer to the *Transfers and terminations* section of this manual for additional information.

Termination of employment due to retirement (service or disability)

Effective date is the first of the month after retirement eligibility has been established. If it is a disability retirement, the effective date will be the first of the month following the date on the approval letter from PEBA Retirement Benefits.

For more information on retirement eligibility refer to the [Insurance Benefits Guide](#).

- Submit termination to PEBA immediately. Do not delay!
 - EBS termination: Retired or Disability retired.
 - [Active Termination Form](#): Service retirement (T7) or Disability retirement (T2).

- Provide the [Retiree Packet](#) to the employee. The required forms for establishing eligibility, enrolling in retiree insurance, and certifying tobacco or e-cigarette use are included in the packet.
 - Document in the employee's file the date you provided or mailed the *Packet*.
- Offer the employee and their spouse and/or children COBRA enrollment information by letter.
- Refer to the *COBRA subscribers* section of this manual for additional information.

ASIFlex will send the Medical Spending Account (MSA) COBRA qualifying event letter to the employee if they qualify for COBRA continuation. The employee can continue the MSA for the rest of the year on an **after-tax basis** through COBRA by electing coverage and paying the monthly amounts in a timely manner.

The employee can continue the MSA for the rest of the year on a **pretax basis** if:

- The employee declined COBRA continuation coverage;
- The employee elected in advance, on their last enrollment form, to accelerate their pretax deductions up to the full, annual amount; or
- The remainder of their full, annual election was deducted from their final paycheck(s).

Refer to the *Retiree subscribers* section of this manual for additional information.

Termination due to death of subscriber

Effective date is the day after date of death, except for Optional Life (date of death).

- Submit termination to PEBA immediately. Do not delay!
 - EBS termination: Death.
 - [Active Termination Form](#): Deceased (T1).
- If the death was accidental, attach the police/accident report, newspaper article, etc., and write Accidental at the top of the *Life Insurance Claim* form. If the employee was receiving disability benefits, send a copy of the *claim form* to The Standard so any potential benefits can be paid to eligible survivors.
- Explain survivor benefits to any covered spouse and/or children.

Refer to the *Survivors* section of this manual for additional information.

Termination due to nonpayment of premiums

Effective the first of the month following the last month in which premiums were due and paid in full.

- Submit termination to PEBA immediately. Do not delay!
 - [Active Termination Form](#): Nonpayment (TN).

Optional employers should complete the appropriate termination for Retiree, COBRA and Survivor subscribers.

Do not send COBRA notification letters, because COBRA does not apply.

If the employee returns to work after coverage has been terminated, reinstatement of coverage must be requested within 31 days of returning to work. Otherwise, the employee and any eligible spouse and/or children must wait until the next open enrollment period or until a special eligibility situation occurs and enroll as late entrants. Returning to work is **not** a special eligibility situation that allows an employee to reenroll in benefits.

Termination during military leave

- Submit termination to PEBA immediately. Do not delay!
 - [Active Termination Form](#): Military leave (TM).
- If not continuing coverage during leave, refer to the information in Military Leave in the **Active subscribers** chapter.

A copy of the employee's military orders is required.

If the employee does not continue coverage during military leave, refer to the *Military Leave* information in the *Active subscribers* section of this manual. Coverage can be reinstated within 31 days of returning to work.

Termination of covered spouse and/or child

Coverage changes must be made within 31 days of a special eligibility situation. Coverage changes can be made during the next October enrollment period.

- Submit in EBS or complete a paper [Active Notice of Election](#) to terminate coverage and change coverage level, if applicable.
 - Upload or attach any supporting documentation, if applicable. If submitting on paper and, if the subscriber's tobacco-use status has changed, attach a completed [Certification Regarding Tobacco or E-cigarette Use](#) form.
- Offer the employee and their spouse and/or child(ren) COBRA enrollment information by letter. Refer to the *COBRA subscribers* section of this manual for additional information.
- If the spouse or child(ren) is covered under Dependent Life insurance, that coverage can be converted.

Death of covered spouse or child

- Complete an Active NOE to terminate coverage of a deceased spouse or child and change coverage level, if applicable.
 - *Effective date*: Day after death.
 - Forward a copy of the form to PEBA.
- If applicable, complete *Notice of Election* form and send to PEBA if the employee is making a change to their Medical Spending or Dependent Care Spending account.

