south carolina peba SM
state health plan | retirement systems

FALL 2017

benefits ADVANTAGE

What's new for 2018

Funded retiree premiums will not increase in 2018. This includes:

- State Health Plan Savings Plan;
- State Health Plan Standard Plan; and
- Medicare Supplemental Plan.

The employer premiums for the three plans will increase by 3.3 percent. Premiums for non-funded retirees, survivors and COBRA subscribers also increased. See Page 9 for premiums.

Other changes effective January 1, 2018, include:

- Members who fill specialty medications must use the State Health Plan's custom credentialed specialty network. The network will include Accredo, Express Scripts' specialty pharmacy, and accredited locally-owned pharmacies. This does not apply to Express Scripts Medicare.
- The State Vision Plan's frame benefit is available every year instead of every two years.

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It's time to make choices for 2018

The 2017 *Benefits Advantage* details your insurance options for 2018. The newsletter includes changes you can make during open enrollment. This takes place October 1-31, 2017.

The 2018 *Insurance Benefits Guide* (IBG) describes insurance programs. The IBG contains information about all PEBA-sponsored insurance benefits. The guide is available online at www.peba.sc.gov/iresources.html.

Reminders

- Satisfied with your current coverage? You do not need to do anything during open enrollment.
- Any changes that you make during open enrollment take effect January 1, 2018.

Open enrollment is easy when you use MyBenefits

MyBenefits is the quickest, easiest way to make changes

MyBenefits is PEBA's online insurance enrollment system. It allows you to make your coverage changes during open enrollment.

All you need is internet access. Using MyBenefits saves a phone call or visit to your benefits office. It also ensures speedy transmission of your coverage changes.

Log in at MyBenefits.sc.gov. Select Open Enrollment to view your current coverage, along with the premiums. Next, select Make Coverage Changes. Here you will see the coverage options available to you during open enrollment. Premiums for these coverage options are also listed.

Premiums for local subdivisions may be different. Former local subdivision employees should contact their former employer to get their premiums.

Select the changes you want and choose Next. You will then see a summary page comparing your current coverage to those you have entered. If you are happy with the changes, choose Apply.

To allow your changes, you will need to enter the last four digits of your Social Security number and click Sign. Your changes are not complete until you submit your electronic signature. You should also print a copy of the Summary of Change for your records. Some coverage changes need supporting documentation. PEBA must receive the documents to approve the changes.

Changed your mind about your coverage selections? No problem! You have until 11:59 p.m. on October 31, to return to MyBenefits to make more changes.

Important reminders

- Enrolling a dependent for the first time requires supporting documentation. Be sure to submit legible photocopies of the documents to your benefits administrator.
- To see the benefits you have now, you can print your statement from MyBenefits.
- Use MyBenefits year-round to review your benefits and update your contact information.

Can't remember your password?

Click the Forgot/Reset Password link on the MyBenefits page. You must answer one of the four security questions you chose when you created your account. After three incorrect answers to the security question, your account will be reset. You will need to register as a new user.

Register for MyBenefits in three easy steps

1. Visit MyBenefits.sc.gov.
2. You will need your benefits identification number (BIN). Your BIN is the numeric part of your Member ID located on your State Health Plan card. You can also get it by clicking Get my BIN at the bottom right of the MyBenefits page.
3. Click Register on the left of the MyBenefits page. Follow the instructions to enter your personal information and create a password. The password must be eight characters long. It must include at least one number and one special character (! : # $ % * [ ] { } @). You will also need to choose four security questions.

What you can do during the 2017 open enrollment

Open enrollment is October 1-31, 2017. Any coverage changes that you make will take effect January 1, 2018. Happy with your current coverage? You do not need to do anything. You will be re-enrolled for 2018, and your coverage will continue.

Health options

- Change from one health plan to another:
  - State Health Plan Savings Plan
  - State Health Plan Standard Plan
  - GEA TRICARE Supplement Plan (available to eligible members of the military community)
- Enroll yourself or any eligible dependents in health coverage
- If you are eligible for Medicare, you may enroll in or change from the Medicare Supplemental Plan
- Drop health coverage for yourself or any dependents

If you change to the Savings Plan during October, the change will go into effect January 1, 2018. You may also sign up for Health Savings Account (HSA). On January 1, 2018, you will be eligible to contribute to an HSA if:

- You are not covered by other health insurance, including Medicare, and
- No one can claim you as a dependent on their income tax return.

The HSA contribution limits for 2018 are $3,450 for single coverage and $6,900 for family coverage. Subscribers age 55 and older can contribute an extra $1,000 catch-up amount. You can enroll in an HSA through any institution that offers an HSA.

If you are changing health plans, review the chart on Page 8. Be sure to note any differences in deductibles and copayments. Premiums are available on Pages 9-12.

Dental

Enroll yourself or any eligible dependents in State Dental Plan or Dental Plus. Drop State Dental Plan or Dental Plus coverage for yourself or any dependents. Your next opportunity to add or drop dental coverage will be October 2019. See Pages 9-12 for premiums.

State Vision Plan

Enroll in or drop vision coverage for yourself and/or your eligible family members. See Pages 9-12 for premiums.

Follow up on your changes

In January, log in to MyBenefits at MyBenefits.sc.gov. Select Review Benefits from the drop-down list to see your 2018 benefits. If you notice any discrepancies, contact PEBA or, if you retired from a local subdivision, your former employer immediately.

