peba academy

PEBA℠
SC Retirement Systems and State Health Plan

Health plans

Insurance Benefits Training

2022

Important information

- This overview is not meant to serve as a comprehensive description of the insurance benefits offered by PEBA.
- More information can be found in the following:
  - *Benefits Administrator Manual*; and
  - *Insurance Benefits Guide*.
- The plan of benefits documents and benefits contracts contain complete descriptions of the health and dental plans and all other insurance benefits. Their terms and conditions govern all health benefits offered by or through PEBA.

Available plans

- State Health Plan:
  - Standard Plan.
  - Savings Plan.
- TRICARE Supplement Plan.

State Health Plan

- Self-funded insurance plan:
  - Members' and employers' premiums are held in a trust fund, and these funds are used to pay claims.
  - BlueCross BlueShield of South Carolina processes health claims.
  - Express Scripts processes prescription claims.
- Cost of the State Health Plan compares favorably to other plans.
  - Learn more at peba.sc.gov/facts.
- Health management is key to maintaining a low cost for the Plan and premiums.

State Health Plan: Standard Plan and Savings Plan

- Common features.
- Worldwide coverage.
- Network and out-of-network benefits.
  - Patient-centered medical homes (PCMH).
  - Pharmacy network.
- Prior authorization for certain services.
- Online access at statesc.southcarolinablues.com.

State Health Plan provider network

- Worldwide coverage.
- Subscribers pay copayments, deductible and coinsurance.
- Network provider files claims and accepts the Plan's allowed amount, even if its charges are higher.
  - Subscribers who use an out-of-network provider may have to file claims and can be balance billed. They pay a higher coinsurance, too.
- Use Find Care link under Resources at StateSC.SouthCarolinaBlues.com to find a network provider.

Patient-centered medical home (PCMH)

- Offers a health care team to provide comprehensive, coordinated care.
- Standard Plan subscribers do not pay $14 copayment for in-person care received at PCMH.
- Once Standard and Savings Plan members meet their deductible, pay 10 percent coinsurance, not 20 percent, for in-person care received at PCMH.
- To find a list of PCMH providers and learn more, go to statesc.southcarolinablues.com.

State Health Plan prescription drug benefit

- Administered by Express Scripts.
- Must use network pharmacy.
  - No benefits paid for out-of-network prescription drugs.
- Prior authorization required for certain drugs.
- Prescription birth control covered at no cost.
- Compare costs online at www.express-scripts.com.

Standard Plan

Annual deductible	Individual: $490 Family: $980
Coinsurance[1]	In network: • Subscriber pays 20%; Plan pays 80%. • Coinsurance maximum of $2,800 per individual or $5,600 per family.
Physician's office visit[2]	$14 copayment
Outpatient facility[3]	$105 copayment
Emergency care[4]	$175 copayment
Tax-favored accounts	Medical Spending Account

[1]Out of network, subscribers will pay 40 percent coinsurance, and the coinsurance maximum is different.
[2]The $14 copayment is waived for routine mammograms and well-child visits. Standard Plan members who receive in-person care at a BlueCross-affiliated patient-centered medical home (PCMH) provider will not be charged the $14 copayment for a physician's office visit. After Standard Plan and Savings Plan members meet their deductible, they will pay 10 percent coinsurance, rather than 20 percent, for in-person care at a PCMH.
[3]The $105 copayment for outpatient facility services is waived for physical therapy, speech therapy, occupational therapy, dialysis services, partial hospitalizations, intensive outpatient services, electroconvulsive therapy and psychiatric medication management.
[4]The $175 copayment for emergency care is waived if admitted.

Prescription drugs for Standard Plan[1,2]

Tier 1 (generic)	Tier 2 (preferred brand)	Tier 3 (non-preferred brand)
30-day supply: $9 90-day supply: $22	30-day supply: $42 90-day supply: $105	30-day supply: $70 90-day supply: $175

Pay up to $3,000 in prescription drug copayments.

[1]Prescription drugs are not covered at out-of-network pharmacies.
[2]With Express Scripts' Patient Assurance Program, members in the Standard and Savings plans will pay no more than $25 for a 30-day supply of preferred and participating insulin products in 2022. This program is year-to-year and may not be available in the following year. It does not apply to Medicare members, who will continue to pay regular copays for insulin.

Savings Plan

Annual deductible	Individual: $3,600 Family: $7,200[1]
Coinsurance[2]	In network: • Subscriber pays 20%; Plan pays 80%. • Coinsurance maximum of $2,400 per individual or $4,800 per family.
Prescription benefits[3,4]	Pay full allowed amount for prescriptions until meeting deductible. Then, pay 20%.
Tax-favored accounts	Health Savings Account

[1]If more than one family member is covered, no family member will receive benefits, other than preventive benefits, until the $7,200 annual family deductible is met.
[2]Out of network, subscribers will pay 40 percent coinsurance, and the coinsurance maximum is different.
[3]Prescription drugs are not covered at out-of-network pharmacies.
[4]With Express Scripts' Patient Assurance Program, members in the Standard and Savings plans will pay no more than $25 for a 30-day supply of preferred and participating insulin products in 2022. This program is year-to-year and may not be available in the following year. It does not apply to Medicare members, who will continue to pay regular copays for insulin.