Retiree orientation checklist

Determining retiree insurance eligibility is complicated, and only PEBA can make that determination. Provide the [Retiree Packet](#) to the employee.

Explain that enrollment in retiree insurance coverage is not automatic. To enroll in retiree insurance, they will first need to confirm their eligibility for retiree group insurance by completing and submitting an [Employment Verification Record](#) to PEBA. This can be done up to six months prior to their anticipated retirement date. It is exceptionally important to contact PEBA before making final arrangements for retirement.

If PEBA determines they are eligible for retiree insurance coverage, they must complete and submit the [Retiree Notice of Election](#) and any other applicable forms within 31 days of their retirement date. These completed forms should be submitted to PEBA for state agency, public school district or higher education institution employees. These forms can be submitted to the employer's benefits office for optional employers.

At retirement, MetLife will mail a conversion/continuation packet. The packet will include instructions for available options. Call MetLife at 888.507.3767 if the retiree does not receive the packet.

Refer to the *Retiree group insurance* chapter of the [Insurance Benefits Guide](#) for a detailed description of benefits for retirees. Medicare-eligible retirees should refer to the [Insurance Coverage for the Medicare-eligible Member](#) handbook.

Explain optional employer funding, if applicable.

Health insurance

- Review options and benefits.
 - If the employee and their eligible spouse and/or children are not eligible for Medicare, they cannot choose the Medicare Supplemental Plan.
 - If eligible for, or enrolled in, Medicare:
 - Enroll in Part A **and** Part B for maximum coverage and to avoid the carve-out method of claims payment. The employee must notify their employer and PEBA as soon as they become eligible.
 - Subscribers covered by the Medicare Supplemental Plan or the Carve-out Plan will be automatically enrolled in the State Health Plan Medicare Prescription Drug Program, a group-based Medicare Part D Prescription Drug Plan (PDP). In most cases, a retiree will be better served if they remain enrolled in the Medicare Part D plan sponsored by PEBA. If the retiree enrolls in a separate Part D plan, they lose prescription drug coverage with their plan through PEBA; however, their premium through PEBA will not change.
 - If eligible for Medicare, the retiree is no longer eligible for the Savings Plan or an HSA.
- If the tobacco-use status for the retiree is changing, attach a [Certification Regarding Tobacco or E-cigarette Use](#) form to the [Retiree NOE](#).
- Must wait until next open enrollment period or special eligibility situation if **not** enrolled within 31 days of retirement date.

Dental Plus and Basic Dental

- Review options and benefits.
- Must wait until next open enrollment period of an odd-numbered year or special eligibility situation if **not** enrolled within 31 days of retirement date.

State Vision Plan

- Review State Vision Plan benefits.
- Must wait until next open enrollment period or within 31 days of loss of other vision coverage if **not** enrolled within 31 days of retirement date.

Life insurance

- If the employee is eligible for retirement benefits through PEBA, they may choose to continue OR convert their Optional Life coverage with MetLife.
 - MetLife will mail a conversion/continuation packet via U.S. mail three to five business days after MetLife receives the eligibility file from PEBA.

- To continue coverage, the retiree must complete the form that will be included in their packet from MetLife. Coverage must be elected within 31 days of the date coverage is lost due to approved retirement or approved disability retirement.
- To convert coverage, the retiree must follow the instructions in the packet from MetLife. Coverage must be converted within 31 days of the date coverage is lost due to approved retirement or approved disability retirement. It is the retiree's responsibility to contact MetLife regarding conversion.

Long term disability

- Basic Long Term Disability coverage ends at retirement.
- Supplemental Long Term Disability coverage ends at retirement.

MoneyPlus

- MoneyPlus is **not** available in retirement (HSA exception below). Generally, an employee's period of coverage for the flexible spending accounts will end at retirement, with this exception:
 - A Medical Spending Account participant can accelerate their pretax deductions, to extend their period of coverage through the end of the plan year. Otherwise, they can continue coverage on an after-tax basis through COBRA as explained in the *Insurance Benefits Guide*.

Health Savings Account

- A retiree can continue to contribute to an HSA as long as enrolled in the Savings Plan (or other high-deductible health plan) as sole coverage, until eligible for Medicare. Contributions in retirement are paid directly to HSA Central or other HSA custodian, not through payroll deduction or ASIFlex.