Don't wait to get proof of insurance

You often need proof of health insurance when traveling overseas. This is especially true for students or those working in another country.

Please ask for proof of insurance from PEBA as soon as you know you'll need it. The request may take up to 10 business days to process. Requests must be in writing and must specify what information to provide.

You can make the request through the Contact us link at www.peba.sc.gov/contact/email/insurance.htm. You may also requests the information by mail. Send your request to:

S.C. PEBA
202 Arbor Lake Drive
Columbia, SC 29223

Changes to former spouse State Health Plan coverage

State Health Plan coverage for former spouses will change in 2018. Currently, a subscriber may cover one dependent spouse and any dependent children.

If a subscriber covers a former spouse because a court order requires the him or her to do so, the subscriber cannot also cover his or her current spouse.

Beginning January 1, 2018, a former spouse must have his or her own policy under the State Health Plan. This allows a subscriber to cover a current spouse as a dependent under his or her policy and use pretax dollars to pay premiums and also provide separate coverage for a former spouse.

Premiums for former spouse coverage will include both the employer and employee share. Currently, the premium includes the employee share only. Premiums for the 2018 plan year are on Page 12.

If the former spouse is Medicare eligible, Medicare is primary. If the former spouse is not currently enrolled in Medicare Part B, he or she can enroll during the open enrollment period. Coverage will be effective January 1, 2018.

Important reminders when you qualify for Medicare

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

- Be sure to enroll in Medicare Part A and Part B. If you do not enroll in Part B, you will have to pay the part of your health care costs that Part B would have paid.
- You or one of your dependents may qualify for Medicare because of a disability. If so, you should enroll in the Medicare Supplemental Plan. To enroll, submit a *Notice of Election* form. You need to submit the form within 30 days of eligibility. Be sure to include a copy of your Medicare card with your form.
- PEBA enrolls Medicare-eligible retirees in the State Health Plan Medicare Prescription Drug Program. PEBA also enrolls Medicare-eligible dependents in this program. Subscribers may be better served if they remain enrolled in this prescription program.
- The benefits offered by the Standard Plan and Medicare Supplemental Plan vary. This is especially true in how each plan coordinates with Medicare. The 2017 *Insurance Coverage for the Medicare-eligible Member* handbook contains a plan comparison. This handbook is also useful in determining which plan best suits your needs. You can be find the handbook on PEBA's website at www.peba.sc.gov.

Get connected with PEBA

PEBA is always looking for the most efficient and timely ways to deliver our services to you. We communicate general information and updates through our website, social media and email.

To add yourself to PEBA's insurance email list, register for MyBenefits. See Page 2 for more information. To add yourself to PEBA's retirement email list, register for Member Access.

Social media

Stay informed about important updates related to your insurance and/or retirement benefits. Get access to other resources via PEBA's social media pages. Search for SCPEBA on Facebook and Twitter. On YouTube, search for PEBA TV.

Helpful terms

Insurance lingo can be confusing. But it's important to understand your benefits and how they work. Here are some terms you may need to know.

Allowed amount The maximum amount a provider can be reimbursed for a covered service.

Benefits The items or services covered by your insurance plan.

Claim A request for payment that you or your provider submits after you receive services.

Coinsurance A percentage of the cost of health care you pay after you meet your deductible. For example, say the State Health Plan's allowed amount for an office visit is $112 and the member has met his deductible. After a Standard Plan member pays the $12 copayment, his coinsurance payment of 20 percent would be $20. The health plan pays the rest of the allowed amount, or $80.

Coinsurance maximum The amount of coinsurance you are required to pay each year before you are no longer required to pay coinsurance.

Copayment The fixed amount you pay for a covered health care service or drug. Standard Plan members pay prescription drug copayments and copayments for office visits, emergency care and outpatient facility services. Savings Plan members do not pay copayments.

Coverage review A blanket term for the different types of processes the State Health Plan uses to ensure the safe and effective use of prescription drugs and to encourage the use of lower-cost alternatives when possible.

Deductible The amount you pay for covered services before your health plan begins to pay.

Dependent An eligible child or spouse covered by your health plan.

National Preferred Formulary The formulary, or list of covered drugs, used by Express Scripts.

Network A group of facilities, providers and suppliers under contract to provide care for people covered by a health, dental or vision plan.

Out-of-pocket costs Your costs for expenses that aren't reimbursed by insurance. Out-of-pocket costs include deductibles, coinsurance and copayments for covered services, plus all costs for services that aren't covered.

Preauthorization A decision that a service, prescription drug or piece of equipment is medically necessary. Certain services and medications require preauthorization before you receive them except in an emergency. You may also hear this referred to as precertification or prior authorization.

Premium The amount you pay for insurance coverage.

Provider This can refer to the medical professional who delivers care or the location where you receive health care services.

Insurance Benefits Guide

The 2018 *Insurance Benefits Guide* is available online at www.peba.sc.gov.

A very limited supply of printed guides is available on a first-come, first-served basis.

To request a copy, call PEBA at 803.737.6800 or 888.260.9430.