Patient Assurance Program

- State Health Plan members can get a 30-day supply of participating and preferred insulin products for $25 (90-day supply for $75) at a network pharmacy or through home delivery from Express Scripts Pharmacy.
- Members can find out if their insulin product is covered by logging in to their account at express-scripts.com or by calling 855.612.3128.
- Program is not available to Medicare-primary members.

Medical treatment prior authorization

- Prior authorization is required for some medical treatment services, including inpatient hospital care, with Medi-Call.
- Must call at least two business days before receiving services for certain procedures.
- Emergency hospital admissions must be reported within 48 hours or the next business day.
- Contact BlueCross at 800.925.9724.
- Not calling for prior authorization may lead to a $490 penalty.

Radiology services prior authorization

- Prior authorization is required for radiology services with National Imaging Associates.
  - CT scan;
  - MRI;
  - MRA; and
  - PET scan.
- Contact BlueCross at 866.500.7664.
- If a network South Carolina physician or radiology center does not request prior authorization for advanced radiology services, the provider will not be paid for the service, and it cannot bill the subscriber for the service. If a subscriber or a covered family member receives advanced radiology services from an out-of-network provider in South Carolina or from any provider outside of South Carolina without prior authorization, the provider will not be paid by BlueCross and the subscriber will be responsible for the entire bill.

Behavioral health services prior authorization

- Prior authorization is required for behavioral services with Companion Benefit Alternatives (CBA).
  - Inpatient hospital care.
  - Intensive outpatient hospital care.
  - Partial hospitalization care.
  - Outpatient electroconvulsive therapy.
  - Repetitive transcranial magnetic therapy.
  - Applied behavioral analysis therapy.
  - Psychological/neuropsychological testing.
- Some outpatient behavioral health services may not be covered by the Plan if you don't receive prior authorization.
- Claims subject to same deductibles, copayments and coinsurance as medical claims.
- Contact CBA at 800.868.1032.
- If your provider does not call CBA when required, you will pay a $490 penalty for each hospital admission.
  - The penalty amount does not apply to your deductible or coinsurance maximum.

Adult well visits and the Standard Plan

- Covered as a contractual service by the Standard Plan.
- Visit is subject to copayments, deductibles and coinsurance.
- Evidence-based services with an A or B recommendation by the United States Preventive Services Task Force (USPSTF) included.

Adult well visit eligibility for Standard Plan members

- Available to all non-Medicare primary adults ages 19 and older.
- The Plan will cover only one visit in covered years based on the following schedule:

	Once a year	Once every two years	Once every three years
Ages 19-39			✓
Ages 40-49		✓	
Ages 50 and up	✓		

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

Adult well visits and the Savings Plan

- The Plan will cover a well visit every year for Savings Plan members at no cost.
- Covered well visits include evidence-supported services based on USPSTF A and B recommendations.

TRICARE Supplement Plan

- Administered by Selman & Company.
- Provides secondary coverage to TRICARE.
- No deductibles, coinsurance or out-of-pocket expenses for covered services.
- PEBA does not confirm eligibility.
  - Eligible individuals must register with Defense Enrollment Eligibility Reporting System (DEERS).
  - Must not be eligible for Medicare.
  - Must drop State Health Plan coverage to enroll.

TRICARE Supplement Plan

- No COBRA rights.
- No employer contribution per federal regulations.
- Not subject to tobacco-use premium.

2022 Active employee monthly premiums

Premiums for optional employers may vary. Use Monthly premium worksheet for optional employers.

	Employee	Employee/ spouse	Employee/ children	Full family
Standard Plan	$97.68	$253.36	$143.86	$306.65
Savings Plan	$9.70	$77.40	$20.48	$113.00
TRICARE Supplement	$62.50	$121.50	$121.50	$162.50

Tobacco-use premium

- Applies to State Health Plan subscribers only.
- $40 per month for subscriber-only coverage.
- $60 per month for other levels of coverage.
- Automatically charged unless subscriber:
  - Certifies as non-tobacco or e-cigarette user with *Certification Regarding Tobacco or E-cigarette Use* form; or
  - Certifies that all covered tobacco or e-cigarette users have completed the tobacco cessation program, Quit For Life.®
- May pay tobacco-use premium pretax if enrolled in Pretax Group Insurance Premium feature.

Disclaimer

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