Additional information to explain

- The retiree will receive from PEBA:
 - A letter confirming retiree coverage.
 - A *Certificate of Creditable Coverage* since active benefits are ending. PEBA will provide a *Certificate of Creditable Coverage* upon request.
 - A COBRA notification letter since active benefits are ending. (Benefits administrator must send the Qualifying Event Notice according to procedures in **COBRA subscribers** chapter.)
- Premiums for health, dental and vision can be paid directly from their PEBA Retirement Benefits annuity payment, if the annuity payment is enough to cover the premiums.
 - *Exception:* PEBA bills optional employers and those retirees who are not yet receiving annuity payments from PEBA Retirement Benefits.
 - Retirement benefits are paid at the end of the month, for that month (in arrears). However, insurance premiums are deducted at the end of the month, for the next month (in advance).
 - Based on the effective date of retirement, when the Retiree NOE is submitted and processed, more than one month's premiums can be deducted from the first retirement check.
- If retiring due to disability, a copy of the disability approval letter from PEBA Retirement Benefits must be sent to PEBA as soon as it is received. The effective date for insurance purposes will be the first of the month following the date on the approval letter from PEBA Retirement Benefits.

Disability checklist

- The employee should complete and submit an *Application for Disability Retirement* to PEBA Retirement Benefits, if applicable. The BA may apply on behalf of the employee if they are unable to do so.
- The employee should initiate their disability claim with The Standard either by phone, online or by completing and submitting a [Long Term Disability Claim Form](#) packet to The Standard. The BA may apply on behalf of the employee if they are unable to do so.
- The SLTD premium waiver begins the first of the month after the end of the benefit waiting period. Premiums should continue until then. The Standard will contact PEBA, the BA and the employee after approving the claim.
- The employee can continue MoneyPlus and HSA contributions while on disability leave. If the employee does not want to continue MoneyPlus or their HSA, notify ASIFlex via the employer portal that the employee is on leave and will not be continuing their contributions.
- If the employee returns to work after a disability:
 - Complete and send the [SLTD Premium Waiver Form](#) to PEBA.
 - Contact The Standard.

For more information, see the **Disability subscribers** chapter.

Claims checklist

- Make sure you are using the proper claim form for the program as instructed in the **Claims and appeals** chapter.
- Be certain each required section has been completed and the information is legible and correct.
- Make sure the claimant's name is listed exactly as it is on the NOE or in EBS.
- Ensure that the SSN or BIN of the employee/retiree is used for them and their covered spouse and/or children. The providers use individual Medicare numbers when filing for health benefits through Medicare, with Medicare as the primary payer.
- Attach proper and complete documentation as requested, based on the type of claim.
- Send the completed claim form to the address listed on the form.
- For MoneyPlus flexible spending account claims, keep a copy of the MoneyPlus Claim Form, including any itemized receipts or explanation of benefits statements.
- HSA participants are responsible for maintaining their own documentation.

Accounting system checklist

- All balances are due to PEBA on the 10th of the month and must be paid as billed. Do not adjust the billing statement.
- Payment is due as billed. The collection of premiums has no bearing on payment. Do not delay the regular remittance of monthly premiums due to failure to collect payments from subscribers.
- Employers must pay no less than the current employer share of the premiums for their active employees.
- All payments should be made payable to PEBA. If your office also pays for retiree, survivor and COBRA subscriber coverage, you can remit one check for both billing statements. See Submitting premium payments to PEBA on Page 147.
- You must return a completed remittance advice form with every payment. Do not return any other section of the billing statement with your payment.
- Use the return envelope provided, or mail your payment to PEBA's Financial Services Department using the following address:
S.C. PEBA
Attn: Insurance Finance Department
P.O. Box 11661
Columbia, SC 29211
- If there is a keying error on the coverage processing section of the bill, email PEBA Customer Service at peba.sc.gov/contact-employer.
- If you have a question about the Account Summary or Billing Summary, call PEBA's Financial Services Department at 803.734.1696 or 888.260.9430.
- Payment of one month's advance billing is due by July 15 of each year for active employees. The advance billing is the total employer contribution for health, dental, life and LTD as determined by PEBA enrollment files for July.



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