2018 insurance vendor contact information

BlueCross BlueShield of South Carolina

State Health Plan Standard Plan, Savings Plan, Medicare Supplemental Plan

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

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

Medi-Call (medical preauthorization)

AX-650 | I-20 at Alpine Road | Columbia, SC 29219

- 803.699.3337 or 800.925.9724
- Fax: 803.264.0183

Companion Benefit Alternatives (behavioral health)

P.O. Box 100185, AX-315 | Columbia, SC 29202

- Customer Service: 803.736.1576 or 800.868.2520
- Precertification/case management: 800.868.1032
- Fax: 803.714.6456
- Tobacco cessation: 866.784.8454
- www.CompanionBenefitAlternatives.com

Health coaching

- 855.838.5897
- Fax: 803.264.4204

National Imaging Associates (advanced radiology preauthorization)

- 866.500.7664
- www.RadMD.com

State Dental Plan, Dental Plus

P.O. Box 100300 | Columbia, SC 29202-3300

- Customer Service: 888.214.6230 or 803.264.7323
- StateSC.SouthCarolinaBlues.com

Express Scripts

State Health Plan Prescription Drug Program, Express Scripts Medicare®

Claims: Attn: Commercial Claims | P.O. Box 2872 | Clinton, IA 52733-2872

Medicare members: Attn: Medicare Part D | P.O. 14718 | Lexington, KY 40512-4718

- Customer Service: 855.612.3128
- Express Scripts Medicare: 855.612.3128
- www.Express-Scripts.com

EyeMed

State Vision Plan (Group No.: 9925991)

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

- Customer Care Center: 877.735.9314
- www.eyemed.com

Metropolitan Life Insurance Company

Basic, optional and dependent life (Policy No.: 200879-1-G)

MetLife Recordkeeping and Enrollment Services
P.O. Box 14401 | Lexington, KY 40512-4401

- Customer Service: 800.GET.MET8
- Statement of Health: 800.638.6420, option 1
- Claims: 800.638.6420
- Continuation: 866.492.6983
- Conversion: 877.275.6387
- Fax: 866.545.7517

Selman & Company

GEA TRICARE Supplement Plan

6110 Parkland Boulevard | Cleveland, OH 44124

- Customer Service: 866.637.9911, option 1
- Claims fax: 800.310.5514
- www.selmantricareresource.cm/scpeba

The Standard Insurance Company

Long term disability (Group No.: 621144)

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

- Customer Service: 800.628.9696
- Fax: 800.437.0961
- Medical evidence of good health: 800.843.7979
- www.standard.com/mybenefits/southcarolina

Form 1095 for your 2017 taxes

The federal Affordable Care Act requires minimum essential health coverage. This applies to you and your dependents. Internal Revenue Service Form 1095 provides information about your health plan. The form includes the covered individuals. You should keep this form for your records since it verifies that you and your dependents have minimum essential health coverage.

Retirees, survivors and COBRA subscribers

If you are a non-Medicare retiree or COBRA subscriber, your former employer is responsible for sending you Form 1095 by January 31, 2018. If you are a non-Medicare survivor, PEBA is responsible for sending you Form 1095 form by January 31, 2018. If you or your covered dependents became eligible for Medicare during 2017, only the months you were not eligible for Medicare will be reflected on the form. If you or your covered dependents were eligible for Medicare all of 2017, you will not receive Form 1095. Since Medicare is a government-sponsored program, Medicare is responsible for reporting coverage information for you and your covered dependents.

Changes in your subscriber type

You may have changed subscriber types as a non-Medicare eligible member in 2017. If so, Form 1095 may contain all your coverage information. The Form would include your different types of coverage. You may receive two forms if you had different coverage from different employers. One will include your active coverage information. The other will include your retiree, survivor or COBRA coverage information.

Changes in employment status

If you were eligible for benefits as an active employee part of the year and were enrolled part of the year as a retiree, survivor or COBRA subscriber, all of your coverage information will be reported on one Form 1095 and sent by your former employer. If you or your covered dependents were Medicare eligible, only the months you were covered as an active employee will be reflected on the form. You may receive two forms if you had different coverage from different employers. One will include your active coverage information. The other will include your retiree, survivor or COBRA coverage information.

Free flu shot offered

State Health Plan primary members can receive a flu shot at no cost at a network pharmacy.

Vaccinations received at a network doctor's office are also covered. This includes the flu vaccine and the administration fee. But, regular Plan rules apply to any associated office visit charges.

South Carolina's flu season generally runs from October to March. September or October are usually the best times to get a flu shot. If you have questions about whether the vaccine is right for you, talk with your doctor. Learn more at www.PEBAperks.com.

Health benefits offered for 2018[1]

This chart is for comparison purposes only. For more information about these plans, refer to your 2018 *Insurance Benefits Guide*.

