peba academy

PEBA SC Retirement Systems and State Health Plan

Health plans

Insurance Benefits Training
2024

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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, certificates of coverage and benefits contracts contain complete descriptions of the insurance benefits offered by or through PEBA. Their terms and conditions govern all of these benefits.

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Available plans

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

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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.

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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.

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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.

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Patient-centered medical home (PCMH)

- Offers a health care team to provide comprehensive, coordinated care.
- Standard Plan subscribers do not pay $15 copayment for in-person care received at PCMH.
- Once Standard and Savings Plan members meet their deductible, pay 10% coinsurance, not 20%, for in-person care received at PCMH.
- To find a list of PCMH providers and learn more, go to StateSC.SouthCarolinaBlues.com, under Medical, then Using Your Benefits.

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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 for primary subscribers, covered spouses and covered child dependents.
- Compare costs online at www.express-scripts.com.

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Standard Plan

Annual deductible	Individual: $515 Family: $1,030
Coinsurance[1]	In network: • Subscriber pays 20%; Plan pays 80%. • Coinsurance maximum of $3,000 per individual or $6,000 per family.
Physician's office visit[2]	$15 copayment
Outpatient facility[3]	$115 copayment
Emergency care[4]	$193 copayment
Tax-favored accounts	Medical Spending Account

[1]Out of network, subscribers will pay 40% coinsurance, and the coinsurance maximum is different.
[2]The $15 copayment is waived for routine mammograms, adult well visits, well woman visits 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 $15 copayment for a physician's office visit. After Standard Plan and Savings Plan members meet their deductible, they will pay 10% coinsurance, rather than 20%, for in-person care at a PCMH.
[3]The $115 copayment for outpatient facility services is waived for emergency room services, oncology services, dialysis, clinic visits (an office visit at an outpatient facility), partial hospitalization, intensive outpatient services, electroconvulsive therapy and psychiatric medication management. The outpatient hospital copay is reduced to the office visit copay of $15 for physical therapy, occupational therapy, cardiac rehabilitation and pulmonary rehabilitation.
[4]The $193 copayment for emergency care is waived if admitted.

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Prescription drugs for Standard Plan[1,2]

Tier 1 (generic)	Tier 2 (preferred brand)	Tier 3 (non-preferred brand)
30-day supply: $13 90-day supply: $32	30-day supply: $46 90-day supply: $115	30-day supply: $77 90-day supply: $192

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

[1]Prescription drugs are not covered at out-of-network pharmacies. Specialty medications are limited to a 30-day supply per fill.
[2]You will pay a lower copayment for a 90-day supply of prescription drugs at your local network pharmacy that participates in the Smart90 Network than if you purchased the medication one month at a time.

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Savings Plan

Annual deductible	Individual: $4,000 Family: $8,000[1]
Coinsurance[2]	In network: • Subscriber pays 20%; Plan pays 80%. • Coinsurance maximum of $3,000 per individual or $6,000 per family.
Prescription benefits[3,4]	Pay full allowed amount for prescriptions until meeting deductible. Then, pay coinsurance.
Tax-favored accounts	• Health Savings Account • Limited-use Medical Spending Account

[1]If more than one family member is covered, no family member will receive benefits, other than preventive benefits, until the $8,000 annual family deductible is met.
[2]Out of network, subscribers will pay 40% coinsurance, and the coinsurance maximum is different.
[3]Prescription drugs are not covered at out-of-network pharmacies. Specialty medications are limited to a 30-day supply per fill.
[4]You will pay a lower copayment for a 90-day supply of prescription drugs at your local network pharmacy that participates in the Smart90 Network than if you purchased the medication one month at a time.

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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.
- Call BlueCross at 800.925.9724.
- Not calling for prior authorization could lead to a $515 penalty.

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Radiology services prior authorization

- Prior authorization is required for radiology services with National Imaging Associates.
  - CT scan;
  - MRI;
  - MRA; and
  - PET scan.
- Call National Imaging Associates 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.

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Behavioral health services prior authorization

- Prior authorization is required for behavioral services with Companion Benefit Alternatives (CBA) and must be requested at least 24 hours before receipt of:
  - 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.
- Call CBA at 800.868.1032.
- If your provider does not call CBA when required, you will pay a $515 penalty for each hospital admission.
  - The penalty amount does not apply to your deductible or coinsurance maximum.

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Adult well visits and well woman visits

- The State Health Plan covers one well visit every year at no member cost.
- Eligible female members can also receive an annual well woman visit at no member cost in addition to the annual adult well visit.
- Evidence-based services with an A or B recommendation by the United States Preventive Services Task Force (USPSTF) included.
- Available to all non-Medicare primary adults ages 19 and older.
- Adult members can take advantage of this benefit at a network provider specializing in general practice, family practice, pediatrics, internal medicine, gerontology, and obstetrics and gynecology.

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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.

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TRICARE Supplement Plan

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

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2024 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	$306.56
Savings Plan	$9.70	$77.40	$20.48	$113.00
TRICARE Supplement	$62.50	$121.50	$121.50	$162.50

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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; 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.

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Disclaimer

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