Plan[2]	Standard Plan[3]		Savings Plan		Medicare Supplemental Plan[3]
	In-network	Out-of-network	In-network	Out-of-network	
Availability	Coverage worldwide		Coverage worldwide		Same as Medicare Available to retirees and covered dependents/survivors who are eligible for Medicare
Annual deductible	Single: $445 Family: $890		Single: $3,600 Family: $7,2004		Pays Medicare Part A and Part B deductibles
Coinsurance[5]	Plan pays 80% You pay 20%	Plan pays 60% You pay 40%	Plan pays 80% You pay 20%	Plan pays 60% You pay 40%	Pays Part B coinsurance of 20%
Coinsurance maximum	Single $2,540 Family $5,080 Excludes deductible and copayments	Single $5,080 Family $10,160 Excludes deductible and copayments	Single $2,400 Family $4,800 Excludes deductible	Single $4,800 Family $9,600 Excludes deductible	None
Physicians' office visits	$12 copayment Plan pays 80% You pay 20%	$12 copayment Plan pays 60% You pay 40%	No copayment Plan pays 80% You pay 20%	No copayment Plan pays 60% You pay 40%	Pays Part B coinsurance of 20%
Blue CareOnDemand[5]	$12 copayment Plan pays 80% You pay 20%		No copayment Plan pays 80% You pay 20%		
Hospitalization/ emergency care	Outpatient facility services: $95 copayment Emergency care: $159 copayment Plan pays 80% You pay 20%	Outpatient facility services: $95 copayment Emergency care: $159 copayment Plan pays 60% You pay 40%	No copayments for outpatient facility services or emergency care		**For inpatient hospital stays:** Plan pays Medicare deductible; coinsurance for days 61-150; (Medicare benefits may end sooner if the member has previously used any of his 60 lifetime reserve days); 100% beyond 150 days (Medi-Call approval required) **Skilled nursing facility care:** Plan pays coinsurance for days 21-100; Plan pays 100% of approved days beyond 100 days, up to 60 days per year
Chiropractic	$2,000 limit per covered person		$500 limit per covered person		
Prescription drugs	**Retail pharmacies (up to 30-day supply)** • Tier 1 (generic): $9 • Tier 2 (brand): $38 • Tier 3 (brand): $63 **Retail maintenance network and mail order pharmacies (up to 90-day supply)** • Tier 1: $22 • Tier 2: $95 • Tier 3: $158 Copay maximum: $2,500 **Prescription drugs are not covered at out-of-network pharmacies.**		**Retail pharmacies and mail order** You pay the State Health Plan's allowed amount until your annual deductible is met. Afterward, the Plan will pay 80% of the allowed amount; you pay 20% in coinsurance. Drug costs are applied to your coinsurance maximum. When you reach the maximum, the Plan will pay 100% of the allowed amount, and you can get medications at no cost. **Prescription drugs are not covered at out-of-network pharmacies.**		**Retail pharmacies (up to 30-day supply)** • Tier 1 (generic): $9 • Tier 2 (brand): $38 • Tier 3 (brand): $63 **Retail maintenance network and mail order pharmacies (up to 90-day supply)** • Tier 1: $22 • Tier 2: $95 • Tier 3: $158 Copay maximum: $2,500

Footnotes listed on Page 12

2018 monthly premiums for funded retirees[1]

Retiree eligible for Medicare/spouse eligible for Medicare

Plan	Standard Plan	Savings Plan	Medicare Supp[7]	TRICARE Supp[2]	Dental	Dental Plus[6]	Vision
Retiree	$79.68	N/A	$97.68	N/A	$0	$27.12	$8.00
Retiree/spouse	$217.36	N/A	$253.36	N/A	$7.64	$54.80	$16.00
Retiree/children	$125.86	N/A	$143.86	N/A	$13.72	$63.20	$17.16
Full family	$270.56	N/A	$306.56	N/A	$21.34	$82.10	$25.16

Retiree eligible for Medicare/spouse not eligible for Medicare

Plan	Standard Plan	Savings Plan	Medicare Supp[7]	TRICARE Supp[2]	Dental	Dental Plus[6]	Vision
Retiree/spouse	$235.36	N/A	$253.36	N/A	$7.64	$54.80	$16.00
Full family	$281.54	N/A	$299.54	N/A	$21.34	$82.10	$25.16

Retiree not eligible for Medicare/spouse eligible for Medicare

Plan	Standard Plan	Savings Plan	Medicare Supp[7]	TRICARE Supp[2]	Dental	Dental Plus[6]	Vision
Retiree/spouse	$235.36	$77.40	$253.36	N/A	$7.64	$54.80	$16.00
Full family	$281.54	$113.00	$299.54	N/A	$21.34	$82.10	$25.16

Retiree not eligible for Medicare/spouse not eligible for Medicare

Plan	Standard Plan	Savings Plan	Medicare Supp[7]	TRICARE Supp[2]	Dental	Dental Plus[6]	Vision
Retiree	$97.68	$9.70	N/A	$62.50	$0	$27.12	$8.00
Retiree/spouse	$253.36	$77.40	N/A	$121.50	$7.64	$54.80	$16.00
Retiree/children	$143.86	$20.48	N/A	$121.50	$13.72	$63.20	$17.16
Full family	$306.56	$113.00	N/A	$162.50	$21.34	$82.10	$25.16

Retiree not eligible for Medicare/spouse not eligible for Medicare/one or more children eligible for Medicare

Plan	Standard Plan	Savings Plan	Medicare Supp[7]	TRICARE Supp[2]	Dental	Dental Plus[6]	Vision
Retiree/children	$143.86	$20.48	$161.86	N/A	$13.72	$63.20	$17.16
Full family	$306.56	$113.00	$324.56	N/A	$21.34	$82.10	$25.16

Footnotes listed on Page 12

2018 monthly premiums for non-funded retirees[1]

Retiree eligible for Medicare/spouse eligible for Medicare

Plan	Standard Plan	Savings Plan	Medicare Supp[7]	TRICARE Supp[2]	Dental	Dental Plus[6]	Vision
Retiree	$454.64	N/A	$472.64	N/A	$13.48	$27.12	$8.00
Retiree/spouse	$960.08	N/A	$996.08	N/A	$21.12	$54.80	$16.00
Retiree/children	$701.34	N/A	$719.34	N/A	$27.20	$63.20	$17.16
Full family	$1,200.46	N/A	$1,236.46	N/A	$34.82	$82.10	$25.16

Retiree eligible for Medicare/spouse not eligible for Medicare

Plan	Standard Plan	Savings Plan	Medicare Supp[7]	TRICARE Supp[2]	Dental	Dental Plus[6]	Vision
Retiree/spouse	$978.08	N/A	$996.08	N/A	$21.12	$54.80	$16.00
Full family	$1,211.44	N/A	$1,229.44	N/A	$34.82	$82.10	$25.16

Retiree not eligible for Medicare/spouse eligible for Medicare

Plan	Standard Plan	Savings Plan	Medicare Supp[7]	TRICARE Supp[2]	Dental	Dental Plus[6]	Vision
Retiree/spouse	$978.08	$820.12	$996.08	N/A	$21.12	$54.80	$16.00
Full family	$1,211.44	$1,042.90	$1,229.44	N/A	$34.82	$82.10	$25.16

Retiree not eligible for Medicare/spouse not eligible for Medicare

Plan	Standard Plan	Savings Plan	Medicare Supp[7]	TRICARE Supp[2]	Dental	Dental Plus[6]	Vision
Retiree	$472.64	$384.66	N/A	$62.50	$13.48	$27.12	$8.00
Retiree/spouse	$996.08	$820.12	N/A	$121.50	$21.12	$54.80	$16.00
Retiree/children	$719.34	$595.96	N/A	$121.50	$27.20	$63.20	$17.16
Full family	$1,236.46	$1,042.90	N/A	$162.50	$34.82	$82.10	$25.16

Retiree not eligible for Medicare/spouse not eligible for Medicare/one or more children eligible for Medicare

Plan	Standard Plan	Savings Plan	Medicare Supp[7]	TRICARE Supp[2]	Dental	Dental Plus[6]	Vision
Retiree/children	$719.34	$595.96	$737.34	N/A	$27.20	$63.20	$17.16
Full family	$1,236.46	$1,042.90	$1,254.46	N/A	$34.82	$82.10	$25.16

Footnotes listed on Page 12

2018 monthly premiums for non-funded survivors[1]

Spouse eligible for Medicare/children eligible for Medicare

Plan	Standard Plan	Savings Plan	Medicare Supp[7]	TRICARE Supp[2]	Dental	Dental Plus[6]	Vision
Spouse	$454.64	N/A	$472.64	N/A	$13.48	$27.12	$8.00
Spouse/children	$701.34	N/A	$737.34	N/A	$27.20	$63.20	$17.16
Children only	$246.70	N/A	$264.70[8]	N/A	$13.72	$36.08	$9.16

Spouse eligible for Medicare/children not eligible for Medicare

Plan	Standard Plan	Savings Plan	Medicare Supp[7]	TRICARE Supp[2]	Dental	Dental Plus[6]	Vision
Spouse	$454.64	N/A	$472.64	N/A	$13.48	$27.12	$8.00
Spouse/children	$701.34	N/A	$719.34	N/A	$27.20	$63.20	$17.16
Children only	$246.70	$211.30	N/A	N/A	$13.72	$36.08	$9.16

Spouse not eligible for Medicare/children eligible for Medicare

Plan	Standard Plan	Savings Plan	Medicare Supp[7]	TRICARE Supp[2]	Dental	Dental Plus[6]	Vision
Spouse	$472.64	$384.66	N/A	N/A	$13.48	$27.12	$8.00
Spouse/children	$719.34	$595.96	$737.34[8]	N/A	$27.20	$63.20	$17.16
Children only	$246.70	N/A	$264.70[8]	N/A	$13.72	$36.08	$9.16

Spouse not eligible for Medicare/children not eligible for Medicare

Plan	Standard Plan	Savings Plan	Medicare Supp[7]	TRICARE Supp[2]	Dental	Dental Plus[6]	Vision
Spouse	$472.64	$384.66	N/A	$62.50	$13.48	$27.12	$8.00
Spouse/children	$719.34	$595.96	N/A	$121.50	$27.20	$63.20	$17.16
Children only	$246.70	$211.30	N/A	$61.00	$13.72	$36.08	$9.16

Footnotes listed on Page 12

2018 monthly premiums for COBRAs[1]

18 and 36 months

Plan	Standard Plan	Savings Plan	Medicare Supp[7]	Dental	Dental Plus[6]	Vision
Subscriber	$482.10	$392.36	$482.10	$13.76	$27.66	$8.16
Subscriber/spouse	$1,016.00	$836.52	$1,016.00	$21.54	$55.90	$16.32
Subscriber/children	$733.74	$607.88	$733.74	$27.74	$64.46	$17.50
Full family	$1,261.20	$1,063.76	$1,261.20	$35.52	$83.74	$25.66
Children only	$251.60	$215.52	$251.64	$14.00	$36.80	$9.34

29 months

Plan	Standard Plan	Savings Plan	Medicare Supp[7]	Dental	Dental Plus[6]	Vision
Subscriber	$708.96	$577.00	$708.96	$13.76	$27.66	$8.16
Subscriber/spouse	$1,494.12	$1,230.18	$1,494.12	$21.54	$55.90	$16.32
Subscriber/children	$1,079.02	$893.94	$1,079.02	$27.74	$64.46	$17.50
Full family	$1,854.70	$1,564.36	$1,854.70	$35.52	$83.74	$25.66
Children only	$370.06	$316.94	$370.06	$14.00	$36.80	$9.34

2018 monthly premiums for former spouses[1,2]

Plan	Standard Plan	Savings Plan	Medicare Supp[7]	Dental	Dental Plus[6]	Vision
Not eligible for Medicare	$523.44	$435.46	N/A	$21.12	$32.54	$8.00
Eligible for Medicare	$505.44	N/A	$523.44	$21.12	$32.54	$8.00
COBRA (18 or 36 months)	$533.92	$444.18	$533.92	$21.54	$33.20	$8.16
COBRA (29 months)	$785.16	$653.20	$785.16	$21.54	$33.20	$8.16

Footnotes for comparison and premium charts on Pages 8-12:

[1]Premiums for local subdivisions may vary. To verify your rates, contact your benefits office.

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

[3]Refer to your 2018 *Insurance Benefits Guide* for information on how this plan coordinates with Medicare.

[4]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.

[5]Standard Plan subscribers who receive care at a BlueCross BlueShield of South Carolina-affiliated PCMH provider will not be charged the $12 copayment for a physician office visit. After Savings Plan and Standard Plan subscribers meet their deductible, they will pay 10 percent coinsurance, rather than 20 percent, for care at a PCMH.

[6]If you enroll in Dental Plus, you must also be enrolled in the State Dental Plan. You will pay the combined premiums for both plans.

[7]If the Medicare Supplemental Plan is elected, claims for covered subscribers not eligible for Medicare will be based on the Standard Plan provisions.

[8]This premium applies only if one or more children are eligible for Medicare.

See for yourself the convenience of your vision benefits

Your life is busy. Your benefits need to be convenient, easy-to-use and fit your lifestyle. In other words, your benefits should feel like—a benefit.

The State Vision Plan gives you that. You can use your in-network vision benefits online at Glasses.com and ContactsDirect. You also have access to thousands of independent providers and top optical retailers.

Here's a quick look at what you can expect from EyeMed's online providers:

Glasses.com	ContactDirect
• Access the award-winning 3D virtual try-on app. • Choose from a large selection of high quality frames and lenses, including some of the world's leading brands. • In-browsing benefit application allows you to see what you'll pay while you are shopping .	• Apply your in-network vision benefits to your online transaction. • Order contact lenses and have them shipped straight to your door for free once your prescription is verified.

All you will need is a valid prescription from your eye doctor to get started. Log on to www.eyemed.com to use your benefits online or to find a provider near you. You will also find a detailed description of all your vision benefits.

How much health insurance do you need?

Do you have more than one Medicare Supplement plan? You only need one supplement to traditional Medicare.

Having too much health insurance can cost you more. It can also cause claims issues as insurance companies try to determine who the primary payer is.

Are you eligible for Medicare and TRICARE for life? If so, you don't need the State Health Plan Medicare Supplemental plan.

Open enrollment is the perfect time to drop unneeded insurance. You can still keep your dental and vision coverage even if you don't have the health insurance.

If changes occur, you can always re-enroll in the Medicare Supplemental plan. You may do so within 30 days of the change.

You can switch to the Medicare Supplemental plan during any open enrollment period. Your effective date of coverage would be the following January 1.

Federally mandated notices

Federal law requires health plans to send a variety of notices to subscribers and their dependents, concerning their rights under the health plan. The notices are included on Pages 14-23. It is important that you read these notices. It is also important that each family member you cover be familiar with this information. Questions regarding these notices can be directed to PEBA at 803.737.6800, 888.260.9430 or online at www.peba.sc.gov.

Newborn's and mother's health protection act

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section.

However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Summaries of Benefits and Coverage

The 2018 *Summaries of Benefits and Coverage* for the Standard Plan and Savings Plan are available online at www.peba.sc.gov/ipublications.html. To request a copy at no charge, call PEBA at 803.737.6800 or 888.260.9430.

Grandfathered notice

The S.C. Public Employee Benefit Authority believes the State Health Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted.

Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

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

HIPAA notice of special enrollment rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage).

However, you must request enrollment within 31 days after our or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

To request special enrollment or obtain more information, contact your benefits administrator.

Notice of Privacy Practices

Effective: April 14, 2003
Revised: September 1, 2016

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

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

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

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

How PEBA may use and disclose protected health information

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

- **For treatment.** PEBA may use and disclose your protected health information to coordinate and manage your health care-related services by one or more of your health care providers. For example, a representative of PEBA, a case manager and your doctor may discuss the most beneficial treatment plan for you if you have a chronic condition such as diabetes.
- **For payment.** PEBA may use and disclose your protected health information to bill, collect payment and pay for your treatment/services from an insurance company or another third party; to obtain premiums; to determine or fulfill its responsibility for coverage or provision of benefits; or to provide reimbursement for health care. For example, PEBA may need to give your protected health information to another insurance provider to facilitate the coordination of benefits or to your employer to facilitate the employer's payment of its portion of the premium.
- **For health care operations.** PEBA may use and disclose protected health information about you for other PEBA operations. PEBA may use protected health information in connection with conducting quality assessment and improvement activities; reviewing the competence or qualifications of health care professionals; evaluating practitioner, provider and health plan performance; underwriting, premium rating and other activities relating to health plan coverage; conducting or arranging for medical review, legal services, audit services and fraud and abuse detection programs; business planning and development such as cost management; and business management and general administrative activities. For example, PEBA may disclose your protected health information to an actuary to make decisions regarding premium rates, or it may share your protected health information with other business associates that, through written agreement, provide services to PEBA. These business associates, such as consultants or third-party administrators, are required to protect the privacy of your protected health information.
- **For purposes of administering the plan.** PEBA may disclose your protected health information to its Plan sponsor, the South Carolina Public Employee Benefit Authority, for the purpose of administering the Plan. For example, PEBA may disclose aggregate claims information to the Plan sponsor to set Plan terms. However, consistent with the Genetic Information Nondiscrimination Act (GINA), PEBA will not use or disclose, for underwriting purposes, protected health information that is genetic information.
- **Business associates.** PEBA may contract with

individuals or entities known as Business Associates to perform various functions on PEBA's behalf or to provide certain types of services. For example, PEBA may disclose your protected health information to a Business Associate to process your claims for Plan benefits, pharmacy benefits, or other support services, but the Business Associate must enter into a Business Associate contract with PEBA agreeing to implement appropriate safeguards regarding your protected health information.

- **Treatment alternatives and health-related benefits and services.** PEBA may use and disclose your protected health information to contact you about health-related benefits or services that may be of interest to you. For example, you may be contacted and offered enrollment in a program to assist you in handling a chronic disease such as disabling high blood pressure.
- **Individuals involved in your care or payment for your care.** PEBA may, in certain circumstances, disclose protected health information about you to your representative such as a friend or family member who is involved in your health care, or to your representative who helps pay for your care. PEBA may disclose your protected health information to an agency assisting in disaster relief efforts so that your family can be notified about your condition, status and location.
- **Research.** PEBA may use and disclose your de-identified protected health information for research purposes or PEBA may share protected health information for research approved by an institutional review board or privacy board after review of the research rules to ensure the privacy of your protected health information. For example, a research project may compare the health/recovery of patients who receive a medication with those who receive another medication for the same condition.
- **As required by law.** PEBA will disclose protected health information about you when it is required to do so by federal or South Carolina law. For example, PEBA will report any suspected insurance fraud as required by South Carolina law.
- **To avert a serious threat to health or safety, or for public health activities.** PEBA may use and disclose protected health information about you when necessary to prevent a serious threat to your health and safety, or to the health and safety of the public, or for public health activities.
- **Organ and tissue donation.** If you are an organ donor, PEBA may disclose your protected health information to organizations that handle organ, eye or tissue procurement, transplantation or donation.
- **Coroners, medical examiners and funeral directors.** PEBA may share your protected health information with a coroner/medical examiner or funeral director as needed to carry out their duties.
- **Military and veterans.** If you are a member of the armed forces, PEBA may disclose protected health information about you after the notice requirements are fulfilled by military command authorities.
- **Workers' compensation.** PEBA may disclose protected health information about you for workers' compensation or similar programs that provide benefits for work-related injuries or illness. Health oversight activities. PEBA may disclose your protected health information to a health oversight agency for authorized activities such as audits and investigations.
- **Lawsuits and disputes.** PEBA may disclose your protected health information in response to a court or administrative order, a subpoena, discovery request, or other lawful process if PEBA receives assurance from the party seeking the information that you have either been given notice of the request, or that the party seeking the information has tried to secure a qualified protective order regarding this information.
- **Law enforcement.** PEBA may disclose information to a law enforcement official in response to a court order, subpoena, warrant, summons, or similar process.
- **National security, intelligence activities and protective services.** PEBA may disclose your protected health information to authorized officials for intelligence, counterintelligence and other national security activities; to conduct special investigations; and to provide protection for the President, other authorized persons or foreign heads of state.
- **Inmates.** If you are an inmate of a correctional institution or are in the custody of a law enforcement official, PEBA may disclose your protected health information if the disclosure is necessary to provide you with health care, or to protect your health and safety or the health and safety of others.
- **Fundraising.** PEBA will not use or release your protected health information for purposes of fund-raising activities.
- **Sale or marketing.** Your authorization is required for PEBA's use or disclosure of any PHI for marketing purposes, or for any disclosure by PEBA that constitutes the sale of PHI.

Your rights regarding your protected health information

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

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

right to request a paper copy of this notice at any time by contacting PEBA's HIPAA Privacy Officer at: S.C. Public Employee Benefit Authority, Attn: HIPAA Privacy Officer, 202 Arbor Lake Drive, Columbia, SC 29223. You may obtain a copy of this notice at PEBA's website at www.peba.sc.gov

- **Right to breach notification.** You have the right to be notified of any breach of your unsecured protected health information.

Complaints

If you believe that your protected health information rights, as stated in this notice, have been violated, you may file a complaint with PEBA's HIPAA Privacy Officer and/or with the Office for Civil Rights, US Department of Health and Human Services.

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

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

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

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

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

Changes to this notice

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

Other uses of protected health information

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

New health insurance marketplace coverage options and your health coverage

PART A: General information

To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-¬based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2017 for coverage starting as early as January 1, 2018.

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5 percent of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How can I get more information?

For more information about your coverage offered by your employer, please check your summary plan description or contact your employer's human resources department.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

Medicare Part D creditable coverage letter

Important notice from PEBA about your prescription drug coverage and Medicare

Please read this notice carefully and keep it where you can find it.

This notice has information about your current prescription drug coverage with PEBA and about your options under Medicare's prescription drug coverage. This information can help you decide whether you want to join a Medicare prescription drug plan other than Express Scripts Medicare, the State Health Plan's Medicare prescription drug program.

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

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

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

When can you join a Medicare prescription drug plan?

You can join a Medicare prescription drug plan when you first become eligible for Medicare and each year from October 15 to December 7. However, if you lose your current creditable prescription drug coverage, through no

fault of your own, you will also be eligible for a two-month Special Enrollment Period to join a Medicare prescription drug plan.

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

If you decide to join a Medicare prescription drug plan other than the one sponsored by PEBA, you will lose your prescription drug coverage provided through your health plan with PEBA, and your premiums will not decrease. Please note that you and your dependents will be able to get this coverage back. Before you decide to switch to other Medicare prescription drug coverage and drop your PEBA coverage, you should compare your PEBA coverage, including which drugs are covered, with the coverage and cost of any plans offering Medicare prescription drug coverage in your area.

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

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

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1 percent of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19 percent higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

Contact PEBA at the address or telephone number listed below.

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

For more information about your options under Medicare prescription drug coverage

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

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

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

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

Contact PEBA for further information.

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

S.C. Public Employee Benefit Authority

202 Arbor Lake Drive

Columbia, SC 29223

803.737.6800 | 888.260.9430

www.peba.sc.gov

Women's health and cancer rights act

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses and complications resulting from a mastectomy, including lymphedema?

Call your plan administrator at 803.737.6800 or 888.260.9430 for more information.

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

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

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available. If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1.877.KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan. If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1.866.444.EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2017. Contact your State for more information on eligibility. To see if any other states have added a premium assistance program since January 31, 2017, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration

www.dol.gov/agencies/ebsa
866.444.EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
877.267.2323, Menu Option 4, Ext. 61565

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1.855.692.5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1.877.357.3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1.866.251.4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid Click on Health Insurance Premium Payment (HIPP) Phone: 404.656.4507
ARKANSAS– Medicaid	**INDIANA– Medicaid**
Website: http://myarhipp.com/ Phone: 1.855.MyARHIPP (855.692.7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 877.438.4479 Other Medicaid: Website: http://www.indianamedicaid.com Phone: 800.403.0864

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	IOWA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 800.221.3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 800.359.1991/ State Relay 711	Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 888.346.9562
KANSAS – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://www.kdheks.gov/hcf/ Phone: 785.296.3512	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603.271.5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://chfs.ky.gov/dms/default.htm Phone: 800.635.2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609.631.2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 800.701.0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 888.695.2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 800.541.2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 800.442.6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919.855.4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 800.462.1120	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 844.854.4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 800.657.3739	Website: http://www.insureoklahoma.org Phone: 888.365.3742

MISSOURI – Medicaid	OREGON – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573.751.2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1.800.699.9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 800.694.3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1.800.692.7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 855.632.763	Website: http://www.eohhs.ri.gov/ Phone: 401.462.5300
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: https://dwss.nv.gov/ Medicaid Phone: 800.992.0900	Website: https://www.scdhhs.gov Phone: 888.549.0820
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 888.828.0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 800.562.3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 800.440.0493	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 877.598.5820, HMS Third Party Liability
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 877.543.7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 800.362.3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307.777.7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 800.432.5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 855.242.8282	

south carolina peba
state health plan | retirement systems

202 Arbor Lake Drive
Columbia, SC 29223

Tobacco cessation at no cost

This benefit provides enrollment in the Quit For Life® program at no cost. It also includes a $0 copay for tobacco cessation drugs to eligible participants. Covered spouses and dependent children age 13 or older are also eligible for the program.

The American Cancer Society and Alere Wellbeing sponsors the research-based Quit For Life Program. An expert Quit Coach® will support you over the phone, online and via text. He'll help you follow a Quitting Plan customized to your needs.

Your Quit Coach may recommend that a doctor prescribe a tobacco cessation drug, such as bupropion or Chantix. These drugs are available through the State Health Plan's prescription drug coverage at no cost at an in-network pharmacy. For eligible members age 18 and older, the program also provides free nicotine replacement therapy. This may include patches, gum or lozenges, if appropriate.

To enroll

You can enroll by phone or online. After verifying your eligibility, you can talk to a Quit Coach.

1. Call 800.652.7230 (the State Health Plan's dedicated Quit for Life phone line) or call 866.QUIT.4.LIFE (866.784.8454).
2. Visit www.quitnow.net/SCStateHealthPlan.

Have you moved? Let us know!

If you have recently moved or if you plan to move soon, be sure to use MyBenefits, to change your address in our system.

It is particularly important that you keep your address up to date. This ensures that you receive benefits information, including Internal Revenue Service Form 1095.

You will receive Form 1095 by January 31. The form shows you have "minimum essential" health insurance coverage. The federal Affordable Care Act requires that you have this coverage.

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